Sunset Review

November 1, 2014

Department of Consumer Affairs
DENTAL BOARD OF CALIFORNIA

DENTAL BOARD of CALIFORNIA

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Executive Officer

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TABLE OF CONTENTS

SECTION 4: LICENSURE PROGRAM (CONTINUED)

SECTION 5: ENFORCEMENT PROGRAM

DENTAL BOARD OF CALIFORNIA
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of October 3, 2014

Section 1
Background and Description of the Dental Board and Regulated Profession

Provide a short explanation of the history and function of the Dental Board.[1] Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

1. Describe the makeup and functions of each of the Dental Board's committees (cf., Section 12, Attachment B).

History and Function of the Board:
The Dental Board of California was created by the California Legislature in 1885, and was originally established to regulate dentists. Today, the Dental Board is responsible for regulating the practice of approximately 98,000 licensed dental healthcare professionals in California, including but not limited to, 43,385 dentists, 52,676 registered dental assistants (RDAs), and approximately 1,617 registered dental assistants in extended functions (RDAEFs). In addition, the Dental Board is responsible for setting the duties and functions of approximately 50,000 unlicensed dental assistants. The Dental Board, as a whole, generally meets at least four times throughout the year to address work completed by various committees of the Board and hear disciplinary cases.

Chapter 4, Article 1, § 1601.2 of The Dental Practice Act states:

> "Protection of the public shall be the highest priority for the Dental Board of California in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests Sought to be promoted, the protection of the public shall be paramount."

In concert with this statutory mandate, the Board formally adopted a mission statement in its 2013-2015 Strategic Plan, as follows: "The Dental Board of California's mission is to protect and promote the oral health and safety of California consumers by ensuring the quality of dental health care within the State." Additionally the Strategic Plan also includes a vision statement as follows: "The Dental Board of California will be the recognized leader in public protection, promotion of oral health, and access to quality care.

[1] The term "board" in this document refers to a board, bureau, commission, committee, department, division, program, or agency, as applicable. Please change the term "board" throughout this document to appropriately refer to the entity being reviewed.

To meet its stated priorities, the Board implements regulatory programs and performs a variety of functions. These programs and activities include setting licensure requirements for dentists and dental assistants, including examination requirements, issuing and renewing licenses, and a variety of permits and certifications. The Board also has its own enforcement division (sworn and non-sworn) tasked with investigating both criminal and administrative violations of the Dental Practice Act and other laws. As part of the disciplinary function of the Board, probationer dentists and RDAs are monitored, and the Board manages a Diversion Program for its licensees whose practice may be impaired due to chemical dependence or mental illness.

Dental Board Composition:

The Board is composed of 15 members; eight (8) practicing dentists, one (1) registered dental hygienist (RDH), one (1) RDA, and five (5) public members. The licensed dentists, the RDH, the RDA, and three (3) public members are appointed by the Governor. Of the remaining two public members, one is appointed by the Speaker of the Assembly and one by the Senate Rules Committee. Public membership accounts for a third of the composition of the Board. Of the eight (8) practicing dentists, one must be a member of the faculty of any California dental school, and one is required to be a dentist practicing in a nonprofit community clinic.

Members of the Dental Board are appointed for a term of four (4) years. Board members may continue to hold office beyond their term until the appointment of a successor or until one (1) year has elapsed since the expiration of the term, whichever occurs first. Each member may serve no more than 2 full terms.

Board Committees, Their Make-up, and Functions:

The Dental Board has eight (8) Committees, one (1) Council, and several Subcommittees which assist with the work of the Board. Four (4) of the Committees and the Council are statutorily mandated, others are established by the Board to meet specific needs. Committee members are Dental Board members who are appointed by, and serve at, the will of the Board President. There are a minimum of four (4) meetings per year. Committees meet on the first day of the two-day meeting and give their reports to the full board on day two. Issues may be brought before a Committee by consumers, stakeholders, and/or Board members. When necessary, staff researches the issues and reports to the Committee. During the Committee meeting, issues are discussed and public comment is accepted. When appropriate, the Committee brings a recommendation before the full Board for adoption or direction on proceeding.

At various times, the Board President will appoint a two-member subcommittee (both Board members) to work closely with staff on issues such as infection control, dental assisting scope of practice, dental assisting educational program and course requirements, licensure requirements, and examination requirements.

Currently there are active Committees dealing with enforcement, examinations, legislation, license certification and permits, access to care, prescription drug abuse, elective facial cosmetic surgery permit credentialing, and diversion evaluation.

Enforcement Committee (Statutory Committee – B&P Code* § *1601.1)
The Enforcement Committee is made up of five (5) members; one (1) public member, three (3) dentists, and one (1) registered dental hygienist. This Committee reviews complaint and compliance case aging statistics, citation and fine information, and investigation case aging statistics in order to identify trends that might require changes in policies, procedures, and/or regulations. This Committee also receives updates on the Diversion Program.

Examination Committee (Statutory Committee – B&P Code* § *1601.1)
This Committee reviews clinical/practical and written examination statistics and receives reports on all examinations conducted by staff. Any issues relating to examinations can be brought before this Committee by consumers, stakeholders, or a Board member. The Committee consists of seven (7) members; one (1) public member, five (5) dentists, and one (1) registered dental assistant.

Elective Facial Cosmetic Surgery Permit Credentialing Committee (Statutory Committee – B&P Code* § *1638.1)
Senate Bill 438 (Chapter 909, Statutes of 2006) enacted B&P Code § 1638.1 which authorized the Board to issue Elective Facial Cosmetic Surgery (EFCS) permits to qualified licensed dentists and established the EFCS Credentialing Committee to review the qualifications of each applicant for a permit. The Credentialing Committee is composed of five (5) members; three (3) oral and maxillofacial surgeons, one (1) physician and surgeon with a specialty in plastic and reconstructive surgery, and one (1) physician and surgeon with a specialty in otolaryngology, all of whom must maintain an active status on the staff of a licensed general acute care hospital in California. Credentialing Committee members are not members of the Dental Board.

Credentialing Committee members review the qualifications of an applicant for an EFCS permit in closed session at Committee meetings. The information discussed in closed session is confidential. Upon completion of the application review, the Committee makes a recommendation to the Board on whether to issue or not issue a permit to the applicant. The permit may be unlimited, entitling the permit holder to perform any facial cosmetic surgical procedure authorized by the statute, or it may contain limitations if the Credentialing Committee is not satisfied that the applicant has the training or competence to perform certain classes of procedures, or if the applicant has not requested a permit for all procedures authorized in the statute.

Diversion Evaluation Committee (Statutory Committee – B&P Code* § *1695.3)
A 1982 legislative mandate required the Dental Board to seek ways and means to identify and rehabilitate licensees whose competency may be impaired due to alcohol, or substance abuse. Given the ability to establish one or more committees to carry out this mandate, the Board established two (2) such committees, one (1) in Southern California and one (1) in Northern California.

Each committee is composed of three (3) licensed dentists, one (1) licensed dental auxiliary, one (1) public member and one (1) licensed physician or psychologist. All must

be experienced or knowledgeable in chemical dependency either through education, training, experience or personal recovery.

Dental Assisting Council (Statutory Committee – B&P Code* § *1742)
Senate Bill 540 (Chapter 385, Statutes of 2011) enacted B&P Code § 1742 created the Dental Assisting Council (Council) of the Dental Board of California. The Council considers all matters relating to dental assistants in the State of California, on its own initiative or at the request of the Board. Issues might relate to:

- exam requirements
- licenses and permits, and renewal
- criteria for approval of dental assisting educational programs
- continuing education
- dental assistant duties, settings, and supervision levels
- appropriate standards of conduct
- enforcement issues for dental assistants
- requirements regarding infection control

The Council meets in conjunction with other Board committees and at other times as deemed necessary. Any resulting recommendations are made to the Board for consideration and possible further action.

The Council is composed of seven (7) members, including the RDA member of the Board, another member of the Board, and five (5) RDAs who represent as broad a range of dental assisting experience and education as possible. Two of the five RDA members are required to be employed as faculty members of a registered dental assisting educational program approved by the Board and must have been so employed for at least the five (5) years prior to appointment. Three of the five RDA members, one of which must be licensed as a RDAEF, are required to be employed clinically in private dental practice or public safety net or dental health care clinics. All five of the RDA members must have possessed a current, active RDA or RDAEF license for at least the prior five years and cannot be employed by a current member of the Dental Board. Council members serve for a term of four (4) years.

Legislative and Regulatory Committee (non-statutory)
This Committee monitors legislation relative to the field of dentistry that may impact the Board, consumers, and/or licensees, and makes recommendations to the full Board whether or not to support, oppose, or watch the legislation. The Committee Chair attends Senate and Assembly Committee hearings and may meet with legislators if the Board so directs. The Committee also discusses prospective legislative proposals and pending regulatory actions. Regulations are promulgated and amended by this Committee, with its recommendations going before the full Board. There are five (5) committee members; two (2) public members and three (3) dentists.

Licensing, Certification, and Permits Committee (non-statutory)
The Licensing, Certification, and Permits Committee has five (5) members; two (2) public members, two (2) dentists, and one (1) registered dental assistant. This Committee reviews licensure and permit statistics for dentists and auxiliaries, and looks for trends that might indicate efficiency and effectiveness or might identify areas in the licensing units that need modifications. When necessary, the Committee meets in closed session to review applications for reissuance of cancelled licenses.

Access to Care Committee (non-statutory)
The Committee consists of six (6) members including three (3) public members, two (2) dentists, and one (1) dental hygienist. This Committee was established to maintain awareness of the changes and challenges within the dental community. An ongoing objective is to identify areas where the Board can assist with workforce development, such as through the existing Dental Loan Repayment Program. A new focus on publicizing this program will help fulfill the original intent of the Legislature to recruit dentists to practice in underserved areas, while assisting with dental education loan repayment.

Prescription Drug Abuse Committee (non-statutory)
The Prescription Drug Abuse Committee was assembled in May 2014 to examine the rise in prescription drug overdoses and to develop strategies to address the issue within the practice of dentistry. The Committee consists of six (6) members; five (5) dentists and one (1) public member.

2. In the past four years, was the Dental Board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

During the past four years, the Dental Board has had a quorum present at each meeting to conduct Board business.

3. Describe any major changes to the Dental Board since the last Sunset Review, including:

- Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)
- All legislation sponsored by the Dental Board and affecting the Dental Board since the last sunset review.
- All regulation changes approved by the Dental Board since the last sunset review. Include the status of each regulatory change approved by the Board.

<u>Internal Changes:</u>

Since the Board's last Sunset Review in 2011, the following internal changes have occurred:

- Established a new Investigative Analysis Unit (IAU) within the Board's Enforcement Program, using funding and positions from the Department's Consumer Protection Enforcement Initiative (CPEI). The unit, composed of one (1) staff manager, two (2) special investigators, and three (3) associate governmental program analysts (AGPA), is focused on quality of care and criminal conviction cases and has streamlined investigative timelines. CPEI also added two (2) sworn investigators and two (2) special investigators to the field offices, and one and a half (1.5) AGPA positions to the Discipline Coordination Unit to handle the increase in investigations that have resulted in an increase in accusations filed.

- Implemented an automated Investigator Activity Reporting (IAR) system in the Enforcement Program to enhance management of cost recovery information and investigative casework.

- Implemented computer-based testing for the Board's CA Law and Ethics examination to make it easier for DDS applicants to complete this requirement and qualify for licensure.

- Appointed a Dental Assisting Council to consider all matters relating to dental assistants in California and to make recommendations to the Board and its committees. Council members participated in their first Board meeting in May 2012.

- Revised the RDA Written and CA Law and Ethics examinations.

- Updated and adopted the goals and objectives of the Board's Strategic Plan which will cover the years 2013-2016. The Dental Board, working with DCA's strategic plan facilitators, held an open meeting with staff managers, board members and stakeholders to develop a comprehensive and inclusive plan for the next four years. Staff developed tasks and measures to go with the new and expanded goals and objectives.

- Revised the Orthodontic Assistant Permit examination.

- Revised the Dental Sedation Assistant Permit examination.

- Conducted the Examination Validation for the WREB.

- Appointed a new Executive Officer.

- The Governor appointed six (6) new Board members and reappointed three (3).

Legislation Sponsored by the Board:

The Board sponsored the following legislation since its last Sunset Review in 2011:

- Senate Bill 1416 (Block, Chapter 73, Statutes of 2014) B&P Code § 1724 establishes a fee of $525 that the Board may assess for initial DDS licensure and biennial renewal. As a result of raising these fees, the following ancillary fees are impacted because they are determined by the initial DDS licensure and renewal fee, as provided in statute:
    - Inactive Licenses;
    - Licenses on Retirement Status;
    - Licenses on Disability Status;
    - Oral and Maxillofacial Surgery (OMS) Permit Renewal Fees;
    - Fictitious Name Permit Application Fees; and,
    - Delinquent Retirement/Disability Renewal

Legislation Affecting the Board Since Last Sunset Review:

The Board has been affected by the following legislation since its last Sunset Review in 2011:

- AB 1088 (Eng, Chapter 689, Statutes of 2011) requires every state agency, board, or commission that directly or by contract, collects demographic data as to the ancestry or ethnic origin of Californians shall use additional separate collection categories and tabulations for each major Asian groups, including, but not limited to, Bangladeshi, Fijian, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Thai, and Tongan Asian Indian, Bangladeshi, Cambodian, Chinese, Filipino, Hmong, Indonesian, Japanese, Korean, Laotian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Thai, Vietnamese, Fijian, Native Hawaiian, Guamanian (also known as Chamorro), Samoan, and Tongan. This information shall be included in every demographic report on ancestry or ethnic origins of Californians that it publishes or releases on or after July 1, 2012, and be available to the public in accordance with state and federal law. A state agency shall, within 18 months after the United States Census is released to the public, update their data collection to reflect the additional Asian groups and additional Native Hawaiian and Pacific Islander groups as they are reported by the United States Census Bureau. This bill further requires the State Department of Health Care Services, the State Department of Public Health, the Department of Industrial Relations, and the Department of Fair Employment and Housing to make this information publicly available, except for personal identifying information, which shall be deemed confidential, by posting the data on the Internet Website of the agency on or before July 1, 2012, and annually thereafter. This would not prevent any other state agency from posting the information on their Internet Web site.

- AB 1424 (Perea, Chapter 455, Statutes of 2011) requires the State Board of Equalization, quarterly, and the Franchise Tax Board, at least twice each calendar year, to make available a list of the 500 largest tax delinquencies in excess of $100,000. This bill requires the Franchise Tax Board to include additional information on the list with respect to each delinquency, including the type, status, and license number of any occupational or professional license

held by the person or persons liable for payment of the tax and the names and titles of the principal officers of the person liable for payment of the tax if that person is a limited liability company or corporation. This bill requires a person whose delinquency appeared on either list and whose name has been removed, as provided, to comply with the terms of the arranged resolution, and would authorize the State Board of Equalization and the Franchise Tax Board, if the person fails to comply with the terms of the arranged resolution, to add the person's name to the list without providing prior written notice, as provided. This bill requires a state governmental licensing entity, other than the Department of Motor Vehicles, State Bar of California, and Alcoholic Beverage Control Board, as provided, that issues professional or occupational licenses, certificates, registrations, or permits, to suspend, revoke, and refuse to issue a license if the licensee's name is included on either list of the 500 largest tax delinquencies described above. This bill would not include the Contractors' State License Board in the definition of "state governmental licensing entity." This bill also requires those licensing entities to collect the social security number or federal taxpayer identification number of each individual applicant of that entity for the purpose of matching those applicants to the names on the lists of the 500 largest tax delinquencies, and would require each application for a new license or renewal of a license to indicate on the application that the law allows the State Board of Equalization and the Franchise Tax Board to share taxpayer information with a board and requires the licensee to pay his or her state tax obligation and that his or her license may be suspended if the state tax obligation is not paid. This bill authorizes the State Board of Equalization and the Franchise Tax Board to disclose to state governmental licensing entities identifying information, as defined, of persons on the list of the 500 largest tax delinquencies, as specified. This bill authorizes a motor carrier permit of a licensee whose name is on the certified list of tax delinquencies to be suspended, as provided. The bill requires the State Board of Equalization and the Franchise Tax Board to meet certain requirements and would make related changes.

- AB 1588 (Atkins, Chapter 742, Statutes of 2012) requires boards within the Department of Consumer Affairs, with certain exceptions, to waive the renewal fees, continuing education requirements, and other renewal requirements as determined by the board, if any are applicable, of any licensee or registrant who is called to active duty as a member of the United States Armed Forces or the California National Guard if certain requirements are met. The bill, except as specified, prohibits a licensee or registrant from engaging in any activities requiring a license while a waiver is in effect. The bill requires a licensee or registrant to meet certain renewal requirements within a specified time period after being discharged from active duty service prior to engaging in any activity requiring a license. The bill requires a licensee or registrant to notify the board of his or her discharge from active duty within a specified time period.

- AB 1896 (Chesbro, Chapter 119, Statutes of 2012) Under existing federal law, licensed health professionals employed by a tribal health program are required to be exempt, if licensed in any state, from the licensing requirements of the state in which the tribal health program performs specified services. A tribal

health program is defined as an Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service. AB 1896 codifies that federal requirement by specifying that a person who is licensed as a health care practitioner in any other state and is employed by a tribal health program is exempt from this state's licensing requirements with respect to acts authorized under the person's license where the tribal health program performs specified services.

- AB 1904 (Block, Chapter 399, Statutes of 2012) requires boards within the Department of Consumer Affairs to expedite the licensure process for an applicant who holds a license in the same profession or vocation in another jurisdiction and is married to, or in a legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

- AB 2041 (Swanson, Chapter 723, Statutes of 2012) requires an agency that proposes specified types of regulations to include within the notice of proposed action a specified statement regarding the availability of narrative descriptions for persons with visual or other specified disabilities.

- AB 2570 (Hill, Chapter 561, Statutes of 2012) prohibits a licensee who is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs, or an entity or person acting as an authorized agent of a licensee, from including or permitting to be included a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program, or that requires the other party to withdraw a complaint from the department, board, bureau, or program, except as specified. A licensee in violation of these provisions would be subject to disciplinary action by the board, bureau, or program. The bill also prohibits a board, bureau, or program from requiring its licensees in a disciplinary action that is based on a complaint or report that has been settled in a civil action to pay additional moneys to the benefit of any plaintiff in the civil action. This bill authorizes a board, bureau, or program within the Department of Consumer Affairs to adopt a regulation exempting agreements to settle certain causes of action from these provisions.

- SB 540 (Price, Chapter 385, Statutes of 2011) extends the operation the Dental Board of California until January 1, 2016, and specifies that the board would be subject to review by the appropriate policy committees of the Legislature. The bill changes the membership of the board to include one additional public member, to be appointed by the Governor. The bill creates a Dental Assisting Council of the board, to be appointed by the board, to consider matters relating to dental assistants and make recommendations to the board and standing committees of the board, as specified. This bill contains other related provisions and other existing laws.

- SB 541 (Price, Chapter 339, Statutes of 2011), sponsored by the Medical Board of California and the Contractors State License Board, is an urgency measure that authorizes any board, within the Department of Consumer Affairs, the State Board of Chiropractic Examiners, and the Osteopathic Medical Board of California to enter into an agreement with an expert consultant to do any of the following:
    - Provide an expert opinion on enforcement-related matters, including providing testimony at an administrative hearing.
    - Assist the board as a subject matter expert in examination development, examination validation, or occupational analyses.
    - Evaluate the mental or physical health of a licensee or an applicant for a license as may be necessary to protect the public health and safety.

  An executed contract between a board and an expert consultant shall be exempt from the State Contract Act. Each board is required to establish policies and procedures for the selection and use of expert consultants. Nothing in this bill should be construed to expand the scope of practice of an expert consultant providing services pursuant to this section.

- SB 943 (Senate Business, Professions and Economic Development Committee, Chapter 350, Statutes of 2011) makes several non-controversial, minor, non-substantive or technical changes to various miscellaneous provisions pertaining to healing arts boards of the Department of Consumer Affairs and professions regulated under the Business and Professions Code, including the Dental Hygiene Committee of California.

- SB 1099 (Wright, Chapter 295, Statutes of 2012) makes the following changes to the Administrative Procedure Act:
    - Provides that a regulation or order of repeal is effective on January 1, April 1, July 1, or October 1, as specified, subject to certain exceptions, including, but not limited to, specified regulations adopted by the Fish and Game Commission.
    - Requires the Office of Administrative Law to provide on its Internet Web site a list of, and a link to the full text of, each regulation filed with the Secretary of State that is pending effectiveness, as specified.
    - Requires a state agency to post on its Internet Web site each regulation that is filed with the Secretary of State, as specified, and to send to the Office of Administrative Law the Internet Web site link of the regulation. The bill does not apply to a state agency that does not maintain an Internet Web site.

- SB 1202 (Leno, Chapter 331, Statutes of 2012) makes changes to the Dental Practice act as it relates to the licensure and regulation of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions by the Dental Hygiene Committee of California. This bill eliminates the good standing requirement and would instead authorize any dental hygiene program accredited by the commission to be

approved by the Committee. The bill authorizes the Committee to withdraw or revoke program approval if the commission intends to withdraw or has withdrawn approval. This bill additionally requires an applicant for licensure as a registered dental hygienist to satisfactorily complete Committee-approved instruction in gingival soft tissue curettage, nitrous oxide-oxygen analgesia, and local anesthesia. The bill authorizes the Committee to issue a special permit to a registered dental hygienist licensed in another state authorizing him or her to teach in a dental hygiene college without being licensed by this state if certain requirements are met, including, but not limited to, the completion of educational requirements and the payment of an application fee, subject to a biennial renewal fee. This bill requires that proof of prior experience to have been obtained at least 5 years immediately preceding the applicant's date of application and would expand that proof relating to disciplinary action to include any other state where the applicant was previously issued any professional or vocational license. This bill prohibits an examinee for a registered dental hygiene license who either fails to pass the clinical examination after 3 attempts or fails to pass the clinical examination because he or she imposed gross trauma on a patient from being eligible for further reexamination until the examinee completes specified remedial education. This bill requires a registered dental hygienist in alternative practice to register his or her place or places of practice, within a specified timeframe, with the executive officer. The bill requires a registered dental hygienist in alternative practice to receive permission from the committee, subject to a biennial renewal fee, to have an additional place of practice. The bill authorizes a registered dental hygienist in alternative practice to operate a mobile dental hygiene clinic under certain circumstances if various requirements are met, including the payment of a fee not to exceed $250, pursuant to regulations adopted by the committee. This bill increases the respective maximum fee amounts within which the committee shall establish fee amounts for an original license and the biennial renewal fee for such a license, and would also increase the maximum fee amount for curriculum review and site evaluation for specified educational programs, as specified. The bill defines the term "extramural dental facility" and also establishes a fee for certification of licensure and registration of an extramural dental facility. This bill requires the committee to grant or renew approval of only those educational programs that meet the standard described above and, where appropriate, meet the minimum standards set by the commission or an equivalent body, as determined by the committee. The bill requires a new educational program for registered dental hygienists, as defined, to also submit a feasibility study demonstrating a need for a new educational program and would require a new educational program to apply to the committee for specified approval prior to seeking initial accreditation from the commission or an equivalent body, as determined by the committee. This bill also makes various technical, non-substantive, and conforming changes.

- SB 1520 (Calderon, Chapter 766, Statutes of 2012) The Administrative Procedure Act governs the procedure for the adoption, amendment, or repeal of regulations by state agencies and for the review of those regulatory actions by the Office of Administrative Law. The act requires each agency that proposes to adopt, amend, or repeal any major regulation, as defined, on or after November

1, 2013, to prepare a standardized economic impact analysis. The act requires an agency that seeks to adopt, amend, or repeal a major regulation to release a notice of proposed action that includes, among other things, the standardized economic impact analysis. The act requires an agency to file with the office, when it files the notice of proposed action, an initial statement of reasons that includes, among other things, the standardized economic impact analysis for each major regulation proposed on or after January 1, 2013. SB 1520 instead requires that the statement of reasons include a standardized impact analysis for each major regulation proposed on or after November 1, 2013.

- SB 1575 (Senate Business, Professions and Economic Development Committee, Chapter 799, Statutes of 2012) makes several non-controversial, minor, non-substantive, or technical changes to various provisions of the Business and Professions Code (Code) pertaining to healing arts boards within the Department of Consumer Affairs. Specifically, this bill makes changes to provisions within the Dental Practice relating to the Dental Board of California (Board) and the Dental Hygiene Committee of California (DHCC). This bill codifies a federal requirement concerning the licensing of health care professionals employed by a tribal health program, by specifying that a person who possesses a current, valid license as a health care practitioner in any other state and is employed by a tribal health program is exempt from the licensing requirements with respect to acts authorized under the person's license where the tribal health program performs specified services. This provision contains technical clean-up language to amend recently chaptered legislation (AB 1896, Chesbro, Chapter 119, Statutes of 2012) to provide better public protection. This bill revises eligibility requirements for a person applying for a special permit with the Board to allow for alternative eligibility for a person who completes an advanced education program accredited by the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the Board. This bill deletes obsolete references in Code section 1715.5. When enacted into law, Code Section 1715.5 applied to the Board and the Committee on Dental Auxiliaries (COMDA). Subdivision (f) specifies that if COMDA ceases to exist, the responsibility of collecting licensure data shall be transferred to the successor entity or entities responsible for licensing registered dental hygienists and registered dental assistants. Since the enactment of AB 269, COMDA has been abolished; the responsibility of regulating the practice of dental assisting has been placed on the Dental Board and the responsibility of regulating the practice of dental hygiene has been placed on the DHCC. These amendments clarify the Board's role in the collection of the specified information. This bill adds Code Section 1902.2 to specify requirements for the reporting of licensure data relative to dental hygienists. This clarifies that the DHCC is the entity responsible for collecting licensure data for dental hygienists. If possible, the Board may wish to consider proposing technical clean-up language to Code Section 1715.5 to clarify that the Board is the entity responsible for collecting licensure data for dentists and dental assistants.

  This bill repeals Code Section 1909.5 and deletes the requirement that courses for instruction for direct supervision duties added to the scope of practice of

dental hygiene on or after July 1, 2009, shall be submitted by the DHCC for approval by the Dental Board. This bill makes technical amendments to Code Section 1934 to specify that licensees are required to notify the DHCC within 30 days if a licensee changes their physical address of record or e-mail address. This bill adds Code Section 1942 to define "extramural dental facility" and specify requirements for the registration of extramural dental facilities in relation to dental hygiene educational programs. This proposed language emulates the Board's regulatory language contained in Cal. Code of Regs., Title 16, Sections 1070.1(c) and 1025(d). This bill amends Code Section 1950.5 relating to unprofessional conduct. This bill would add Code Section 1958.1 to authorize the DHCC deny, revoke, or suspend a license of an individual who is required to register as a sex offender.

- AB 258 (Chavez, (Chapter 227, Statutes of 2013) On or after July 1, 2014, every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran is required to request that information only in the following format: "Have you ever served in the United State military?" The Board will need to implement the provisions of this bill by updating forms, publications, and it's Web site. It is currently unknown how many forms and publications may require updating; however, staff estimates it to be a minimal amount.

- AB 512 (Rendon, Chapter 111, Statutes of 2013) Existing law, Business and Professions Code Section 901, provides an exemption for a health care practitioner, licensed or certified in another state, from the licensing and regulatory requirements of the applicable California healing arts board. To be exempted from California licensure requirements, a health care practitioner must provide services at a sponsored healthcare event to uninsured or underinsured people on a short-term, voluntary basis. Section 901 requires the out-of-state health care practitioner to seek authorization from the applicable healing arts board in California and provides the regulatory framework for the approval of an out-of-state health care practitioner and a sponsoring entity to seek approval from the applicable healing arts boards. Each individual healing arts board was responsible for promulgating regulations to specify the requirements for the approval of an out-of-state practitioner and a sponsoring entity. Existing law specifies that the Section 901 would be repealed on January 1, 2014 unless a later enacted statute deletes or extends the repeal date. This bill extends the repeal date of Section 901 until January 1, 2018. The Board will be able to continue registering out-of-state dentists for participation in sponsored free health care events until January 1, 2018. There are no additional implementation concerns.

- AB 836 (Skinner, Chapter 299, Statutes of 2013) The Board requires licensees to complete continuing education hours as a condition of license renewal. The Board is authorized to, by regulation, reduce the renewal fee for a licensee who has practiced dentistry for 20 years of more in California, has reached the age of retirement under the federal Social Security Act, and customarily provides his or her services free of charge to any person, organization, or agency. This bill prohibits the Board from requiring a retired dentist who provides only

uncompensated care to complete more than 60% of the hours of continuing education that are required of other licensed dentists. All of those hours of continuing education are required to be gained through courses related to the actual delivery of dental services to the patient or the community, as determined by the Board. The Board is required to report on the outcome of these provisions, pursuant to, and at the time of its regular sunset review process.

- SB 562 (Galgiani, Chapter 624, Statutes of 2013) Existing law authorizes a dentist to operate one mobile dental clinic or unit that is registered and operated in accordance with regulations adopted by the board. Existing law exempts specified mobile units from those requirements. Other provisions of existing law, the Mobile Health Care Services Act, require, subject to specified exemptions, licensure by the State Department of Health Care Services to operate a mobile service unit. This bill eliminates the one mobile dental clinic or unit limit and requires a mobile dental unit or a dental practice that routinely uses portable dental units, as defined, to be registered and operated in accordance with the regulations of the board. The bill requires any regulations adopted by the board pertaining to these matters to require the registrant to identify a licensed dentist responsible for the mobile dental unit or portable practice, and to include requirements for availability of follow-up and emergency care, maintenance and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties.

- SB 809 (DeSaulnier, Chapter 400, Statutes of 2013) Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified. This bill establishes the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES. Beginning April 1, 2014, this bill requires an annual fee of $6 to be assessed on specified licensees, including licensees authorized to prescribe, order, administer, furnish, or dispense controlled substances, and require the regulating agency of each of those licensees to bill and collect that fee at the time of license renewal. The bill authorizes the Department of Consumer Affairs to reduce, by regulation, that fee to the reasonable cost of operating and maintaining CURES for the purpose of regulating those licensees, if the reasonable regulatory cost is less than $6 per licensee. The bill requires the proceeds of the fee to be deposited into the CURES Fund for the support of CURES. The bill permits specified insurers, health care service plans, qualified manufacturers, and other donors to voluntarily contribute to the CURES Fund, as described.

  Existing law requires the Medical Board of California (MBC) to periodically develop and disseminate information and educational materials regarding various subjects, including pain management techniques, to each licensed

physician and surgeon and to each general acute care hospital in California. This bill additionally requires the MBC to periodically develop and disseminate to each licensed physician and surgeon and to each general acute care hospital in California information and educational materials relating to the assessment of a patient's risk of abusing or diverting controlled substances and information relating to CURES.

Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual. This bill requires, by January 1, 2016, or upon receipt of a federal Drug Enforcement Administration registration, whichever occurs later, health care practitioners authorized to prescribe, order, administer, furnish, or dispense controlled substances, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under their care. The bill requires the Department of Justice, in conjunction with the Department of Consumer Affairs and certain licensing boards, to, among other things, develop a streamlined application and approval process to provide access to the CURES database for licensed health care practitioners and pharmacists. The bill would make other related and conforming changes.

- SB 821 (Senate Business, Professions and Economic Development Committee, Chapter 473, Statutes of 2013) This bill makes several non-controversial minor, non-substantive or technical changes to various provisions pertaining to the healing arts boards within the Department of Consumer Affairs. Specifically, this bill corrects a reference to the Board's name from "Board of Dental Examiners" to "Dental Board of California".

The following bills from the past four years require regulations to implement, interpret and make specific the provisions of the enacted statutes:

- AB 1588 (Atkins, Chapter 742, Statutes of 2012)
- AB 1904 (Block, Chapter 399, Statutes of 2012)
- AB 836 (Skinner, Chapter 299, Statutes of 2013
- SB 562 (Galgiani, Chapter 624, Statutes of 2013)

The regulatory process can take 18 to 24 months for each proposal from inception to completion. If possible, the Board makes changes to internal business processes to implement the provisions of new bills while regulations are pending, as has been the case with AB 1588 and AB 1904. Otherwise, Board staff is able to process three to five regulatory packages per year upon direction of the Board.

Regulations Promulgated by the Board:

The Board promulgated the following rulemakings since its last Sunset Review in 2011:

1. Retroactive Fingerprinting for Licensees, Cal. Code of Regs. Title 16, Sections 1007, 1008, and 1017.2 (Effective July 1, 2011): This rulemaking action requires that dentists, RDAs, and RDAEFs, licensed prior to January 1, 1999, or for whom an electronic record of submission of fingerprints to the Department of Justice does not exist, must furnish a full set of fingerprints to the Department of Justice for the purpose of conducting a criminal history record check and information search when the licensee next seeks to renew his or her license.

2. Minimum Standards for Infection Control, Cal. Code of Regs. Title 16, Section 1005 (Effective August 20, 2011): This rulemaking action amended and updated the Board's regulation entitled "Minimum Standards for Infection Control". This rulemaking implements B & P Code § 1680(ad) which provides for infection control guidelines of the Board and for their periodic review.

3. Dental Assisting Educational Programs and Courses, Cal. Code of Regs. Title 16, Sections 1070, 1070.1, 1070.2, 1070.6, 1070.7, 1070.8, 1071, 1071.1 (Effective November 11, 2011): This rulemaking establishes the rules governing Board approval of educational programs and courses or training RDAs, RDAEFs, Orthodontic Assistants (OAs), and Dental Sedation Assistants (DSAs).

4. Consumer Protection Enforcement Initiative, Cal. Code of Regs. Title 16, Sections 1018.05 and 1020 (Effective March 9, 2012): This rulemaking provides the Board with the means to expedite the enforcement process by further defining unprofessional conduct and providing the Board with authority to require the examination of an applicant who may be impaired by a physical or mental illness that may affect competency.

5. Notice to Consumers of Licensure by the Dental Board, Cal. Code of Regs. Title 16, Section 1065 (Effective November 28, 2012): This rulemaking requires a licensed dentist engaged in the practice of dentistry to provide notice to each patient of the fact that he or she is licensed and regulated by the Board. The notice must include a statement that dentists are licensed and regulated by the Board and must contain the Board's toll free telephone number and web site address. The notice is required to be prominently posted in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services and be in at least 48-point type font.

6. Sponsored Free Health Care Events, Cal. Code of Regs. Title 16, Sections 1023.15, 1023.16, 1023.17, 1023.18, and 1023.19 (Effective December 7, 2012): This rulemaking governs the requirements and procedures to allow dental practitioners with valid, current, and active licenses to practice dentistry in states other than California, to participate in sponsored free health care events in California.

7. Uniform Standards Related to Substance Abusing Licensees, Cal. Code of Regs. Title 16, Sections 1018 and 1018.1 (Effective April 1, 2014): This rulemaking adopts the uniform standards established by the Substance Abuse Coordination Committee (SACC) and adopts standard language for probationary orders to be used by an administrative law judge, if an individual is determined to be a substance abuser after a formal adjudicative hearing.

8. Dentistry Fee Increase, Cal. Code of Regs. Title 16, Section 1021 (Effective July 1, 2014): This rulemaking increased the fees associated with initial licensure as well as the biennial renewal of licensure for dentists from $365 to $450, which is the statutory cap for this category of fees.

9. Portfolio Examination Requirements, Cal. Code of Regs. Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036; Adopt Cal. Code of Regs., Title 16, Sections 1032.7, 1032.8, 1032.9, 1032.10, 1036.01; and Repeal California Code of Regulations, Title 16, Sections 1035.1, 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039 (Pending): This proposed rulemaking implements the requirements of the Board's portfolio examination as a new pathway to dental licensure in California pursuant to Assembly Bill 1524 (Hayashi, Chapter 446, Statutes of 2010).

10. Revocation for Sexual Misconduct, Cal. Code of Regs. Title 16, Sections 1018 (Pending): This rulemaking proposal requires an administrative law judge (ALJ) order revocation of a license when issuing a proposed decision that contains any finding of fact that: (1) a licensee engaged in any act of sexual contact with a patient, client, or customer; or, (2) the licensee has been convicted of, or has committed, a sex offense. This proposal prohibits a proposed order staying the revocation of the license or placing the licensee on probation, under such circumstances.

11. Delegation of Authority to the Board's Executive Officer, Cal. Code of Regs. Title 16, Section 1001 (Pending): This rulemaking proposal delegates authority to the Board's Executive Officer to approve settlement agreements for the revocation, surrender, or interim suspension of a license in the interest of expediting the Board's enforcement process.

12. Abandonment of Applications, Cal. Code of Regs. Title 16, Sections 1004 (Pending): This rulemaking proposal would set forth the necessary changes relating to the abandonment of deficient applications and to provide the ability for a RDAEF candidate to only retake the failed component of the RDAEF examination.

4. Describe any major studies conducted by the Dental Board (cf. Section 12, Attachment C).

Western Regional Examination Board

In November 2013, the Department of Consumer Affairs (DCA), Office of Professional Examination Services (OPES), completed a comprehensive review of the Western Region Examination Board's (WREB) licensing examination program. The purpose of the OPES review was to evaluate the suitability of the WREB examinations for continued use in California and to identify if there are areas of California dental practice not covered by the WREB examinations.

OPES received and reviewed documents provided by WREB. A comprehensive evaluation of the documents was made to determine whether (a) job analysis, (b) examination development, (c) passing scores, (d) test administration, (e) examination performance, and (f) test security procedures, met professional guidelines and technical standards. OPES utilized the professional guidelines and technical standards outlined in the Standards for Educational and Psychological Testing (Standards) and California B & P Code § 139 to determine the validity and defensibility of the WREB program components listed above.

OPES convened a panel of licensed California dentists to serve as subject matter experts (SMEs) to review the WREB examination content and to compare the content to the description of practice determined for California dentists. The SMEs were selected by the Board based on their geographic location, experience, and practice specialty. The SMEs were asked to review the scope of practice for dentists as determined by the 2005 California General Dentist Occupational Analysis, performed by OPES (OPES, 2005), and link it with the examination content for WREB as determined by the 2007 General Dentist Practice Analysis performed by WREB.

The SMEs were also asked to link the job task and knowledge statements that make up the examination outline for the California Law and Ethics Examination with the content for the WREB examination. This linkage was performed to identify if there are areas of California dental practice not covered by the WREB examination. The California Law and Ethics Examination is structured to cover these content areas. The examination outline specifies the job tasks related to California laws and regulations that a dentist is expected to master at the time of licensure.

In February 2014, OPES completed its comprehensive analysis and evaluation of the documents provided by WREB and submitted its report to the Board. The Board selected a subcommittee to review the report and based on the subcommittee's recommendation, the report was accepted by the full board at its May 2014 meeting.

Portfolio Examination Pathway

In April 2013, the Dental Board received the third and final report from a consultant firm to examine the implementation of the proposed Portfolio Examination as a pathway for dental licensure. The Portfolio Examination, mandated by statute, is a series of exams in six subject areas that assesses clinical experiences and competency over the normal course

of clinical training. Unlike other pathways, the Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a board-approved school located in California.

The report included the procedures used to define the competencies to be tested in the examination. Using focus groups, participants identified the competencies to be assessed in a systematic way beginning with an outline of major competency domains and ending with detailed rating (grading) scales for evaluating candidate performance. All participants provided input in a systematic, iterative fashion, until consensus was achieved. The competencies identified from this process served as the framework for the training and calibration procedures for examiners, and audit procedures for evaluating the efficacy of the process.

The report also noted that all six California dental schools already use similar criteria to evaluate students' performance and use similar procedures to calibrate their faculty according to performance criteria.

In summary, the dental schools reached consensus in identifying critical competencies to be measured in the Portfolio Examination, thereby standardizing the competencies to be measured, providing the framework for the evaluation (grading) system, training and calibration procedures for examiners, and audit procedures for evaluating the efficacy of the process.

5. List the status of all national associations to which the Dental Board belongs.

- Does the Dental Board's membership include voting privileges?

The Dental Board of California pays annual dues to continue its membership in the American Association of Dental Boards (AADB). Because the AADB meets out of state, Dental Board members must attend these meetings at their own expense and cannot serve as official representatives of the Board. For this reason, they are unable to obtain voting privileges.

The Dental Board also participates as a member state with the Western Region Examination Board (WREB). A Board member acts as a liaison but attends these meetings at their own expense. Several board members also act as WREB examiners.

- List committees, workshops, working groups, task forces, etc., on which Dental Board participates. How many meetings did Dental Board representative(s) attend? When and where?

The Board's Enforcement Program staff has participated in the following:

1) CURES 2.0 – This workgroup involves sworn and non-sworn users of the Department of Justice's (DOJ) *Controlled Substance Utilization and Review System.* Attending staff are providing input to DOJ staff as they design a system upgrade. Meetings have been conducted monthly over the past six months and are expected to continue for the next six to 12 months.

2) Western States Information Network (WISN) – This organization provides law enforcement officers with deconfliction intelligence. Sworn staff are members of WISN and use this centralized organization as a resource prior to any undercover operations or search warrant service to reduce personnel risks. Sworn staff are participating members and share information on an as needed basis; there are no regularly scheduled meetings with this group.

3) Prescription Drug Information Network (PDIN) and Prescription Drug Abuse Task Force (PDATF) – The PDIN was hosted by the FBI to share information about prescription drug fraud and related issues with law enforcement in Orange and Los Angeles counties. Beginning in 2012, one Investigator in the Southern California office attended quarterly. PDIN dissolved in late 2013 and PDATF was established; consisting of sworn and consumer stakeholders, the primary focus of this group is drug abuse prevention. Members discuss trends, safety issues and sponsor "take back days" in local communities to help combat the prescription drug abuse within San Diego County. The group also hosted a one-day symposium on emerging drugs such as synthetic marijuana and "bath salts."

4) San Diego Medical Insurance Fraud Task Force – One sworn investigator attends this grant-based task force. Quarterly meetings are limited to law enforcement agencies and focus on medical or dental cases.

5) San Diego Consumer Fraud Task Force – Focused on consumer scams and rip-offs, quarterly attendance with this group recently ended with the retirement of the lead District Attorney who hosted the task force.

6) California Department of Public Health Symposium – The Southern California Inspector attended this one day event and discussed infection control enforcement.

7) Prescription Drug Overdose Prevention – This recently created workgroup consists of staff from a number of state public health agencies and stakeholders. The group is dedicated to greater education and prevention of prescription drug overdoses. The Enforcement Chief and the Board President have been attending monthly meetings for the past four months.

8) Diversion Program Managers – Consists of participants from all the Boards and Bureaus that have Diversion Programs, and the contracted vendor; meetings are held at least monthly. One DBC staff services manager attends; discussions focus on monitoring and compliance processes and best practices.

9) Medical Board of CA Prescribing Task Force – Management staff (1 – 3 people) are attending these quarterly stakeholder meetings hosted by the Medical Board as they seek input to refine their existing prescribing guidelines.

- If the Dental Board is using a national exam, how is the Board involved in its development, scoring, analysis, and administration?

At present, the Dental Board does not use a national exam as one of its pathways to licensure, but will be taking this issue up in 2015. [See Section 11, New Issues for additional information]

Section 2
Performance Measures and Customer Satisfaction Surveys

6. Provide each quarterly and annual performance measure report for the Dental Board as published on the DCA website.

To ensure that DCA and its stakeholders can review progress in meeting enforcement goals and targets, DCA developed an easy-to-understand, transparent system of accountability – performance measures. Performance measures are critical for demonstrating that DCA and the Dental Board are making and will continue to make, the most efficient and effective use possible of its resources. Performance measures are linked directly to an agency's mission and vision, strategic objectives, and strategic initiatives.

In some cases, each board, bureau, and program was allowed to set their individual performance targets, or specific levels of performance against which, actual achievement would be compared. In other cases, standards were established by DCA. As an example, a target of an average of 540 days for the cycle time of formal discipline cases was set by the previous Director.

Data is collected quarterly and reported on the Department's website at: http://www.dca.ca.gov/about_dca/cpei/index.shtml

Intake Target is 10 days. The average cycle time from complaint receipt to the date the complaint is acknowledged and assigned to an analyst in the Complaint and Compliance Unit (CCU) for processing is considered as intake. This 10-day time frame is mandated by B&P Code § 129(b). Between FY 2010/11 and FY 2013/14 the average intake time was nine (9) days.

Intake and Investigation Target is 270 days. This is the average time from complaint receipt to closure of the investigative process. This target does not include cases referred to the Attorney General (AG) or other forms of formal discipline. Between FY 2010/11 and FY 2013/14 the average time to complete all investigations was 174 days.

Approximately 74% of complaints received are closed in the CCU. The average time to close these complaints was 95 days.

The remaining 26% of the Board's complaints are referred to either the non-sworn Investigative Analysis Unit (IAU) or to one of the Board's two field offices with sworn investigators. The IAU, established in 2011, has an average case closure rate of 374 days. These cases are considered more complex and may require subpoenas, field interviews, and document collection, at minimum.

Investigations conducted by sworn staff have an average case closure rate of 442 days. In addition to those tasks discussed above, peace officers investigate criminal allegations, as

well as the administrative components of their cases. These investigations may include coordination with allied law enforcement agencies, undercover operations, surveillance, search warrant service, pharmacy audits and evidence collection.

Formal Discipline Target is 540 days. This tracks the average number of days to complete the entire enforcement process for cases resulting in formal discipline. The Board's average over the last four (4) years is 998 days.

Challenges to meet this target include factors that are outside the Board's control – including continuances and scheduling conflicts from opposing counsel, difficulty in securing hearing dates, criminal trials which may delay the subsequent administrative matter, and scheduling amongst witnesses, patients, and other parties.

In an effort to address these challenges, enforcement staff established several internal benchmarks for administrative referrals to the AG's office. Monthly reports are run to identify case exceptions; staff is assigned to make contact with the AG's office and the assigned attorney to address issues that may be contributing to delays.

Probation Intake Target is 10 days. Probation intake measures the time between when the probation monitor is assigned the case file and the date the monitor meets with their assigned probationer to review monitoring terms and conditions. The four year average between these two events is 19 days. Data outliers can be attributed to the availability of the licensee to meet with their assigned monitor (out of state applicants have not begun residing in California), an order requiring testing before the license can be issued (physical or competency exam requirements), and in some instances, the availability of the monitor within the target window.

Probation Violation Response Target is 10 days. This target represents the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

In general, once a violation is discovered, the decision to take action is made immediately. However, the monitor must collect any supporting evidence (arrest/conviction records, positive drug test results) and write a report documenting the event. Once the report is referred for discipline, "appropriate action" has been initiated and the clock stops. Factors which may affect the turnaround time on this measure include how the violation is reported, and how quickly the monitor can write up and refer the violation for administrative action. Incoming complaints or arrest/conviction reports from the Department of Justice may take several days to be processed and reported to the assigned monitor.

The Board's quarterly and annual performance measures for FY2010/11 – FY2013/14 as published on the Department of Consumer Affairs Web site are listed below.

7. Provide results for each question in the Dental Board's customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

Consumer Satisfaction Survey Results

Beginning in 2010, DCA launched an online Consumer Satisfaction Survey. The Survey is included as a web address within each closure letter which directs consumers to an online "survey monkey" with 19 questions. Overall participation has been low. During the past four years, the board has received an average survey return rate of approximately 2.55%, below the minimum level of 5% needed to be considered statistically relevant. By comparison, DCA has reported a 2.6% average participation rate from all boards and bureaus.

In consideration that consumers may not wish to participate in an online survey, the Board has begun to include self-addressed, postage-paid survey postcards to further encourage participation and feedback.

The table below provides the number of case closures by fiscal year in comparison to the number of survey responses received.

Dental Board of California	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Number of consumer complaints closed by the Board*	2,431	2,151	2,272	2,370
Number of surveys collected	65	66	45	64
Return rate	2.6%	3%	1.9%	2.7%

*Closed complaint statistics represent the number of complaints closed, with a survey having been sent. Typically,
surveys are not sent to complainants from professional organizations or government entities. Those who file anonymously and provide no contact information do not receive surveys.

With regard to specific survey results, the Board has identified that the participating consumers expressed dissatisfaction surrounding the Complaint Intake process, regarding:

- Initial Response Time
- Complaint Resolution Time, and
- Explanation regarding the outcome of the complaint.

The Performance Measure established for Initial Response Time (the period between the Board's receipt of the complaint and the time to send an acknowledgement letter) is ten (10) days, as established in statute (B&P Code § 129). The Board's average time to complete this task over the past four-year period has been seven days, which is below the maximum time allowed by law. It is possible that consumers who are dissatisfied with the outcome of their complaint have used the survey as a tool to communicate their dissatisfaction by providing all survey questions with a low rating.

With the exception of complaints that result in discipline, the Board's four-year average resolution time, 164 days, is also below the performance target of 270 days.

The third issue involves the language in our closure letter that explains to consumers that their complaint was closed. In some instances (9%), issues are non-jurisdictional (refund requests) and cannot be resolved by the board. In other instances, (27%), the dental issues were reviewed by a dental consultant, and although the outcome was not satisfactory for the patient, the treatment was categorized as Simple Negligence which is not a violation of the Dental Practice Act. Both of these circumstances may not be sufficiently defined for consumers, causing dissatisfaction when their complaint is closed without the desired resolution.

It is the Board's practice to provide consumers with alternative resources (dental societies for low cost re-treatment or peer review, legal counsel for remuneration) to address these concerns when the complaint is first received.

The Board is also reviewing the content of the current closure letter to determine if revisions may be necessary.

Below are results for FY10/11 thru FY13/14 CPEI Consumer Satisfaction Survey:

1. How did you contact our Board/Bureau?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Phone	9	6	3	10
In Person	38	44	23	26
Regular Mail	5	8	8	16
Email	9	4	10	9
Website	1	2	0	5
No Response	3	2	1	6
Totals	**65**	**66**	**45**	**72**

2. How satisfied were you with the format and navigation of our website?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very Satisfied	2	1	1	2
Somewhat satisfied	1	1	0	0
Neither satisfied nor dissatisfied	3	2	0	2
Somewhat dissatisfied	0	0	0	0
Very Dissatisfied	3	0	0	3
Skipped the Question	56	62	44	65
Totals	**65**	**66**	**45**	**72**

3. How satisfied were you with available information on our website pertaining to your complaint?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	1	1	1	1
Somewhat satisfied	2	0	0	1
Neither satisfied nor dissatisfied	3	3	0	1
Somewhat dissatisfied	0	0	0	1
Very dissatisfied	2	0	0	3
Skipped the question	57	62	44	65
Totals	**65**	**66**	**45**	**72**

4. How satisfied were you with the time it took to respond to your initial correspondence?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	6	2	5	0
Somewhat satisfied	5	9	8	5
Neither satisfied nor dissatisfied	3	8	2	5
Somewhat dissatisfied	10	5	3	1
Very dissatisfied	17	12	5	15
Skipped the question	24	30	22	46
Totals	**65**	**66**	**45**	**72**

5. How satisfied were you with the time it took for our response to your initial correspondence?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	3	6	2	0
Somewhat satisfied	9	9	6	6
Neither satisfied nor dissatisfied	1	2	7	6
Somewhat dissatisfied	5	2	3	1
Very dissatisfied	22	17	5	13
Skipped the question	25	30	22	46
Totals	**65**	**66**	**45**	**72**

6. How satisfied were you with the time it took to speak to a representative of our Board/Bureau?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	0	2	0	2
Somewhat satisfied	3	1	1	2
Neither satisfied nor dissatisfied	1	0	3	2
Somewhat dissatisfied	1	0	2	0
Very dissatisfied	2	1	1	3
Skipped the question	58	62	38	63
Totals	**65**	**66**	**45**	**72**

7. How satisfied were you with our representative's ability to address your complaint?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	1	0	0	1
Somewhat satisfied	2	2	2	1
Neither satisfied nor dissatisfied	1	0	1	1
Somewhat dissatisfied	0	0	1	1
Very dissatisfied	3	2	3	5
Skipped the question	58	62	38	63
Totals	**65**	**66**	**45**	**72**

8. How satisfied were you with the time it took for us to resolve your complaint?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	6	6	0	3
Somewhat satisfied	8	8	5	5
Neither satisfied nor dissatisfied	7	9	8	8
Somewhat dissatisfied	8	4	9	3
Very dissatisfied	24	32	17	46
Skipped the question	12	7	6	7
Totals	**65**	**66**	**45**	**72**

9. How satisfied were you with the explanation you were provided regarding the outcome of your complaint?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	4	3	0	1
Somewhat satisfied	3	4	1	6
Neither satisfied nor dissatisfied	4	2	2	4
Somewhat dissatisfied	7	6	8	6
Very dissatisfied	35	46	29	48
Skipped the question	12	5	5	7
Totals	**65**	**66**	**45**	**72**

10. Overall, how satisfied were you with the way in which we handled your complaint?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Very satisfied	4	6	1	1
Somewhat satisfied	5	5	1	6
Neither satisfied nor dissatisfied	4	0	5	5
Somewhat dissatisfied	4	3	6	6
Very dissatisfied	35	46	28	48
Skipped the question	13	6	4	6
Totals	**65**	**66**	**45**	**72**

11. Would you contact us again for a similar situation?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 10-11**	**FY 10-11**	**FY 10-11**
Definitely	7	11	6	15
Probably	5	4	3	5
Maybe	6	6	9	5
Probably Not	13	11	11	15
Absolutely Not	20	27	12	26
Skipped the question	14	7	4	6
Totals	**65**	**66**	**45**	**72**

12. Would you recommend us to a friend or family member experiencing a similar situation?

	Response Volume			
Response Choices:	**FY 10-11**	**FY 11-12**	**FY 12-13**	**FY 13-14**
Definitely	7	8	3	10
Probably	5	5	5	2
Maybe	4	5	6	8
Probably Not	13	9	9	13
Absolutely Not	23	34	19	33
Skipped the question	13	5	5	6
Totals	**65**	**66**	**47**	**72**

Section 3
Fiscal and Staff

Fiscal Issues

8. Describe the Dental Board's current reserve level, spending, and if a statutory reserve level exists.

The Dental Board is a self-supporting, special fund agency that obtains its revenues from licensing and permits fees of dentists and registered dental assistants (RDAs). The revenues are deposited and maintained in two separate funds which are not comingled. The Dentistry Fund (0741) supports operations for dentists and related ancillary services, and the Dental Assisting Fund (3142) supports operations for dental assistants and related ancillary services. The Board has separated the following tables into Dentistry and Dental Assisting funds to provide a more accurate accounting of fiscal matters. Although there is no statutory requirement, the Board's objective is to maintain a three-month reserve of funds for economic uncertainties and to operate with a prudent reserve in each fund. As you can see in the Dental Assisting Fund Condition table, that fund is solvent with a healthy annual reserve. The fund maintains a good balance between revenues and expenditures. Conversely, the Dentistry Fund has had a growing imbalance between revenues and expenditures for several years, leaving a decreasing Fund reserve. Licensing fees had not been increased for dentists in over fourteen years. In an effort to prevent the Fund from falling into a negative balance, the Board promulgated regulations to increase license fees from $365 to the statutory limit of $450, effective July 1, 2014. This fee increase was a short-term fix and not sufficient to alleviate the impending imbalance of the Dentistry Fund. Senate Bill 1416 (Block, Chapter 73, Statutes of 2014) establishes the initial licensure and biennial renewal fee for dentists at $525 beginning January 1, 2015.The projections for FYs 2014/15 and 5015/16 reflect this fee increase. The Board has initiated an audit of the Board's fee structure and workload to assist with determining future legislation for statutory limits.

9. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the Dental Board.

Based on data from the past five (5) fiscal years, the DBC has calculated that with the addition of average estimated savings and reimbursements to the new fee of $525, the State Dentistry Fund will be able to sustain expenditures into BY 2017-18 before facing a deficit once again. The Board is currently undergoing a fee rate audit to determine the appropriate fee amounts to assess and will be providing that information as part of the Sunset Review process in 2015. The Board anticipates establishing new maximum fee ceilings in statute to provide the Board with the necessary authority to promulgate regulations to increase fees in FY 2017-18.

Table 2a. Fund Condition – Dentistry Fund (0741)						
(Dollars in Thousands)	**FY 10/11**	**FY 11/12**	**FY 12/13**	**FY 13/14**	**FY 14/15**	**FY 15/16**
Beginning Balance	$ 7,885	$ 6,087	$ 6,180	$ 4,772	$ 6,086	$ 3,712
Revenues and Transfers	7,955	9,926	8,121	11,489	10,080	11,126
Total Revenue	$15,840	$ 16,086	$ 14,434	$ 16,261	$ 16,166	$ 14,838
Budget Authority	11,159	11,383	11,547	12,403	12,155	Not avail.
Expenditures	9,753	9,906	9,662	10,175	12,454	12,703
Loans to General Fund	0	0	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0	0	0
Loans Repaid From General Fund	0	1,700	0	2,700	0	0
Fund Balance	$ 6,087	$ 6,180	$ 4,772	$ 6,086	$ 3,712	$ 2,135
Months in Reserve	7.4	7.7	4.7	5.9	3.5	2.0

Table 2b. Fund Condition – Dental Assisting Fund (3142)						
(Dollars in Thousands)	**FY 10/11**	**FY 11/12**	**FY 12/13**	**FY 13/14**	**FY 14/15**	**FY 15/16**
Beginning Balance	$ 1,931	$ 2,263	$ 2,445	$ 2,724	$ 2,826	$2,674
Revenues and Transfers	1,641	1,634	1,758	1,703	1,735	1,771
Total Revenue	$ 3,554	$3,946	$4,192	$4,462	$ 4,561	$ 4,445
Budget Authority	1,715	1,688	1,744	1,851	1,885	Not avail.
Expenditures	1,291	1,501	1,468	1,636	1,887	1,923
Loans to General Fund	0	0	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0	0	0
Loans Repaid From General Fund	0	0	0	0	0	0
Fund Balance	$ 2,263	$2 ,445	$ 2,724	$ 2,826	$ 2,674	$ 2,522
Months in Reserve	18.1	20.0	20.0	18.0	16.7	15.4

10. Describe the history of general fund loans. When were the loans made? When have payments been made to the Dental Board? Has interest been paid? What is the remaining balance?

In FY 02/03 and FY 03/04 loans were made to the State General Fund from the Dentistry Fund of $5 million in each fiscal year, for a total of $10 million. The loan was repaid incrementally as shown in the following table:

Fiscal Year	Loan Repayment	Interest	Total Returned
FY 04/05	$600,000	$17,000	$617,000
FY 05/06	$2,500,000	$194,000	$2,694,000
FY 06/07	$2,500,000	$248,000	$2,748,000
FY 07/08	-	-	-
FY 08/09	-	-	-
FY 09/10	-	-	-
FY 10/11	-	-	-
FY 11/12	$1,700,000	$210,000	$1,910,000
FY 12/13	-	-	-
FY 13/14	$2,700,000	$384,000	$3,084,000
TOTALS	$10,000,000	$1,053,000	$11,053,000

10. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the Dental Board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

As the following tables indicate, Enforcement related expenditures generally represent in excess of 60% of the total budgeted expenditure authority for the Dentistry Fund, as has been the trend in past years. Licensing follows at 11%, then Examinations at 2% and Administration at 9%. Diversion represents a small portion at less than 1%, with DCA Pro Rata takes in the balance of the budgeted expenditure authority. The costs for Enforcement and Administration are expended from the Dentistry Fund; therefore the Dental Assisting Fund expenditures are distributed between Examinations at 45% and Licensing at 34% of total budgeted authority. DCA Pro Rata takes in the balance of the expenditures.

Table 3a. Expenditures by Program Component (list dollars in thousands)								
DENTAL BOARD	FY 10/11		FY 11/12		FY 12/13		FY 13/14	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	$2,910	$4,065	$3,406	$3,386	$3,527	$3,061	$3,740	$3,297
Examination	46	144	54	249	58	186	61	141
Licensing	816	355	955	335	806	280	856	343
Administration *	548	173	630	170	796	180	692	222
DCA Pro Rata		984		1,068		1,173		1,328
Diversion (if applicable)	13	5	16	5	16	5	17	7
TOTALS	$4,333	$5,726	$5,061	$5,213	$5,203	$4,885	$5,366	$5,338
*Administration includes costs for executive staff, board, administrative support, and fiscal services.								

Table 3b. Expenditures by Program Component (list dollars in thousands)								
DENTAL ASSISTING	FY 10/11		FY 11/12		FY 12/13		FY 13/14	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Examination	224	344	213	508	236	457	256	470
Licensing	278	199	265	261	294	233	321	235
Administration *	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
DCA Pro Rata	n/a	245	n/a	253	n/a	241	n/a	348
Diversion (if applicable)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
TOTALS	$502	$788	$478	$1,022	$530	$931	$577	$1,053
*Administration includes costs for executive staff, board, administrative support, and fiscal services.								

11. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the Dental Board.

The DBC's primary sources of revenue are the initial and renewal fees for the seventeen (17) license and permit types issued by the Board. Renewal fees are collected on a biennial basis with the exception of the Special Permit, which is renewed annually. DBC currently charges a $450 DDS renewal fee which was increased from $365 effective July 1. 2014. That fee will increase to the new statutory limit of $525 on January 1, 2015. Prior to July 2014 there had not been a fee increase for dentists since 1998. The DBC currently charges a $70 renewal fee for RDAs with a statutory limit of $80.The following tables provide the various fees charged by DBC for dentists and dental assistants in addition to the statutory limit, if applicable, and the legal authority for that fee.

Table 4a. Fee Schedule and Revenue – Dentistry Fund (list revenue dollars in thousands)								
License, Certificate or Permit	**Current Fee Amount**	**Statutory Limit**	**Legal Authority B & P Code**	**FY 10/11 Revenue**	**FY 11/12 Revenue**	**FY 12/13 Revenue**	**FY 13/14 Revenue**	**% of Total Revenue**
Init'l App Elective Facial Cosmetic Surgery	500.00	500.00	**§1724 (a)**	2,000	1,000	3,000	1,500	
Initial DDS License (pro-rated)	450.00	450.00	**§1724 (d)**	243,613	246,999	252,233	245,302	
Clinical Exam Fee	450.00	800.00	**§1724 (c)**	450	450	1800	0	
DDS Biennial Renewal	450.00	450.00	**§1724 (d)**	6193,302	6208,599	6259620	6288,729	
Oral/Maxillofacial Renewal Fee	450.00	450.00	**§1724 (d) §1638.3**	13,140	16,060	15,330	14,600	
Fictitious Name App	450.00	Not > $450 or < $5	**§1724.5 (a) (b)**	127,202	117,165	122,822	168,812	
Special Permit App	300.00	300.00	**§1724 (e)**	665	1,275	600	3,050	
License by Credential	283.00	0.00	**§1635.5 (a)**	50,091	52,638	48,110	46,684	
Continuing Ed RP App	250.00	250.00	**§1724 (k)**	34,000	34,500	30,750	30,250	
Onsite Insp – GA/CS Permit	250.00	350.00	**§1646.6 (b)**	54,250	50,750	47,250	46,000	
CE Registered Provider Renewal	250.00	250.00	**§1646.6 (a)**	110,250	157,820	119,500	153,500	
Fictitious Name ½ fee	225.00	Not > $450 Or < $5	**§1724.5 (a) (b)**	38,142	41,609	38,690	43,070	
DDS Biennial Renewal -Retired	225.00	225.00	**§1716.1 (a) (b)**	106,032	109,767	93,622	91,946	
Conscious Sedation App	200.00	250.00	**§1647.8 (a)**	6,600	12,400	9,400	10,400	
Gen Anesthesia Permit	200.00	250.00	**§1646.6 (a)**	11,400	11,400	12,600	11,450	
Gen Anesthesia Perm Renewal	200.00	250.00	**§1724 (j)**	76,600	87,600	81,475	90,400	
Conscious Sedation Renewal	200.00	250.00	**§1647.8 (a)**	42,200	42,000	48,200	45,300	
Oral Conscious Sedation Certificate	200.00	Administration Costs	**§1646.6 (a)**	52,800	33,000	42,000	45,800	
Renew Elective Facial Cosmetic Surgery	200.00	200.00	**§1638 (d)**	1,800	2,000	2,200	2,400	
Oral/Maxillofacial Surgery Permit	150.00	500.00	**§1638 (d)**	900	900	450	300	
Fictitious Name Permit Renewal	150.00	0.00	**§1635.5 (a)**	337,350	376,350	381,300	408,600	
DDS Delinquent	150.00	Not < $25 nor > $150	**§1724 (f) §163.5 (a)**	53,550	58,500	48,450	55,069	
Oral/Maxillofacial Delinq	150.00	Not < $25 nor > $150	**§1724 (f) §163.5 (a)**	200	300	150		
Mobile Dental Clinic Del	150.00	Not < $25 nor > $150	**§1724 (f) §163.5 (a)**				75	
DDS Delinquent Renewal - Retired	112.50	Not < $25 nor > $150	**§1724 (k)**	912	912	638	1,641	

Table 4a. Fee Schedule and Revenue – Dentistry Fund, continued (revenue dollars in thousands)								
License, Certificate or Permit	**Current Fee Amount**	**Statutory Limit**	**Legal Authority B & P Code**	**FY 10/11 Revenue**	**FY 11/12 Revenue**	**FY 12/13 Revenue**	**FY 13/14 Revenue**	**% of Total Revenue**
Additional Office App	100.00	200.00	**§1724 (h)**	27,700	24,800	33,500	30,300	
Initial App Clinical Exam	100.00	500.00	**§1724 (a)**	100	100	400	0	
Initial App Licensure	100.00	Established By Board	**§1724 (d)**	20,100	18,200	18,700	20,000	
Initial App WREB	100.00	500.00	**§1724 (g)**	73,600	69,200	78,600	82,700	
Special Permit Renewal	100.00	100.00	**§163**	3117	2,800	2,800	2,900	
Add'l Office Permit Ren	100.00	100.00	**§1724 (g)**	90,500	95,100	96,800	102,500	
Mobile Dent Clinic Lic Ren	100.00	100.00	**§1724 (c)**	900	700	1,000	1,400	
Delinq Ren Gen Anesthesia	100.00	Not < $25 nor > $150	**§1724 (h)**	200	400	300	600	
Special Permit Delinq	91.25	Not < $25 nor > $150	**§1724 (e)**		50	100		
Fictitious Name Delinq	75.00	Not > $450 or < $5	**§1724.5 (b)**	12,000	8,625	8,325	9,525	
App for Clinical Re-Exam	75.00	100.00	**§1724 (b)**	0	0	0	0	
Oral Conscious Sedation Renewal	75.00		**§1724 (b)**	74,250	79,050	81,150	83,775	
Change of Practice Late	50.00	75.00	**§1724(g)**	0	0	50	0	
Additional Office Permit Del	25.00	Not < $25 nor > $150	**§1724 (f)** **§163.5 (a)**	2,775	1,675	1,175	1,750	
License Certification	2.00	2.00	**§163**	1,900	1,770	1,808	1,776	
Prior Year Accrual Delinq	Various			2,828	3,712	3,947	3,750	

Table 4b. Fee Schedule and Revenue – Dental Assisting Fund (list revenue dollars in thousands)								
Fee	**Current Fee Amount**	**Statutory Limit**	**Legal Authority (B & P Code)**	**FY 2010/11 Revenue**	**FY 2011/12 Revenue**	**FY 2012/13 Revenue**	**FY 2013/14 Revenue**	**% of Total Revenue**
RDAEF Program App	1400.00	1400.00	**§1725 (n)**	1,400	0	0	0	
RDA Program Application	1400.00	1400.00	**§1725 (n)**	9,800	7,000	1,400	4,200	
OA Permit Course App	300.00	300.00	**§1725 (o)**	1,800	5,700	7,800	6,900	
DSA Permit Course App	300.00	300.00	**§1725 (o)**	1,200	2,400	2,100	600	
Inf Control Course App	300.00	300.00	**§1725 (o)**	5,100	3,900	600	3,300	
Coronal Polish Course App	300.00	300.00	**§1725 (o)**	2,100	1,500	600	2,100	
Pit and Fissure Course App	300.00	300.00	**§1725 (o)**	1,500	1,800	300	900	
Rad Safety Course App	300.00	300.00	**§1725 (o)**	4,500	2,400	1,200	2,400	
RDAEF Clinical Fee	250.00	250.00	**§1725 (f)**	26,000	28,750	26,750	39,750	
RDA Biennial Renewal	70.00	80.00	**§1725 (k)**	1198,140	118,0807	1198,215	1205,330	
RDAEF Biennial Renewal	70.00	80.00	**§1725 (k)**	45,700	43,625	44,175	46,060	
DSA Biennial Renewal	70.00	80.00	**§1725 (k)**	0	0	630	630	
OAP Biennial Renewal	70.00	80.00	**§1725 (k)**	0	490	1,260	3,955	
RDA Practical Exam Fee	60.00	60.00	**§1725 (b)**	185,580	194,080	287,760	216,900	
OAP Delinq Renl Fee	35.00	½ Renewal Fee	**§1725 (l)**	0	35	0	70	
RDA Delinq Renewal Fee	35.00	½ Renewal Fee	**§1725 (l)**	63,584	64,460	64,284	67,908	
RDAEF Delinq Ren Fee	35.00	½ Renewal Fee	**§1725 (l)**	1,610	2,100	1,785	2,310	
DSA Delinq Ren Fee	35.00	½ Renewal Fee	**§1725 (l)**	0	0	0	0	
Duplicate License/Cert Fee	25.00	25.00	**§1725 (m)**	13,400	16,025	15,150	17,575	
Dental Sedation Asst App	20.00	50.00	**§1725 (c)**	380	260	160	80	
Orthodontic Assistant App	20.00	50.00	**§1725 (c)**	500	1,260	2,600	4,040	
RDA Application Fee	20.00	50.00	**§1725 (a)**	53,080	55,500	86,420	62,760	
RDAEF Application Fee	20.00	50.00	**§1725 (a)**	1,480	1,560	1,160	1,620	
RDAEF2 Application Fee	20.00	50.00	**§1725 (a)**	0	400	400	160	
Prior Yr Accr Del Fee RDA	Varies	N/A		340	6,230	2,060	184,304	

12. Describe Budget Change Proposals (BCPs) submitted by the Dental Board in the past four fiscal years.

Table 5a. Budget Change Proposals (BCPs) – Dentistry Fund

BCP ID	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Reqd	$ Apprvd	$ Req'd	$ Apprvd
1110-009	14/15	Clerical Support	Two OT	0	$118K in FY 15/16 and Ongoing	0	$30K in FY15/16 $14K Ongoing	0
1110-08L	13/14	Addit'l Staff to Implement SB 562	One .05 SSA, 3 Yr Limited term	1, .05 SSA, 3 Yr Limited term	FY 14/15 $34K FY 15/16 $34K FY 16/17 $34K	FY14/15 $34K FY15/16 $34K FY16/17 $34K	FY14/15 $20K FY15/16 $2K FY16/17 $2K	FY14/15 $20K FY15/16 $2K FY16/17 $2K

Table 5b. Budget Change Proposals (BCPs) – Dental Assisting Fund

BCP ID	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Reqd	$ Apprvd	$ Requested	$ Apprv
1110-008	13/14	AG Budget Augmentation	0	0	0	0	$105K FY 15/16 and ongoing	TBD

Staffing Issues

13. Describe any Dental Board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

The Board does not experience many staffing issues or challenges with regard to turnover and vacancies. Turnover remains low; however, as vacancies arise, standard recruitment practice is initiated immediately after notification of such separation. Vacancies are typically filled within one to two months of the recruitment process, with the exception of sworn (peace officers) that require a full background which can take up to 6 months for completion. Since the previous sunset review, the majority of the Board's vacancies have been due to retirements.

The Enforcement Program has identified the need for additional support analytical, and investigative staff. Although it recently received 12.5 PY's with a recent CPEI BCP to address case backlogs, the growth of the overall program has resulted in a strain on the existing administrative support staff.

CPEI did not include technical staff to perform support functions (copying, filing, mailing) generated by the increase in completed investigations. The result is investigative staff performing administrative support functions to avoid delays. The use of investigative staff in this manner reduces their efficiency in working investigations. The board has recently submitted a BCP to add two Office Technician positions to address this gap.

In addition, the Enforcement Program has identified the need for an analyst dedicated to program reports, training contracts and budget support. Previously, the Enforcement Chief was responsible for many of these program-related tasks. However, with the increase in program size, more complex contract requirements for peace officer training and Subject Matter Experts, and a need for greater accountability in enforcement, these tasks are better suited to an analyst position. The Board will be seeking a BCP to address this need in the next year.

Although the number of sworn and non-sworn investigative staff was increased in 2010, the disparity in caseloads between the Dental Board's investigative program and the Medical Board or Division of Investigation (see Table below) needs to be addressed further. The Board will be studying options to determine if additional sworn or non-sworn staff will be sufficient to reduce caseloads, or if the development of a probation unit will better support this challenge.

DCA – Enforcement Program	Average Caseload per Investigator
Division of Investigation	20-22 cases
Medical Board of California	20 cases
Dental Board of California	45-55 cases (plus 10 probationers)

The Dental Board also recognizes the value of succession planning as staff promotions and retirements affect business continuity. At present, the management team is focused on ensuring routine functions are captured in desk and procedural manuals, and that staff are trained to back-up other employee desks. Managers are performing cross-over roles between programs to avoid knowledge gaps and retiring employees are meeting with management prior to their end date to facilitate smooth transitions.

14. Describe the Dental Board's staff development efforts and how much is spent annually on staff development (cf., Section 12, Attachment D).

Government Code § § 19992 – 19992.4 and the Department of Personnel Administration Rule 599.798 require supervisors to complete written evaluations and discuss overall work performance with permanent employees. This written evaluation, referred to as the Individual Development Plan (IDP) should occur at least once every 12 months after the completion of the employee's probationary period. The purpose of the IDP is to inform the employee of the caliber of his/her work. It aids the supervisor in identifying areas where performance could be improved and develops a plan to accomplish these improvements. Supervisors are required to use the IDP to provide the employee recognition of effective performance or for documenting substandard performance. Board managers strive to complete these evaluations on a timely basis.

Section 4
Licensing Program

Protection of the public shall be the highest priority for the Dental Board of California in exercising its licensing and regulatory functions. The California Dental Practice Act (DPA), with related statutes and regulations, establishes the requirements for licensure within dentistry. It is the responsibility of the Dental Board's Licensing Program to ensure licenses and permits are issued only to applicants who meet the minimum requirements, and have not done anything that would warrant denial.

In addition to the licensure of dentists, the Dental Board licenses and/or issues permits for the following:

- Registered Dental Assistant (RDA)
- Registered Dental Assistant in Extended Functions (RDAEF)
- Oral and Maxillofacial Surgery Permit (OMS)
- Elective Facial Cosmetic Surgery Permit (EFCS)
- Conscious Sedation Permit (CS)
- General Anesthesia Permit (GA)
- Medical General Anesthesia Permit (MGA)
- Mobile Dental Clinic Permit (MDC)
- Oral Conscious Sedation Certificate (OCS)
- Special Permit (SP)
- Orthodontic Assistant Permit (OA)
- Dental Sedation Assistant Permit (DSA)
- Fictitious Name Permit (FNP)
- Additional Office Permit (AO)
- Registered Provider (RP) – For Continuing Education

15. What are the Dental Board's performance targets/expectations for its licensing[2] program? Is the Board meeting those expectations? If not, what is the Board doing to improve performance?

California Code of Regulations (CCR), 1061 Permit Processing Times provides for the maximum amount of time the Board has to notify an applicant that their application or permit is complete or deficient, what information may be outstanding, as well as the maximum period of time from filing of a completed application to a permit or licensing decision.

As stated in the regulation, issuance of a dental license should be completed within 90 days of receipt of a completed application with renewal applications completed within 30 to 90 days. The Dental Board is meeting and exceeding these expectations, with initial licensure averaging 15 days in 2014 and 43 days for renewals for dentists.

[2] The term "license" in this document includes a license certificate or registration.

The Dental Assistant (DA) Program has a similar regulation for processing times (CCR 1069). As stated in the regulation, the board should take no longer than 90 days to notify an applicant that their application is complete or deficient, with a licensing decision within 180 days. Licensure renewal review should be completed within 30 days with issuance within 90 days maximum. It should be noted that DA applications may be received for different exam dates. Applications are processed in the order of the upcoming exam dates to ensure adequate space planning at the exam site and to allow adequate time for applicants to correct any deficiencies. At present, the average time from receipt of a completed RDA application to approval is 50 days. An incomplete application is processed in an average of 60 days.

16. Describe any increase or decrease in the Dental Board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the Dental Board to address them?

The volume of incoming applications has grown for nearly every licensing category over the previous four year period, with a growth rate ranging from 0.5% to over 2,000%. Since 2008, the number of active dental licenses has grown 4.2%, with a similar increase of 4.7% for active RDA licenses and 6% for RDAEF licenses. The greatest growth has been seen in the two newest permit types: Dental Sedation Assistant (over 1,000%) and Orthodontic Assistant (over 2,000%). Despite these increases, the licensing units (both DDS and DA) have not experienced backlogs or increases to processing times.

What are the performance barriers and what improvement plans are in place? What has the Dental Board done and what is the Board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

Challenges to processing timeframes include all of the following:

- Problems receiving electronic fingerprint results. Although applicants are provided with accurate live scan forms with accounts and codes already filled in, the Dental Board has experienced a number of instances when the results are never received from the Department of Justice (DOJ). In other instances, live scan operators may incorrectly enter agency information and results are routed to the incorrect board. There is currently no mechanism in place to alert the Board that an applicant has performed the live scan process and to anticipate a result. Applicants are obligated to contact the Board when they have not received a licensing response within a reasonable time period. This is the only trigger to alert the Board that the live scan results were not received and to request a re-print with the DOJ. If the applicant waits longer than one year to follow-up, their results are no longer maintained by DOJ and they are required to re-print and pay a fee.
- Unanticipated workload as a result of legislative changes. In several instances (e. g. Sponsored Free Health Care events, Mobile/Portable Dental Units, Notice to Consumer), the impact to the Licensing programs was not thoroughly understood, and

additional resources were not sought. Many of these changes were not large enough to justify a full position increase, but combined have caused the Board to divert resources from other responsibilities.

- Difficulty in collecting arrest and conviction records from law enforcement agencies in a timely manner. In the event an applicant discloses or is discovered to have criminal history information, board staff requests certified copies of the records prior to making a final licensing decision. Results of these requests vary from agency to agency, with some agencies requiring fees prior to releasing information (which extends the processing timeframe). Other agencies may refuse to provide records to a regulatory agency despite our authority under B&P Code § 13300(3)(b)(11).

- Loss of a Staff Services Manager 1 (SSM1) over the DA unit. Effective May 2013, DCA downgraded the existing SSM 1 position to an Associate Government Program Analyst (AGPA). Although an AGPA position can act in a lead capacity, staff cannot address day-to-day performance issues that were handled by a manager. This change has caused the Dental Board to shift responsibility for the unit to the Assistant Executive Officer to manage, which does not provide the same level of oversight as previously provided.

- Vacancies caused by staff retirements, transfers or extended absences. Although temporary, vacancies will continue to cause minor impact to processing timeframes. Licensing managers are addressing this by cross-training staff within both DDS and DA licensing units to be able to more quickly respond to these changes when they occur.

17. How many licenses or registrations does the Dental Board issue each year? How many renewals does the Board issue each year?

The Board is responsible for regulating the practice of approximately 98,000 licensed dental health professionals, including dentists (DDS), registered dental assistants (RDA), and registered dental assistants in extended functions (RDAEF). In addition, the Board has the responsibility for setting the duties and functions of approximately 50,000 unlicensed dental assistants. Licensees renew licenses and permits/certificates every two years with the exception of a Special Permit, which is issued for limited practice in a dental school setting, which is renewed annually.

There are approximately 36,225 actively licensed dentists (DDS), of which 17,662 (48%) renewed during the 13/14 Fiscal year. There are 34,464 active registered dental assistants (RDA) licenses, with 16,390 (47%) renewals processed in 13/14. Of the 1,357 licensed registered dental assistants in extended functions (RDAEF), there were 654 (48%) renewed in 13/14.

Table 6 displays a breakdown of each license and permit/certificate category and the number of active licenses in each.

Table 6. Licensee Population -Statistics are as of June 30th by FY					
License Type	**License Status**	**FY 2010/11**	**FY 2011/12**	**FY 2012/13**	**FY 2013/14**
DDS (Dentist)	Active/Current	35,844	35,977	36,006	36,225
	Out-of-State	4,201	4,236	4,134	4,091
	Out-of-Country	259	261	248	247
	Delinquent	2,806	2,984	3,368	3,640
	Inactive	3,630	3,636	3,757	3,796
	In Renewal Process	165	177	254	298
OMS (Oral and Maxillofacial Surgery)	Active/Current	79	83	85	83
	Out-of-State	7	7	6	7
	Out-of-Country	1	1	0	0
	Delinquent	4	3	5	8
	Inactive	1	1	1	2
	In Renewal Process	1	1	0	0
SP (Special Permit -Dental School Practice)	Active/Current	30	33	30	39
	Out-of-State	0	0	0	1
	Out-of-Country	0	0	0	0
	Delinquent	9	11	14	14
	Inactive	0	0	0	0
	In Renewal Process	0	0	1	0
FCS (Elective Facial Cosmetic Surgery)	Active/Current	19	20	26	27
	Out-of-State	1	1	0	0
	Out-of-Country	0	0	0	0
	Delinquent	0	0	0	0
	Inactive	0	0	0	0
	In Renewal Process	0	0	0	0
MGA (General Anesthesia-M.D.)	Active/Current	56	64	76	80
	Out-of-State	1	1	1	2
	Out-of-Country	0	0	0	0
	Delinquent	16	22	27	26
	Inactive	0	0	0	0
	In Renewal Process	0	1	0	1
GA (General Anesthesia)	Active/Current	797	817	816	830
	Out-of-State	15	21	20	19
	Out-of-Country	0	0	0	0
	Delinquent	16	16	25	33
	Inactive	0	0	0	0
	In Renewal Process	1	1	3	7

Table 6. Licensee Population, continued -Statistics are as of June 30th by FY					
License Type	**License Status**	**FY 2010/11**	**FY 2011/12**	**FY 2012/13**	**FY 2013/14**
CS (Conscious Sedation)	Active/Current	447	481	480	512
	Out-of-State	9	10	10	12
	Out-of-Country	0	0	1	1
	Delinquent	19	20	25	23
	Inactive	0	0	0	0
	In Renewal Process	0	0	2	1
OCS (Oral Conscious Sedation)	Active/Current	2,124	2,238	2,328	2,440
	Out-of-State	31	32	28	33
	Out-of-Country	0	0	2	2
	Delinquent	324	2	477	583
	Inactive	0	0	0	0
	In Renewal Process	2	3	6	9
AO (Additional Office)	Active/Current	1,968	1,964	2,086	2,243
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	455	451	383	398
	Inactive	0	0	0	0
	In Renewal Process	22	67	93	53
FNP (Fictitious Name)	Active/Current	4,980	5,154	5,290	5,714
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	855	937	1,036	1,138
	Inactive	0	0	0	0
	In Renewal Process	33	141	208	277
MDC (Mobile Dental Clinic)	Active/Current	21	23	25	31
	Out-of-State	1	1	0	0
	Out-of-Country	0	0	0	0
	Delinquent	12	11	11	9
	Inactive	0	0	0	0
	In Renewal Process	0	0	0	0
RP (Registered Provider - Continuing Educ.)	Active/Current	1,281	1,261	1,247	1,226
	Out-of-State	122	114	113	113
	Out-of-Country	2	2	2	2
	Delinquent	535	628	687	765
	Inactive	0	0	0	0
	In Renewal Process	6	51	90	130

Table 6. Licensee Population, continued -Statistics are as of June 30th by FY					
License Type	**License Status**	**FY 2010/11**	**FY 2011/12**	**FY 2012/13**	**FY 2013/14**
RDA (Registered Dental Assistant)	Active/Current	34,269	33,895	34,303	34,464
	Out-of-State	1,200	1,117	1,063	1,032
	Out-of-Country	16	9	11	13
	Delinquent	9,099	9,143	9,156	0
	Inactive	9,274	8,893	8,647	8,298
	In Renewal Process	410	624	570	689
RDAEF (Extended Function)	Active/Current	1,278	1,270	1,302	1,357
	Out-of-State	36	35	34	30
	Out-of-Country	0	0	0	0
	Delinquent	156	168	178	172
	Inactive	118	121	122	116
	In Renewal Process	14	21	15	16
DSA (Dental Sedation Assistant)	Active/Current	2	11	21	27
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	0	0	0	2
	Inactive	0	0	0	0
	In Renewal Process	0	0	0	0
OA (Orthodontic Assistant	Active/Current	7	22	85	153
	Out-of-State	0	0	0	1
	Out-of-Country	0	0	0	0
	Delinquent	0	1	2	5
	Inactive	0	0	0	1
	In Renewal Process	0	2	1	6

Table 7a. Licensing Data by Type, by FY

	Application Type	Recvd	Apprvd	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	*Outside Board Control	*Within Board Control	Compl Apps	Incompl Apps	Combined IF unable to sepa-rate out
FY10/11	DDS (Exam)	not applicable									
	(License)	1,082	1,046	n/a	1,046						
	(Renewal)	17,548	17,680	n/a	17,680						
	OMS (Exam)	not applicable									
	(Permit)	6	7	n/a	7						
	(Renewal)	36	31	n/a	31						
	SP (Exam)	not applicable									
	(Permit)	2	2	n/a	2						
	(Renewal)	31	32	n/a	32						
	EFCS (Exam)	not applicable									
	(Permit)	5	1	n/a	1						
	(Renewal)	9	9	n/a	9						
	GA (Exam)	not applicable									
	(Permit)	59	55	n/a	55						
	(Renewal)	383	395	n/a	395						
	CS (Exam)	not applicable									
	(Permit)	37	34	n/a	34						
	(Renewal)	211	215	n/a	215						
	OCS (Exam)	not applicable									
	(Certificate)	262	217	n/a	217						
	(Renewal)	990	1,017	n/a	1,017						
	AO (Exam)	not applicable									
	(Permit)	304	300	n/a	300						
	(Renewal)	1,102	1,102	n/a	1,102						
	FNP (Exam)	not applicable									
	(Permit)	604	604	n/a	604						
	(Renewal)	2249	2,514	n/a	2,514						
	MDC (Exam)	not applicable									
	(Permit)	2	2	n/a	2						
	(Renewal)	9	9	n/a	9						
	RP (Exam)	not applicable									
	(Permit)	129	123	n/a	123						
	(Renewal)	441	518	n/a	518						
	RDA(Exam)	2,527	1,991	n/a	n/a						
	(License)	2,991	1,391	n/a	1,391						
	(Renewal)	17,238	16,868	n/a	16,868						

Table 7a. Licensing Data by Type, by FY, continued											
						Pending Applications			Cycle Times		
	Application Type	Recvd	Apprvd	Closed	Issued	Total (Close of FY)	*Outside Board Control	*Within Board Control	Compl Apps	Incompl Apps	Combined IF unable to sepa-rate out
FY10/11 (cont'd)	AEF (Exam)	85	75	n/a	n/a						
	(License)	95	69	n/a	69						
	(Renewal)	624	632	n/a	632						
	DSA (Exam)	not applicable									
	(License)	20	2	n/a	2						
	(Renewal)	0	0	n/a	0						
	OA (Exam)	not applicable									
	(License)	25	7	n/a	7						
	(Renewal)	0	0	n/a	0						
FY11/12	DDS (Exam)	not applicable									
	(License)	1,070	1,031	n/a	1,031						
	(Renewal)	17,613	17,426	n/a	17,426						
	OMS (Exam)	not applicable									
	(Permit)	6	4	n/a	4						
	(Renewal)	44	38	n/a	38						
	SP (Exam)	not applicable									
	(Permit)	4	5	n/a	5						
	(Renewal)	28	27	n/a	27						
	EFCS(Exam)	not applicable									
	(Permit)	2	1	n/a	1						
	(Renewal)	8	11	n/a	11						
	GA (Exam)	not applicable									
	(Permit)	57	40	n/a	57						
	(Renewal)	438	412	n/a	412						
	CS (Exam)	not applicable									
	(Permit)	62	56	n/a	56						
	(Renewal)	210	210	n/a	210						
	OCS (Exam)	not applicable									
	(Certificate)	167	202	n/a	202						
	(Renewal)	1,054	7,020	n/a	7,020						

Table 7a. Licensing Data by Type, by FY, continued											
						Pending Applications			Cycle Times		
	Application Type	Recvd	Apprvd	Closed	Issued	Total (Close of FY)	*Outside Board Control	*Within Board Control	Com-plete Apps	Incom-plete Apps	Combined IF unable to sepa-rate out
FY11-12 contd.	AO (Exam)	not applicable									
	(Permit)	247	238	n/a	238						
	(Renewal)	951	886	n/a	886						
	FNP (Exam)	not applicable									
	(Permit)	544	580	n/a	580						
	(Renewal)	2,509	2,403	n/a	2,403						
	MDC(Exam)	not applicable									
	(Permit)	3	3	n/a	3						
	(Renewal)	10	10	n/a	10						
	RP (Exam)	not applicable									
	(Permit)	139	127	n/a	127						
	(Renewal)	631	562	n/a	562						
	RDA (Exam)	3,235	3,040	n/a	n/a						
	(License)	2,842	1,767	n/a	1,767						
	(Renewal)	16,869	15,745	n/a	15,745						
	AEF (Exam)	115	112	n/a	n/a						
	(License)	100	65	n/a	65						
	(Renewal)	609	622	n/a	622						
	DSA (Exam)	not applicable									
	(License)	8	9	n/a	9						
	(Renewal)	0	0	n/a	0						
	OA (Exam)	not applicable									
	(License)	54	18	n/a	18						
	(Renewal)	7	6	n/a	6						
FY 12/13	DDS (Exam)	not applicable									
	(License)	1151	1059	n/a	1059						
	(Renewal)	17,664	17,559	n/a	17,559						
	OMS (Exam)	not applicable									
	(Permit)	2	4	n/a	4						
	(Renewal)	42	41	n/a	41						
	SP (Exam)	not applicable									
	(Permit)	2	2	n/a	2						
	(Renewal)	28	28	n/a	28						

Table 7a. Licensing Data by Type, by FY continued											
						Pending Applications			Cycle Times		
	Application Type	Recvd	Apprvd	Closed	Issued	Total (Close of FY)	*Outside Board Control	*Within Board Control	Com-plete Apps	Incom-plete Apps	Combined IF unable to sepa-rate out
FY12/13 contd.	FCS (Exam)	not applicable									
	(Permit)	8	6	n/a	6						
	(Renewal)	9	10	n/a	10						
	GA (Exam)	not applicable									
	(Permit)	63	37	n/a	37						
	(Renewal)	407	373	n/a	373						
	CS (Exam)	not applicable									
	(Permit)	46	42	n/a	42						
	(Renewal)	241	237	n/a	237						
	OCS (Exam)	not applicable									
	(Certificate)	207	202	n/a	202						
	(Renewal)	1,082	1,105	n/a	1,105						
	AO (Exam)	not applicable									
	(Permit)	333	305	n/a	305						
	(Renewal)	968	936	n/a	936						
	FNP (Exam)	not applicable									
	(Permit)	549	537	n/a	537						
	(Renewal)	2,542	2,449	n/a	2,449						
	MDC (Exam)	not applicable									
	(Permit)	0	5	n/a	5						
	(Renewal)	10	11	n/a	11						
	RP (Exam n/a)	not applicable									
	(Permit)	124	92	n/a	92						
	(Renewal)	478	423	n/a	423						
	RDA (Exam)	4,796	3,195	n/a	n/a						
	(License)	3,456	1,903	n/a	1,903						
	(Renewal)	17,117	16,727	n/a	16,727						
	AEF (Exam)	107	98	n/a	n/a						
	(License)	108	69	n/a	69						
	(Renewal)	631	649	n/a	649						

Table 7a. Licensing Data by Type, by FY, continued											
						Pending Applications			Cycle Times		
	Application Type	Recvd	Apprvd	Closed	Issued	Total (Close of FY)	*Outside Board Control	*Within Board Control	Com-plete Apps	Incom-plete Apps	Combined IF unable to sepa--rate out
FY12/13 contd.	DSA (Exam)	not applicable									
	(License)	8	9	n/a	9						
	(Renewal)	9	10	n/a	10						
	OA (Exam)	not applicable									
	(License)	26	63	n/a	63						
	(Renewal)	18	18	n/a	18						
FY 13/14	DDS (Exam)	not applicable									
	(License)	1,201	1,035	n/a	1,035						
	(Renewal)	17,156	17,662	n/a	17,662						
	OMS (Exam)	not applicable									
	(Permit)	1	1	n/a	1						
	(Renewal)	39	40	n/a	40						
	SP (Exam)	not applicable									
	(Permit)	10	10	n/a	10						
	(Renewal)	29	30	n/a	30						
	EFC S(Exam)	not applicable									
	(Permit)	3	1	n/a	1						
	(Renewal)	10	10	n/a	10						
	GA (Exam)	not applicable									
	(Permit)	59	48	n/a	48						
	(Renewal)	452	445	n/a	445						
	CS (Exam)	not applicable									
	(Permit)	52	53	n/a	53						
	(Renewal)	227	235	n/a	235						
	OCS(Exam)	not applicable									
	(Permit)	230	241	n/a	241						
	(Renewal)	1,117	1,084	n/a	1,084						
	AO(Exam)	not applicable									
	(Permit)	305	329	n/a	329						
	(Renewal)	1025	1,071	n/a	1,071						

Table 7a. Licensing Data by Type, by FY, continued											
Application Type		Recvd	Apprvd	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	*Outside Board Control	*Within Board Control	Com-plete Apps	Incom-plete Apps	Combined IF unable to sepa-rate out
FY 13/14 contd.	FNP(Exam)	not applicable									
	(Permit)	695	807	n/a	807						
	(Renewal)	2,724	2,667	n/a	2,667						
	MDC(Exam)	not applicable									
	(Permit)	4	9	n/a	9						
	(Renewal)	14	13	n/a	13						
	RP (Exam n/a)	not applicable									
	(Permit)	121	101	n/a	101						
	(Renewal)	614	580	n/a	580						
	RDA (Exam n/a)	3,615	2,835	n/a	n/a						
	(License)	3,129	2,045	n/a	2,045						
	(Renewal)	17,219	n/a	n/a	16,390						
	AEF (Exam)	159	142	n/a	n/a						
	(License)	145	102	n/a	102						
	(Renewal)	658	658	n/a	654						
	DSA (Exam)	not applicable									
	(License)	8	8	n/a	8						
	(Renewal)	9	9	n/a	9						
	OA (Exam)	not applicable									
	(License)	200	76	n/a	76						
	(Renewal)	57	53	n/a	53						

It should be noted that the Dental Board has not previously tracked pending applications due to the absence of an application backlog. By the time the DDS license application is submitted, all dental licensing requirements have already been met. The only process remaining is the issuance of the actual license and documenting the place of business. Similarly, for RDA applicants, as soon as requirements are met and the successful examination scores have been submitted, the license is automatically issued.

For these reasons, cycle times were not measured due to consistently low application review timeframes. With the Board's participation in Release 2 of BreEZe, the Licensing program has begun tracking this data in anticipation of efficiency comparisons with the new online system.

Table 7b. Total Licensing Data				
	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Initial Licensing Data:				
Initial License/Initial Exam Applications Received – **DDS** Initial License	1,082	1,070	1,151	1,201
Initial License/Initial Exam Applications Approved	1,046	1,031	1,059	1,035
Initial License/Initial Exam Applications Closed				
Licenses Issued	1,046	1,031	1,059	1,035
Initial License/Initial Exam Applications Received – **OMS** Initial Permit	6	6	2	1
Initial License/Initial Exam Applications Approved	7	4	4	1
Initial License/Initial Exam Applications Closed				
Permits Issued	31	38	4	1
Initial License/Initial Exam Applications Received-**SP** Initial Permit	2	4	2	10
Initial License/Initial Exam Applications Approved	2	5	2	10
Initial License/Initial Exam Applications Closed				
Permits Issued	2	5	2	10
Initial License/Initial Exam Applications Received- **EFCS** Initial Permit	5	2	8	3
Initial License/Initial Exam Applications Approved				
Initial License/Initial Exam Applications Closed	1	1	6	1
Permits Issued	1	1	6	1
Initial License/Initial Exam Applications Received-**GA** Initial Permit	59	57	63	59
Initial License/Initial Exam Applications Approved	55	40	37	61
Initial License/Initial Exam Applications Closed				
Permits Issued	55	40	37	61
Initial License/Initial Exam Applications Received-**CS** Initial Permit	37	62	46	52
Initial License/Initial Exam Applications Approved	34	56	42	53
Initial License/Initial Exam Applications Closed				
Permits Issued	34	56	42	53
Initial License/Initial Exam Applications Received- **OCS** Initial Certificate	262	167	207	230
Initial License/Initial Exam Applications Approved	217	202	202	241
Initial License/Initial Exam Applications Closed				
Certificates Issued	217	202	202	241
Initial License/Initial Exam Applications Received- **AO** Initial Permit	304	247	333	305
Initial License/Initial Exam Applications Approved	300	238	305	329
Initial License/Initial Exam Applications Closed				
Permits Issued	300	238	305	329

Table 7b. Total Licensing Data, continued				
	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Initial Licensing Data:				
Initial License/Initial Exam Applications Received- **FNP** Initial Permit	604	544	549	695
Initial License/Initial Exam Applications Approved	604	580	537	807
Initial License/Initial Exam Applications Closed				
Permits Issued	604	580	537	807
Initial License/Initial Exam Applications Received- **MDC** Initial Permit	2	3	0	4
Initial License/Initial Exam Applications Approved	2	3	5	9
Initial License/Initial Exam Applications Closed				
Permits Issued	2	3	5	9
Initial License/Initial Exam Applications Received- **RP** Initial Permit	129	139	124	121
Initial License/Initial Exam Applications Approved	123	127	92	101
Initial License/Initial Exam Applications Closed				
Permits Issued	123	127	92	101
Initial License/Initial Exam Applications Received- **RDA** Exam	2,527	3,235	4,796	3,615
Initial License/Initial Exam Applications Approved-**RDA** Exam	1,991	3,040	3,195	2,835
Initial License/Initial Exam Applications Received- **RDA** Initial License	2,991	2,842	3,456	3,129
Initial License/Initial Exam Applications Approved	1,391	1,767	1,903	2,045
Initial License/Initial Exam Applications Closed				
Licenses Issued	1,391	1,767	1,903	2,045
Initial License/Initial Exam Applications Received- **AEF** Exam	85	115	107	159
Initial License/Initial Exam Applications Approved-**AEF** Exam	75	112	98	142
Initial License/Initial Exam Applications Received- **AEF** Initial License	95	100	108	145
Initial License/Initial Exam Applications Approved	69	65	69	102
Initial License/Initial Exam Applications Closed				
Licenses Issued	69	65	69	102
Initial License/Initial Exam Applications Received- **DSA** Initial Permit	20	8	8	8
Initial License/Initial Exam Applications Approved	2	9	9	8
Initial License/Initial Exam Applications Closed				
Permits Issued	2	9	9	8
Initial License/Initial Exam Applications Received-**OA** Initial Permit	25	247	26	200
Initial License/Initial Exam Applications Approved	7	238	63	76
Initial License/Initial Exam Applications Closed				
Permits Issued	7	238	63	76

Table 7b. Total Licensing Data, continued				
	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Initial Licensing Data:				
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)				
Pending Applications (outside of board control)*	Not tracked by the Dental Board.			
Pending Applications (within the board control)*	Not tracked by the Dental Board.			
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
DDS - Average Days to Application Approval (All - Complete/Incomplete)				
-Average Days to Application Approval (incomplete applications)*	Not tracked by the Dental Board.			
-Average Days to Application Approval (complete applications)*	Not tracked by the Dental Board.			
* Optional. List if tracked by the board.				

Licenses Renewed – **DDS** License (Dental)	17,680	17,426	17,559	17,662
OMS Permit (Oral & Maxillofacial Surgery)	31	38	41	40
SP Permit (Special Permit-Dental School Setting)	32	27	28	30
EFCS Permit (Elective Facial Cosmetic Ssurgery)	9	11	10	10
GA Permit (General Anesthesia)	395	412	373	445
CS Permit (Conscious Sedation)	215	210	237	235
OCS Certificate (Oral Conscious Sedation)	1,017	530	1,105	1,084
AO Permit (Additional Office)	1,102	886	936	1,071
FNP Permit (Fictitious Name)	2,514	2,403	2,449	2,667
MDC Permit (Mobile Dental Clinic)	9	10	11	13
RP Permit (Registered Provider-CE)	518	562	423	580
RDA License (Registered Dental Assistant)	16,868	15,745	16,727	16,390
AEF License (RDA in Extended Functions)	632	622	649	654
DSA Permit (Dental Sedation Assistant)	0	0	10	9
OA Permit (Orthodontic Assistant)	0	6	18	53

18. How does the Dental Board verify information provided by the applicant?

a. What process does the Dental Board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?

All licensing applicants are required to provide electronic fingerprints (live scan). In addition, affirmative responses (arrests or convictions) received from the DOJ, or disclosures by the applicant may trigger the Dental Board to require the applicant provide an explanation in writing describing the event. Similarly, if the dental applicant discloses

any license denials, license surrenders, or prior discipline, the Dental Board requires a full explanation in writing, pursuant to CCR 1028.

In instances when an applicant has criminal history information, staff are responsible for requesting certified copies of the arrest and conviction records for consideration by the licensing managers. Certified records may also be introduced in a Statement of Issues hearing if necessary.

Subsequent to any written explanation provided by an applicant, the Dental Board will review the nature of the act(s) to determine if they may be substantially related to the qualifications, functions, or duties of the profession pursuant to CCR 1019. This information, along with any mitigating documentation will be considered by the board. The applicant may be denied, offered a probationary license, or approved for licensure. In any event, the board maintains a record of the criminal action as a part of the license history.

b. Does the Dental Board fingerprint all applicants? Yes.

c. Have all current licensees been fingerprinted? If not, explain.

Effective July 2011, the Dental Board began the process of requiring all licensees to submit electronic fingerprints in compliance with CCR 1008. Notices were included with renewal paperwork over a two-year period to capture all active licensees. Remaining exceptions include those licensees who have placed their license in an inactive status and active duty military personnel. Inactive licensees will be required to provide electronic fingerprints upon renewal to active status. Military personnel remain exempt until they leave military service and apply for an active license for California.

d. Is there a national databank relating to disciplinary actions? Does the Dental Board check the national databank prior to issuing a license? Renewing a license?

Yes – the Dental Board queries the National Practitioners Data Bank (NPDB) to identify out-of-state discipline as a part of the application process for the Licensure by Credential pathway. Although the Dental Board does not access the NPDB for other licensure pathways or renewals, applicants are required to disclose all of the following:

1) Prior disciplinary action(s) taken against the applicant regarding any dental license or other healing arts license;
2) Whether the applicant is currently the subject of any pending investigation by a government agency;
3) Information regarding any licensing denials or surrenders, and
4) Criminal convictions.

Applicants certify their responses under penalty of perjury.

Renewing licensees, pursuant to CCR 1018.05 are required to disclose:

1) The bringing of an indictment or information charging a felony against the licensee;
2) Convictions (including pleas of no contest) of any felony or misdemeanor; or
3) Any disciplinary action taken by another professional licensing entity or authority of this state, another state, the federal government, or the United States military.

In addition to self-disclosure, external sources are required to report judgments, settlements and awards against licensees for the Dental Board to consider in licensing decisions.

e. Does the Dental Board require primary source documentation?

No, the Board does not require the documentation to come directly from the dental schools. The DDS Licensing program still requires certification of completion of the educational requirement by the dental school, including the school's seal and the "wet" signature of the dean of the dental school.

For the RDA Education pathway, the Board accepts a signed and sealed verification from the school, or copies of diplomas. For the RDA Work Experience pathway, the Board requires an original signature from a licensed dentist certifying the length of employment, the hours worked per week, and that the work performed was at the Dental Assistant level as required.

19. Describe the Dental Board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

Out of State Applicants

Pursuant to B&P Code §§ 1632 and 1634.1, graduates of a Board-approved or Commission on Dental Accreditation (CODA) approved dental school qualify for licensure by passing the WREB examination or, by Licensure by Residency (LBR) which requires a graduate to complete at least 1 year of post-graduate training in an Advanced Education in General Dentistry or General Practice Residency. Applicants are also required to have passed Part 1 and Part 2 of the National Board Dental Examination and must pass the California Law and Ethics examination.

B&P Code § 1635.5 allows applicants to qualify for Licensure by Credential regardless of where they graduated, provided the following requirements are met:

- Hold a current, unrestricted license to practice dentistry in a U.S. State or territory.
- 5,000 hours of clinical practice in the last 5-7 years.
- Credit for two (2) of the five (5) years will be given to applicants who complete a residency program approved by CODA. Applicants not meeting the 5,000 hour

requirement may enter into a two year, full time contract with an approved dental school or community/public clinic.

- National Practitioner Data Bank (NPDB) review.
- Fingerprint clearance from the Department of Justice (DOJ) and Federal Bureau of Investigations (FBI).
- Must not have failed the WREB examination in the last five (5) years.
- Complete 50 hours of continuing education including mandatory courses.

Out of Country Applicants

B&P Code § 1628 requires graduates of foreign dental schools to attend a two-year international dental studies program at a Board approved or CODA accredited program to qualify for one of the licensure pathways. If the international applicant possesses a valid and unrestricted license from another state for five or more years, they may apply using the LBC pathway.

20. Describe the Dental Board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

At present, the U.S. military requires dentists to already have been licensed before they can report for duty in the armed services. The Dental Assisting unit will consider military education, training and experience if the applicant lists this under the general work experience or education requirements.

a. Does the Dental Board identify or track applicants who are veterans? If not, when does the Dental Board expect to be compliant with BPC § 114.5?

The Dental Board is in compliance and waives fees when an applicant identifies themselves pursuant to statute. At present, there is no mechanism in place to track military status within the current licensing system.

b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the Dental Board?

The board is currently unable to track applications based upon military status. This inability is attributed to the hard freeze on changes to the existing Applicant Tracking System (ATS) while the BreEZe computer system is being developed.

c. What regulatory changes has the Dental Board made to bring it into conformance with BPC § 35?

As noted above, existing requirements do not hinder military personnel from having their application or license renewals processed promptly. The Board's current internal business processes are meeting the intent of the statute.

d. How many licensees has the Dental Board waived fees or requirements for pursuant to BPC § 114.3 and what has the impact been on board revenues?

Although the board is unable to track actual numbers, staff estimates 50 – 100 DDS licensees have requested waivers, while no RDA applicants or licensees have requested similar consideration. This volume of fee waivers (less than 1% of the annual licensing and renewal population) is not considered to have a significant impact on the Dental Board's licensing revenue.

e. How many applications has the Dental Board expedited pursuant to BPC § 115.5?

Staff estimates approximately five (5) dental licenses have been expedited since implementation of this statute. To date, there have been no requests received for RDA license expedites.

21. Does the Dental Board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

The Dental Board is actively working to achieve full compliance with the DOJ requirement that removes licensee names from their notification database whenever a license has been disciplined resulting in a surrender or revocation, when an application is withdrawn, abandoned or denied, or if the licensee is deceased. Forms are faxed to DOJ.

Staff are completing the No Longer Interested (NLI) form on an as needed basis when the Dental Board is alerted to a change in licensing status that requires removal. Licensing managers are assigned to run quarterly reports to capture cancelled licenses on a routine basis and assign staff to file the NLI. Enforcement staff perform the same functions when a license has been surrendered or revoked. Due to limited resources, the Dental Board will address old cancellations and disciplinary actions as time allows.

With the implementation of the BreEZe system, there will be an interface with the DOJ that will allow the NLI form to be automatically generated when a license status is changed to deceased, cancelled, revoked, or if an application has been abandoned within specific timeframes.

Examinations

Table 8. Examination Data				
California Examination (include multiple language) if any:				
	License Type	**RDA**	**RDAEF**	
	Exam Title	**Practical Exam**	**Practical Exam**	
FY 2010/11	# of 1st Time Candidates	1991	75	
	Pass %	82.7%	83.3%	
FY 2011/12	# of 1st Time Candidates	3,040	112	
	Pass %	82.3%	66.3%	
FY 2012/13	# of 1st Time Candidates	3195	97	
	Pass %	86.5%	67.3%	
FY 2013/14	# of 1st time Candidates	2835	142	
	Pass %	80.5%	56.4%	
	Date of Last OA	2009	2009	
	Name of OA Developer	OPES	OPES	
	Target OA Date	Pending	Pending	

National Examination (include multiple language) if any: Not Applicable to Dental Board				
	License Type			
	Exam Title			
FY 2010/11	# of 1st Time Candidates			
	Pass %			
FY 2011/12	# of 1st Time Candidates			
	Pass %			
FY 2012/13	# of 1st Time Candidates			
	Pass %			
FY 2013/14	# of 1st time Candidates			
	Pass %			
	Date of Last OA			
	Name of OA Developer			
	Target OA Date			

22. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?

There are four possible pathways to licensure as a **Dentist (DDS)**; briefly stated, they are:

1. **Western Regional Examination Board Clinical Examination (WREB)** The WREB is a regional clinical examination accepted in over 30 states. Passing WREB allows portability for graduates during initial licensure. As one of 13 member boards, the Dental Board actively participates in the exam oversight.

   Applicants must have graduated from an approved dental program or have passed the Board's restorative technique exam and must pass a regional examination and pass the California Law and Ethics examination.

2. **Licensure by Residency (LBR)** Applicants must have completed at least one year of postgraduate education in an approved Advanced Education in General Dentistry or General Practice Residency and pass the California Law and Ethics examination.

Pursuant to B&P Code § 1632, dental applicants applying via the WREB or LBR path also need to provide evidence of passing Part I of the written examination of the National Board Dental Examination (NBDE) of the Joint Commission on National Dental Examinations with their application, and are required to have successfully completed Part II of the NBDE prior to final application approval.

3. **Licensure by Credential (LBC)** Applicants must have been licensed in another state for at least 5 years and in active clinical practice at least 5,000 hours in the preceding 5 of 7 years, or agree to at least a two year contract with an approved dental program in California as an instructor, or practice in a public health clinic in an underserved area as designated by Office of Statewide Health Planning and Development (OSHPD).

4. **Portfolio** AB 1524 (Hayashi, Chapter 446, Stats 2010) will enable licensure candidates to assemble a portfolio of clinical experiences and competencies, as approved by the Board, while completing a dental school program at a board-approved school located in California. After the applicant passes a final assessment of the submitted "portfolio" at the end of his or her dental school program, completes the additional requirements itemized below, and submits a fee, the dental license is issued without additional examination.

   Applicants must complete the National Board Dental Examination, CA Law and Ethics written examination, and must have graduated from a California dental school accredited by the CODA who has chosen to participate in the Portfolio examination pathway. Additionally, the Portfolio Competency examination must be completed with patients of record during final year of dental school.

The Portfolio pathway is anticipated to be effective in November 2014, and could be utilized by the graduating class of 2015 or 2016, depending upon the implementation schedule of the California dental schools.

License renewal requirements are the same for each of the pathways. A dental license expires at the end of the birth month in an even or odd year, depending on when the licensee was born. Licensees certify under penalty of perjury, that they have completed fifty (50) hours of continuing education since their last renewal, including a course in basic life support, infection control (two hours), and CA law and ethics (two hours). The infection control and law and ethics courses must be board-approved.

Licensure as a **Registered Dental Assistant (RDA)** has 3 possible pathways:

1. Graduation from an approved dental assisting program.
2. Completion of 15 months of on the job training, certified by a licensed US dentist.
3. Work experience combined with education from a non-approved program totaling 15 months.

All applicants must pass a written competency examination, a Law and Ethics examination and a Practical examination consisting of three of four statutorily prescribed procedures prior to issuance of the license.

Licensure as a **Registered Dental Assistant in Extended Functions (RDAEF)** requires:

1. Graduation from an approved extended functions program,
2. Passage of a written competency examination, and
3. Passage of a clinical/practical examination.

Applicants licensed prior to January 1, 2010 may qualify to expand their duties by completing additional education and passing a practical examination.

All dental applicants are required to have taken and received a passing score on the California Law and Ethics exam.

23. What are pass rates for first time vs. retakes in the past 4 fiscal years? *(Refer to Table 8: Examination Data)*

As noted in Table 8, the pass rates for the RDA Practical Exam have remained relatively consistent over the past four (4) fiscal years. In contrast, the pass rate for the RDAEF Practical Exam has shown a decrease from 83% in FY 10/11 to just over 56% in 13/14.

Historically, retake pass rates (0% - 52 %) are lower than first time candidates. This trend has remained steady over the last four (4) fiscal years.

In 10/11, there was only one approved program that administered the RDAEF Practical Exam. Since that time, three additional schools have been added.

All the schools are required to maintain the same curriculum as provided in CCR. The Dental Board is authorized to determine if and when a re-evaluation is needed. Currently, the Board is looking at the need for another Occupational Analysis for both practical exams, as well as a new formal exam validation.

Both the NBDE and WREB exams are administered by external sources and as such, pass rates specific to California applicants are not reported to the Dental Board. The California Law and Ethics exam has a pass rate above 99%.

24. Is the Dental Board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

All written exams administered as a condition of licensure are computer based.

The California Law and Ethics exam for dentists, RDAs and RDAEFs are offered by a nationwide contractor, PSI, Inc. PSI offers the exams at fifteen (15) locations throughout California for all license types. It also offers nine (9) exam sites in other states for DDS applicants. The exam is offered six (6) days per week, and allows applicants to schedule their exam date directly with the vendor. LBC applicants are eligible to take an online exam. PSI is also able to provide reasonable accommodations upon request.

The Orthodontic Assistant and Dental Sedation Assistant written exams are also offered by PSI.

25. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

At this time, there are no statutory barriers to processing applications, or in the administration of licensing exams.

School approvals

26. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the Dental Board work with BPPE in the school approval process?

Dental Schools are accredited by the American Dental Association, Commission on Dental Accreditation (CODA) if they are located within the United States. The Board is also authorized to approve foreign dental schools that meet the requirements of B & P Code § 1636.4.

Dental Assisting educational programs and courses in California are regulated by the CCR §§ 1070 and 1070.1. There are eight (8) additional sections, one for each of the educational programs or courses required for licensure as an RDA, RDAEF, Orthodontic Assistant or Dental Sedation Assistant. There are also educational requirements for courses required to become licensed. The majority of these regulations were promulgated in 2011.

The Bureau for Private Postsecondary Education does not have a role in the approval of dental schools, but does provide oversight to some Dental Assisting programs (although DA's are outside the scope of licensure by the Board).

27. How many schools are approved by the Dental Board? How often are approved schools reviewed? Can the Dental Board remove its approval of a school?

There are currently 100 approved dental assisting programs, 5 approved dental assistant in extended functions programs, 70 orthodontic assistant courses, 22 dental sedation assistant courses, and numerous providers of courses in infection control, coronal polish, pit and fissure sealants and use of an ultrasonic scaler.

All courses are required to be re-evaluated approximately every seven years. The Board may withdraw approval of any program or course that does not meet the requirements of the Dental Practice Act.

What are the Dental Board's legal requirements regarding approval of international schools?

International dental schools must meet the requirements of California Code of Regulations, Chapter 2, Article 1. At present, only one foreign dental school, De La Salle School of Dentistry, located in Leon, Guanajuato, Mexico has been approved by the Dental Board. A revisit was conducted in early 2012, and the school's approval was extended at that time.

Continuing Education/Competency Requirements

28. Describe the Dental Board's continuing education/competency requirements, if any. Describe any changes made by the Board since the last review.

Continuing Education (CE)

Pursuant to B & P Code § 1645(a), the Board has adopted and administers standards for the continuing education (CE) of its licensees. CCR § 1017 sets forth the specific amount and type of CE required for renewal of licenses, permits, and certificates issued by the board.

Each dentist is required to complete not less than 50 hours of approved CE during the two year period immediately preceding the expiration of their license. Each registered dental assistant is required to take 25 hours of approved CE during the two year period immediately preceding the expiration of their license. As part of the required CE, courses in basic life support, infection control, and California law and ethics (based upon the Dental Practice Act), are mandatory for each renewal period for all licensees

Effective January 1, 2010, all *unlicensed* dental assistants in California must complete an approved 8-hour infection control course, an approved 2-hour course in CA law and ethics, and a course in basic life support.

In March of 2010 the Board made substantial changes to the CE regulations under CCR § 1016 and 1017. There have been no additional changes that have been made to the requirements over the last four years. The Board will be promulgating regulations to implement AB 836 which allows a retired dentist who has practiced in California for 20

years and currently provides only uncompensated care, to only be required to complete 60% of continuing education required, in courses related to the actual delivery of dental care.

It is also anticipated that the Board will promulgate regulations to establish Basic Life Support equivalency standards to update this section in the near future.

Competency Requirements

The Dental Board has initial and ongoing competency requirements for General Anesthesia (GA) and Conscious Sedation (CS) permit holders. Pursuant to B&P Code § 1646.4, GA permit holders must undergo an onsite inspection and evaluation at least every five (5) years.

B&P Code § 1647.7 provides for the onsite inspection and evaluation for licensees seeking to administer conscious sedation. Evaluations shall occur at least once every six years. The inspection and evaluative process is detailed in CCR 1043.3 and 1043.4.

a. How does the Dental Board verify CE or other competency requirements?

As part of the renewal process, licensees are required to certify under penalty of perjury that they have completed the requisite number of continuing education hours, including any mandatory courses, since their last renewal.

b. Does the Dental Board conduct CE audits of licensees? Describe the Board's policy on CE audits.

Starting with the February 2011 renewal cycle, random CE audits for dentists were resumed. Staff developed written procedures for the auditing process as a part of the Board's ongoing desk manual and succession planning efforts. Staff has been auditing 5% of the dental renewals received each month. Licensees are required to maintain documentation of successful completion of their courses, for no fewer than four years and, if audited, are required to provide that documentation to the Board upon request.

Without additional resources, audits for registered dental assistants are only conducted in response to a complaint or other evidence of noncompliance.

c. What are consequences for failing a CE audit?

A dentist who is not able to provide proof of CE is issued a citation with a fine. The citation also includes an abatement condition requiring the licensee to complete the deficient number of credits within a specified time period. These units are in addition to the credits required for the new renewal cycle. A licensee who fails to pay the fine or comply with the citation's abatement may be referred for discipline.

It should be noted that CE audits are conducted at the completion of the renewal process. The ability to renew the license is not delayed or denied based upon the audit outcome.

d. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?

As of September 30, 2014, staff has conducted 521 CE audits. Seven (7) licensees, or approximately 1% of those audited, failed the audit.

e. What is the Dental Board's course approval policy?

Following an application process, the Board approves Registered Providers (providers), but not the individual course(s), with the exception of the mandatory courses in law and ethics, and infection control.

f. Who approves CE providers? Who approves CE courses? If the Dental Board approves them, what is the Board's application review process?

Providers are approved by a staff analyst. Although course outlines, brochures, and/or summaries are required in the biennial report, CCR §1016(e)(1) states, in pertinent part, "*The board may not grant prior approval to individual courses unless a course is required as a mandatory license renewal course*. …"

As is the case with any board application, the application for approval as a registered provider delineates the requirements set forth in regulation, and the applicant certifies under penalty of perjury that all courses offered for CE meet the board's requirements.

The minimum requirements for course content for all mandated CE courses is set forth in CCR §1016(b)(1)(A-C). Providers must adhere to the minimum requirements for course content or risk their registered provider status.

Providers are required to submit their course content outlines for Infection Control and the California Law and Ethics courses to the board for review and approval. A board staff analyst approves the courses based upon the submitted course outline and the course requirement in regulation.

If a provider wishes to make any significant changes to the content of a previously approved mandatory course, the provider is required to submit a new course content outline to the board. A provider may not offer the course until the new course outline is approved.

g. How many applications for CE providers and CE courses were received? How many were approved?

At the conclusion of FY 13/14, the Dental Board received 121 Registered Provider Permit applications, of which, 101 were approved. At present, there are 1,226 registered CE providers.

The Board does not approve individual CE courses.

h. Does the Dental Board audit CE providers? If so, describe the Board's policy and process.

The Board does not audit registered providers of continuing education at this time.

i. Describe the Dental Board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensee's continuing competence.

The Board is not currently planning on implementing performance based assessments for all licensees' continuing competence. The Board does not have the resources to implement this on an ongoing basis. If a licensee's competency is questionable there are mechanisms within the enforcement disciplinary guidelines that require licensees to prove they are competent to practice.

The Board's continuing education regulations also delineate the types of courses that are acceptable and require continuing education providers to biennially report the courses that have been offered.

Section 5
Enforcement Program

29. What are the Dental Board's performance targets/expectations for its enforcement program? Is the Board meeting those expectations? If not, what is the Board doing to improve performance?

Performance Targets / Expectations

In addition to the performance measures established with the Department, (see Section 2), B&P Code §129 states that each board shall "notify the complainant of the initial administrative action taken on his complaint within 10 days of receipt." As reported previously, the Board's Complaint and Compliance Unit (CCU) has consistently met this requirement, with a four-year average of nine (9) days to respond.

In FY 2010/11, the Board developed an internal performance target to reduce the number of cases in its oldest categories (2 -3+ years). Through focused case reviews and our Unlicensed Activity efforts, the Enforcement Program has reduced cases in these oldest categories from over 147 cases in November 2010 (19% of overall caseload), to 64 (8% of overall caseload) at the end of July 2014.

In addition, the Board has identified "reducing cycle times for investigations by 10%" as an objective within its 2014 strategic plan. It is anticipated that by auditing each step of the investigative process, further efficiencies can be identified and implemented that will enable us to reach this goal by 2016.

30. Explain trends in enforcement data and the Dental Board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the Dental Board done and what is the Board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

Trends in Enforcement Data **(Tables 9a & 9b)**

The Board received between 3,500 and 3,900 complaints per year. This volume has remained fairly constant over the past 8 years. The number of complaints originating from public sources has risen slightly (3%) and may be attributed to increased consumer awareness. In November 2012, the Board implemented CCR 1065 requiring a notice be posted in dental offices to provide consumers with the Board's toll free telephone number and web address to file complaints or conduct license verification.

31. Table 9a. Enforcement Statistics				
	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
COMPLAINT				
Intake				
Received	3734	3563	3965	3682
Closed (w/o inv)	59	6	0	1
Referred to INV	3641	3570	3972	3699
Average Time to Close (Days)	13	9	7	7
Pending (close of FY)	61	48	41	24
Source of Complaint				
Public	2431	2151	2272	2370
Licensee/Professional Groups	90	124	114	101
Governmental Agencies	822	886	1201	772
Other	391	402	378	439
Conviction / Arrest				
CONV Received	678	750	1084	650
CONV Closed	647	775	1082	659
Average Time to Close (Days)	23	10	8	6
CONV Pending (close of FY)	36	11	13	4
LICENSE DENIAL				
License Applications Denied	3	7	4	5
SOIs Filed*	23	41	14	18
SOIs Withdrawn	1	0	3	0
SOIs Dismissed	0	0	0	0
SOIs Declined	0	0	0	0
Average Days SOI (from complaint receipt to case outcome)	570	446	699	776
ACCUSATION				
Accusations Filed	89	103	75	73
Accusations Withdrawn	9	8	10	2
Accusations Dismissed	0	0	2	1
Accusations Declined	7	1	3	0
Average Days Accusations (from complaint receipt to case outcome)	1043	1087	934	1271
Pending (close of FY)	200	234	188	168

*Statement of Issues (SOI) – Upon denial of an application for licensure, an applicant may request an SOI for reconsideration

The number of complaints opened in response to criminal arrests and convictions has risen substantially (over 200%) from the previous reporting period. This can be partially attributed to internal procedural changes the Board has made to record and track a greater range of criminal events reported on its licensees, as well as the implementation of CCR 1008 which became effective in July 2011. Known as *Retroactive Fingerprinting*, this regulation required that a licensee must furnish a full set of fingerprints to the Department of Justice (DOJ) as a condition of renewal with the Dental Board if the licensee was initially licensed prior to 1999 or if an electronic record of the fingerprint submission no longer exists.

The number of license denials has remained constant, although the number of probationary licenses has increased from a previous average of 7 per year to 15 issued

annually. Using its authority under B&P Code §1628.7, as amended in 2012, the Board has issued probationary licenses to applicants with less egregious conviction records that may have previously been denied. Some applicants, following a Statement of Issues hearing, and based upon the findings and recommendation of an administrative law judge, have been issued full and unrestricted licenses. This process ensures licensees are rehabilitated and thereby enhances consumer protection.

Table 9b. Enforcement Statistics

	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
DISCIPLINE				
Disciplinary Actions				
Proposed/Default Decisions	38	43	38	29
Stipulations	68	68	58	63
Average Days to Complete	929	939	862	1185
AG Cases Initiated	148	174	85	91
AG Cases Pending (close of FY)	200	234	188	168
Disciplinary Outcomes				
Revocation	24	30	26	32
Voluntary Surrender	10	6	10	14
Suspension	0	0	0	0
Probation with Suspension	6	6	0	1
Probation	59	57	51	53
Probationary License Issued	22	17	16	5
Other	0	0	0	0
PROBATION				
New Probationers	65	51	51	52
Probations Successfully Completed	55	48	42	42
Probationers (close of FY)	148	206	257	311
Petitions to Revoke Probation	4	15	5	8
Probations Revoked	4	6	4	12
Probations Modified	0	1	1	0
Probations Extended	0	3	0	3
Probationers Subject to Drug Testing	46	52	58	67
Drug Tests Ordered	182	428	361	416
Positive Drug Tests	25	52	32	45
Petition for Reinstatement Granted	4	3	0	3
DIVERSION				
New Participants	9	13	11	12
Successful Completions	6	6	8	4
Participants (close of FY)	52	53	48	46
Terminations	2	0	1	0
Terminations for Public Threat	1	4	1	1
Drug Tests Ordered	1359	1320	1247	1097
Positive Drug Tests	12	39	27	14

The number of accusations filed on behalf of the board has also remained relatively constant over the last 8 years. However, the average number of days to complete a case that has been referred to the Attorney General's Office for disciplinary action has continue to increase from 929 days in 2009/10 to over 1185 days in 2014 (over 27%). The table below further illustrates the days between case referral, filing of an action and case conclusion.

Case Aging (Days)	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Statement of Issues Cases				
Referral to Statement of Issues Filing (Average Days)	114	119	204	102
Statement of Issues to Case Conclusion	267	264	273	357
Total Average from Referral to Case Conclusion	**381**	**383**	**477**	**459**
Licensing Accusations				
Referral to Accusation Filing (Average Days)	157	153	170	231
Accusation to Case Conclusion	440	429	408	528
Total Average from Referral to Case Conclusion	**597**	**582**	**578**	**759**

Probation -The number of licensees placed on probation has nearly doubled, from 148 in FY 10/11 to 311 at the end of FY 13/14. In general, the enforcement time commitment to manage a probationary licensee is four times greater than an investigation due to the number of meetings and quarterly reports that may be required. The Board is studying this trend to determine if internal changes will be sufficient to address this or if a BCP will be necessary to add staff dedicated strictly to these tasks.

Diversion -The Board's Diversion program has shown a 24% decrease in participation from a high of 61 participants in FY 08/09 to its current attendance of 49. The decrease in the number of tests performed directly correlates to the number of participants.

The Diversion program is discussed in more detail in Section 13.

Improvements

The Complaint and Compliance Unit has, over the last four years, reduced the time for a desk investigation from 180 days in FY 09/10 to 95 days currently. Similarly, cases referred for further investigation have decreased from 351 days (from complaint to closure) in FY 09/10 to 174 days. The enforcement program has implemented several processes to accomplish these reductions including:

- Conducting (at minimum) quarterly desk audits and/or case reviews. Case reviews ensure investigative time is focused on highest priority cases, provides guidance, and provides accountability
- Providing managers with a variety of statistical information to measure individual performance and expectations
- Increasing training for enforcement staff. In addition to attendance at the Department's Enforcement Academy, Special Investigators and analysts in the Investigative Analysis Unit (IAU) attended the National Certified Investigator and

Inspector Training provided by the Council on Licensure, Enforcement & Regulation (CLEAR). These courses provide advanced report writing skills in addition to investigative techniques and resources to staff without prior enforcement experience.

The number of cases referred for criminal prosecution has increased over 250% during the last four year period. This can be partially attributed to an increase in both criminal fraud and unlicensed activity investigations.

Consumer Protection Enforcement Initiative (CPEI) -Beginning in 2011, the Board began filling the 12.5 positions allocated under the Department of Consumer Affairs Budget Change Proposal (BCP #1110-1A). Sworn investigator positions were distributed between the two Northern and Southern California field offices, and the Investigative Analysis Unit (IAU) was established in the Sacramento headquarters office. The board's enforcement managers developed case assignment guidelines, conducted an extensive case review of all open, previously unassigned cases, and distributed them amongst new and existing staff, resulting in the elimination of a backlog of over 200 cases.

The benefit of additional sworn and non-sworn staff is also illustrated in the increased volume of case closures from 785 in FY 09/10 to over 900 in FY 13/14.

Case Closure Increases over time	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Number of Investigative Staff	14	26.5	26.5	26.5	26.5
Total Case Closures	785	949	1085	800	904

Performance Barriers

Caseloads -Although the Board has received an augmentation in enforcement staffing levels from CPEI, the caseload per investigator continues to remain significantly higher than other programs within DCA. In addition to an investigation caseload, Dental Board investigators also carry a probation monitoring caseload averaging 10 per sworn investigator and up to 25 for Special Investigators. High caseloads can adversely affect performance when staff is diverted from their work by competing demands.

DCA – Enforcement Program	Average Caseload per Investigators
Division of Investigation	20-22 cases
Medical Board of California	20 cases
Dental Board of California	45-55 cases

Lack of Support Staff -Although the primary responsibility of the IAU's non-sworn analytical staff is investigation, all staff have been assigned enforcement-related support functions (development of procedure manuals, outreach and recruitment for SMEs (Subject Matter Experts), PRA (Public Records Act) requests, statistical reports, etc.) as the ancillary needs of the program have grown. Staff are also responsible for the administrative

processing of their cases (copying, filing, mailing) prior to transmittal to the Attorney General's office for discipline. CPEI did not include technical staff to perform support functions generated by the increase in completed investigations produced. The board has recently submitted a BCP to add two Office Technician positions to address this gap.

Shortage of SMEs -The Board utilizes licensed dentists as SMEs to conduct an in-depth review of the treatment provided to patients in cases alleging substandard care. Experts must be currently practicing, possess a minimum of 5 years' experience in their field, and cannot have had any discipline taken against their license in California or any other state where they have been licensed. Experts are paid $100/hour for their written review.

The Dental Board is currently experiencing a shortage of available SMEs to provide case review of our completed investigations. The lack of available experts can be attributed to several factors, including:

1) In direct correlation to the increase in the number of investigations being conducted by staff, the volume of cases being referred to each expert has risen. The existing pool of experts can only absorb a finite number of case reviews in addition to their regular practice schedule. In some instances, particularly with specialty practice areas, board staff may need to contact multiple experts before finding one willing and able to take on the work required. An increase in the number of experts in the resource pool will allow staff to more quickly refer their cases for review.

2) In most cases, the compensation for the work performed is below the commensurate salary earned as a dentist. Although the majority of our SMEs recognize they are providing a service to consumers and their profession, the possibility of having to testify at hearing and close their practice for several days at a time, can become a financial hardship to an individual licensee. The current compensation rate has not been increased since 2009. [By comparison, physicians at the Medical Board are compensated at $150/hour for case reviews, and $200/hour for testimony]

3) Imposed travel and outreach restrictions have limited the Dental Board's ability to attend professional events which can offer additional opportunities for recruitment.

The Board has been actively recruiting for experts on its website, through outreach to dental societies and by distributing pamphlets at professional society conferences, to increase participation.

Vehicles -Signed in July 2009, Executive Order S-14-09, required all state agencies to reduce the size of their vehicle fleet by 15%. No consideration or priority was made for consumer protection related enforcement responsibilities. Vehicle replacements were also suspended, causing the Board's fleet to age and incur lengthy and expensive repairs. The Dental Board reduced its fleet size from 19 to 14. With the augmentation of CPEI positions, the number of field staff (Inspectors, Investigators and Supervisors) increased from 18 to 24, causing a shortage of vehicles for staff to conduct their duties.

The Board's sworn Investigator staff is responsible for investigating the most egregious consumer complaints – those involving death, great bodily injury, sexual abuse allegations, fraud and substance abuse. In order to perform these functions, sworn staff must conduct

in-person interviews, gather evidence and documents from the location of the alleged violation(s), perform arrests, serve search warrants, and conduct undercover surveillance operations. All of these essential functions rely on readily available transportation. The use of a state vehicle also allows peace officer staff to transport prisoners, collect and secure evidence, transport witnesses, and secure peace officer safety equipment, files, and evidence.

Vehicles previously assigned to Supervising Investigators were reassigned to Investigators to lessen the impact. On many occasions, the lack of an available vehicle resulted in renting commercial vehicles at a substantial time commitment. Other vehicles were reclassified as pool cars and shared between non-sworn investigators, inspectors and investigative analysts with field assignments. Despite these adjustments, the unavailability of vehicles for field work has impacted enforcement staff's ability to complete their cases in a timely and efficient manner.

Furloughs / High Leave Balances – Beginning in February 2009 and continuing through April 2012, the Board's investigators were furloughed between one and three days per month. The direct impact of these cost-saving measures for the state, were a loss of work force hours to investigate and discipline licensees in violation of the Dental Practice Act. In addition, the mandated leave allowed staff to use less accrued vacation and annual leave, and resulted in excessively high leave balances. In order to reduce or maintain leave balances within department guidelines, several staff have been directed to follow leave reduction plans, reducing their work hours up to 60 hours/month. These unanticipated effects of the previous years' furloughs are continuing to affect the board's overall performance.

	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
All Investigations				
First Assigned	3640	3570	3973	3699
Closed	3981	3496	3691	3758
Average days to close	181	173	156	187
Pending (close of FY)	1517	1597	1878	1822
Desk Investigations				
Closed	2987	2404	2889	2855
Average days to close	106	72	87	118
Pending (close of FY)	492	738	1088	1022
Non-Sworn Investigation				
Closed	377	593	257	320
Average days to close	278	364	384	473
Sworn Investigation				
Closed	572	492	543	584
Average days to close	505	453	421	391
Pending (Combines Sworn and Non-Sworn)	1025	859	790	800
ISO & TRO Issued	1	6	4	0
PC 23 Orders Requested	5	6	6	4
Other Suspension Orders	3	0	0	0
Public Letter of Reprimand	9	13	11	12
Cease & Desist/Warning	128	104	111	113
Referred for Diversion	1	0	3	8
Compel Examination	2	2	0	0
Citations Issued	42	15	28	82
Average Days to Complete	127	339	410	272
Amount of Fines Assessed	$135,900	$28,000	$55,200	$301,150
Reduced, Withdrawn, Dismissed	0	7	4	8
Amount Collected	$15,850	$10,469	$88,026	$28,782
Referred for Criminal Prosecution	8	10	18	28

Table 10. Enforcement Aging						
	FY 10/11	FY 11/12	FY 12/13	FY 13/14	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	51	52	43	21	167	36%
2 Years	60	48	45	46	199	43%
3 Years	4	20	9	24	57	13%
4 Years	3	7	5	7	22	5%
Over 4 Years	6	2	3	4	15	3%
Total Cases Closed	124	129	105	102	460	100%
Investigations (Average %)						
Closed Within:						
90 Days	1890	1816	1844	1615	7165	48%
180 Days	995	835	844	923	3597	24%
1 Year	574	346	572	648	2140	14%
2 Years	305	283	290	390	1268	9%
3 Years	166	178	120	153	617	4%
Over 3 Years	51	31	21	29	132	1%
Total Cases Closed	3981	3489	3691	3758	14,919	100%

33. What do overall statistics show as to increases or decreases in disciplinary action since last review.

Disciplinary Action Trends

Most disciplinary outcomes have shown little change. Voluntary surrenders have increased slightly and have been most common in the board's largest cases with multiple patients and high prosecutorial costs.

Enforcement Aging – The Board has placed a high priority on case aging and has made great strides in reducing the number of cases in its oldest categories. In investigations, cases over three years old were reduced from over 22% in FY 09/10 to 5% at present.

For Attorney General cases, closures over three years old were reduced from 15% in FY 09/10 to 8% at the end of the current fiscal year, FY 13/14.

34. How are cases prioritized? What is the Dental Board's compliant prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.

Case Prioritization

The Board follows the case prioritization guidelines set forth in DCA's August 31, 2009, memorandum titled, "*Complaint Prioritization for Health Care Agencies*." Those guidelines are utilized during the Board's complaint intake process, as well as during its investigation processes. However, the Board recognizes that these guidelines offer general parameters -they do not apply uniformly to each and every case.

As the Board's mission is to protect the health and safety of California's consumers, it uses the 2009 guidelines, but it does so *in conjunction with* the background of the complaint/allegation. The nature of the complaint and its attendant details must be taken as a whole in order to designate the complaint with the appropriate priority, and then assign the investigation to the staff person who can best work the case.

During complaint intake, the standard is for cases to be prioritized -with prime consideration assigned to those cases where there has been or is likely to be imminent consumer harm/injury. Allegations involving patient death, sexual misconduct, pharmaceutical and/or substance abuse or physical/mental incapacity, as well as unlicensed activity will likely receive high priority, depending on the specifics of the allegation, and would be immediately referred to a sworn Investigator.

After these highest urgency cases are assigned, the investigator prioritizes it within his/her existing caseload. Factors the investigator, in turn, takes into consideration include (but are not limited to) actual or potential consumer harm, applicable criminal and/or administrative statute of limitations, and travel requirements.

Urgent cases may reveal the need for immediate action, e.g., an interim suspension order (ISO), a temporary restraining order (TRO), or compelling a licensee to undergo a mental or physical examination to determine his/her ability to practice.

Complaints and investigations evaluated as having a "high" (as opposed to "urgent") priority level include allegations relating to actions that *do not pose an immediate threat* to the public's health, safety, or welfare. For example, cases alleging negligence and/or incompetence, physical or mental abuse (without injury), prescription-related allegations, unlicensed activity, aiding and abetting unlicensed activity, or multiple prior complaints.

Depending on the purported facts behind the allegation, high priority cases may be assigned to a sworn Investigator, or to non-sworn staff, i.e., Special Investigators. As with the aforementioned urgent cases, the sworn and non-sworn investigators prioritize them within their caseload.

Complaints deemed to be “routine” include, for example, allegations relating to general quality of care, fraud, patient abandonment, documentation/records, DOJ conviction notifications, out-of-state discipline, and malpractice settlements/judgments.

These “routine” investigations may be assigned to Investigators, non-sworn Special Investigators, or an Enforcement Analyst. After assignment, these, too, are prioritized within the assigned staff’s caseload.

35. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the Dental Board, actions taken against a licensee. Are there problems with the Dental Board receiving the required reports? If so, what could be done to correct the problems?

Mandatory Reporting Requirements

The Board relies on several reporting requirements to aid in identifying violations of the Dental Practice Act.

B&P Code §801(c) requires providers of professional liability insurance report to the Board dental malpractice settlements or arbitration awards, when the payment exceeds $10,000. Insurers are required to notify the Board of the awards within 30 days of the signed settlement agreement, or within 30 days after service of the award. The Board’s primary source for these reports is TDIC (The Dentists Insurance Company).

B&P Code §802 obligates licensees who are not covered by professional liability insurance to report to the Board, within 30 days, any settlement, judgment, or arbitration award over $3,000.

B&P Code §803 specifies that, after a judgment of more than $30,000 by a California court, the Clerk of that court must report the judgment to the Board within ten (10) days.

With reference to judgments, it should be noted that judgments do not automatically or intrinsically meet the criteria for taking disciplinary action. As with routine complaints received by the Board, before it can be decided what course of action to take as a result of a judgment, the Board must obtain patient releases; as well as dental, medical and/or legal records. If the Board is not able to get the patient’s release(s), then it may have to turn to the sometimes unwieldy subpoena process in order to obtain necessary records.

B&P Code §805 et seq. mandates that peer review bodies, health care service plans, dental societies, and committees that review care, report to the Board (within 15 days) whenever any of the following occurs:

1. A licentiate’s application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

2. A licentiate’s membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

3. Restrictions are imposed, or voluntarily accepted, on a licentiate's staff privileges, membership of employment for a cumulative total of 30 days or more for any 12-month period for a medical disciplinary cause or reason.

4. The imposition of summary suspension of a licentiate's staff privileges, membership, or employment, if the suspension remains in effect for more than 14 days.

B&P Code §1680(z) requires licensed dentists to self-report any patient death within seven (7) days of discovery that it may be related to dental treatment. Dentists are also required to notify the Board of any unscheduled or unexpected patient hospitalization or treatment exceeding 24 hours when that hospitalization/treatment is the result of dental treatment.

In addition to reporting treatment-related incidents, CCR, Title 16, Division 10, Chapter 1, Article 4.6, §1018.05(b) became operative on March 9, 2012. As a result, the Board's licensees are now required to report to the Board, within 30 days:

1. The bringing of an indictment or information charging a felony against the licensee.

2. The conviction of the licensee of any felony or misdemeanor. (This requirement excludes traffic infractions unless that conviction includes a fine of $1,000 or more, or if the conviction involves alcohol or controlled substances.)

3. Any disciplinary action taken by another professional licensing entity -- be it from California, another state, the federal government, or the United States military.

Under the provisions of Penal Code §11105.2, the California Department of Justice (DOJ) sends reports to the Board when licensees are arrested and/or convicted of crimes. The DOJ notifications may be generated as a result of retroactive fingerprint requirements, or arrests/convictions occurring subsequent to licensure.

It should be noted that many DOJ notifications are the result of information local law enforcement entities and courts submit to DOJ. If, for whatever reason, those entities do not provide DOJ with arrest and conviction information, then DOJ obviously can't relay that information to the Board. Consequently, it is not uncommon for the Board to receive DOJ notification of a licensee's conviction -- without having been previously provided corresponding arrest information. Similarly, the Board can receive conviction information that relates to a licensee's prior conviction of which the Board had no knowledge.

For example, DOJ might notify the Board of a licensee's misdemeanor or felony DUI conviction (Vehicle Code §23152). After obtaining the court documents, the Board learns the licensee was originally also charged with driving with a suspended license, or perhaps charged with being DUI while on probation for a previous DUI.

It would not be unusual for the Board not to have received DOJ arrest and/or conviction information relating to that licensee's suspended license. A similar lack of information could also apply to that licensee's first DUI. As a result, the Board must obtain records relating to the licensee's past offenses in order to determine if the licensee may pose a threat to public safety.

This historical arrest/conviction information "gap" could be corrected if law enforcement and courts were required to report all arrests and convictions to DOJ. However, imposing

and implementing such a requirement may likely be cumbersome, impractical, and unfeasible.

36. Does the Dental Board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the Dental Board's policy on statute of limitations?

Statute of Limitations

When it comes to prioritizing and managing its cases, the Board uses administrative and criminal statutes of limitations as one of the key components of its approach to investigation timeframes. As a result, the Board has only experienced a limited number of cases that were unable to be completed before that statute of limitations had elapsed.

Fiscal year	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Cases closed due to statute of limitations	3	0	2	0

Per Penal Code §799 *et seq.*, California has numerous specified offenses with different statute of limitations for each. With some exceptions, the statute of limitations for misdemeanors is commonly within one (1) year after the date of the offense, and lesser felonies generally have a three (3) year statute of limitations.

B&P Code §1670.2 addresses the time limits on initiating proceedings for violations of the Dental Practice Act (DPA). Administrative proceedings initiated by the Board are required to be filed within three (3) years after the Board discovers the act or omission alleged as the grounds for disciplinary action, or within seven (7) years after the aforesaid act or omission occurred, whichever occurs first.

As a safeguard, the Dental Board uses the date the Dental Board receives the complaint as the initiation of the statute. However, until patient treatment records can be obtained, along with a subject response and reviewed by a Dental Consultant, the Dental Board considers the Dental Consultant's opinion as the date of "discovery."

Factors that contribute to statute problems include delays by the patient to file a complaint in a timely manner, delays in obtaining a patient release for their dental treatment records, delays by the licensee to provide a complete and diagnostic patient chart, and investigative priorities within individual caseloads.

Records and information requests, when coupled with referrals to Consultants and/or specialists, can consume up to six (6) months on the statute of limitations "clock." In instances when licensees do not comply with the Board's repeated requests for records, (B&P Code §1684.1 requires that requested records be provided within 15 days.) citations are issued to gain compliance. These obstacles (uncooperative licensees, the citation process) can delay having a case assigned to investigation and, as such, further restrict available working time before the statute of limitations becomes imminent.

Investigative staff's standard practice is to, "Work your oldest cases first", with the goal to close cases before they are 365 days old (after assignment). Board Managers and Supervisors use monthly reports to monitor case activity and aging. This enables them, when needed, to take the necessary steps to ensure their subordinates are actively

working cases, and completing investigations well before they meet the statute of limitations.

With reference to administrative action, the Board's investigative staff works in conjunction with the Office of the Attorney General (OAG) for the filing of an administrative Accusation. The Board recognizes that the OAG is constrained by its own staffing, processing, and timeline issues. As such, when referring cases to the OAG for disciplinary action, the Board's strategy is to refer those cases *at least* three (3) months before they reach statute.

37. Describe the board's efforts to address unlicensed activity and the underground economy.

Unlicensed Activity

The Board receives approximately 125 reports of unlicensed activity annually. In some instances (approx. 20%), the allegations involve Dental Assistants and Registered Dental Assistants practicing outside the scope of their licensure. These cases are generally investigated during office visits and inspections and may result in the issuance of a warning notice or citation.

Of greater concern are the true unlicensed dentistry cases that are reported. Although only compromising about 3% of the enforcement caseload, these cases often include patients with infections caused by unsanitary conditions, injections of anesthetics, and distribution of controlled substances. Frequently involving undocumented and non-English speaking patient/complainants, investigating these allegations presents numerous challenges. Operatories have been found in run-down residences, garages, and non-medical commercial locations (barber shops, dental labs, or spas). Suspects are often transient, moving among numerous locations to avoid detection. Patients are often reluctant to come forward due to cultural mistrust of law enforcement combined with their undocumented status. Fortunately, the Board's enforcement program has several bilingual investigators whose combined skills have allowed them to establish trust with complainants, obtain the necessary information to investigate the cases, and have resulted in many successful criminal prosecutions.

In September 2013, to address the growing number of unlicensed activity cases in Southern California, the enforcement program established a Task Force approach. Cases were evaluated and sorted based on case age, location, and staff resources. A focused effort to visit unlicensed locations and determine whether the suspect(s) were still in operation or had moved on was developed.

Teams were selected and assigned unlicensed cases in a specific geographical area. A Supervising Investigator was assigned to oversee the operations of their team. During the four-day operation, staff from both our northern and southern offices worked collaboratively to contact as many locations as feasible. The teams performed surveillance and undercover operations to determine if the suspect(s) were still in business.

Over 50 locations were targeted. The effort resulted in:

- Nine (9) search warrants,

- Nine (9) arrests and convictions,
- Four (4) field admonishments,
- And four (4) felony convictions

In total, 59 unlicensed activity cases were closed during and in the months immediately following this effort.

At present, the Board intends to repeat this effort annually. Although this effort was extremely productive, thorough unlicensed activity investigations are time intensive, and the Dental Board does not have the staff resources to conduct more regular efforts. With the results of the next task force, the Board may wish to consider a Budget Change Proposal for additional funding and resources to continue these efforts at a higher frequency.

Cite and Fine

38. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the $5,000 statutory limit?

B&P Code §125.9 authorizes the Dental Board to issue citations and fines for violations of the Dental Practice Act.

B&P Code § 1611.5 is the guiding statute in use by the Board's Inspection staff to review patient records and facilities to ensure a safe and sanitary experience for dental patients, and maintain compliance with CalOSHA and Infection Control regulations.

B&P Code §1684.1(a)(1) authorizes the Dental Board to issue administrative citations to dentists who failed to produce requested patient records within the mandated 15 day time period. The Dental Board continues to hold licensees accountable to this timeframe and issues citations with a $250/day fine, up to $5,000 maximum.

As discussed in the previous review, the Dental Board has expanded the scope of its use of cite and fine (beyond record production and inspections) to address a wider range of violations that can be more efficiently and effectively addressed through a cite and fine process with abatement and/or remedial education outcomes.

With the exception of B&P 1684.1(a)(1), the Dental Board issues administrative fines up to a maximum of $2,500 per violation, with totals averaging $3,506 per citation. Increasing the maximum fine to $5,000 per violation is to be one of the Board's regulatory priorities for 2015/2016.

39. How is cite and fine used? What types of violations are the basis for citation and fine?

Citations including remedial education may be used as abatement when patient harm is not found, but the quality of care provided to the consumer is substandard. The length of time before administrative discipline could result is also taken into consideration when determining whether a case is referred for an accusation or an administrative citation is more appropriate to send a swift message regarding unprofessional conduct or to achieve prompt abatement.

When issuing citations, the Board's goal is not to be punitive. Rather, the Board seeks to protect California consumers by getting the subject dentist's attention, re-educating him/her as to the DPA, and emphasizing the importance of following dental practices that fall within the community's standard of care.

When deciding whether to issue a citation and an appropriate corresponding fine, factors such as the following are taken into account:

- Nature and severity of the violation
- Length of time that has passed since the date of violation
- Consequences of the violation, e.g., potential or actual patient harm
- History of previous violations of the same, or similar, nature
- Evidence that the violation was willful
- Due process and the spirit of justice

Examples of "lesser" violations of the DPA that may not warrant referral to the OAG, but where a citation and fine may be more appropriate, include documentation issues (e.g., deficient records/recordkeeping), advertising violations, failure to keep up with continuing education requirements, unprofessional conduct for the failure to disclose or report convictions (e.g., DUI), and disciplinary actions taken by another professional licensing entity.

In addition to using citations as a tool to address less egregious violations that would not otherwise result in meaningful discipline, the Board views citation as a means of establishing a public record of an event that might otherwise have been closed without action, and thereby remain non-discloseable. Moreover, citations can address skills and training concerns promptly.

As noted above, the Board issues administrative citations to dentists who failed to produce requested patient records within the mandated 15 day time period. An emerging trend and challenge is the increase in situations where the licensee is no longer in possession of the records sought. Although this may be related to the sale of a practice, instances when the licensee has abandoned the practice and its contents are becoming more common. This issue has been identified as a future regulatory priority.

Dental Board Inspectors issue administrative citations for failure to meet minimum standards for Infection Control pursuant to B&P 1680(t), (ad) and CCR 1005.

It is important to note that the Board does not have the authority to conduct random or periodic inspections of dental offices -- the Board can only act upon a complaint. This past fiscal year, the Board has escalated its inspections, and that new focus is partially responsible for the 192% increase in the number of issued citations from FY 2012/13 to FY 2013/14.

Though the amount of fines actually collected did not have similar corresponding growth, the Board deems it critical to remember that, when it issues citations, its goal is not to be punitive. Rather, the Board uses citations as a tool to protect the health and safety of California's consumers by gaining dentists' compliance and/or helping them become better dental care providers by re-educating them as to the DPA.

40. How many informal office conferences, Disciplinary Review Committee reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

Informal conferences provide the licensee with the opportunity to discuss the merits of the allegations with the Executive Officer or her designee, and to offer any new or mitigating information that may affect the decision to issue the citation or the fine amount. Based upon the information provided, the Dental Board may choose to reduce or withdraw one or more of the causes for citation and its accompanying fine amount.

INFORMAL CONFERENCE REQUESTS				
	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Volume of Informal Conferences	9	1	9	6
Average Fine Pre-Appeal	$5000	$5000	$2817	$1583
Average Fine Post -Appeal	$0	$0	$1353	$1083
Administrative Procedure Act appeals	0	0	0	0

41. What are the 5 most common violations for which citations are issued?

This chart identifies the Board's top five most common violations for which citations are issued.

CODE SECTION	VIOLATION CHARGED
B&P 1684.1	Failure to produce patient records
B&P 1680 (ad)	Failure to follow Infection Control guidelines
B&P 1680 (dd)	Failure to comply with Blood Borne Requirements
B&P 1680 (ae)	DDS using an employee out of scope of licensure
B&P 1680 (ac)	Practicing with an expired license

42. What is average fine pre- and post- appeal?

See Informal Conference Requests Table above

43. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Presently, the Board does not use the Franchise Tax Board's program to collect citation fines. B&P Code § 125.9 authorizes the Board to add the amount of the assessed fine to the fee for license renewal. In the event that a licensee fails to pay their fine, a hold is placed on the license and it cannot be renewed without payment of the renewal fee and the fine amount. This statute also authorizes the Board to take disciplinary action for failure to pay a fine within 30 days from the date issued, unless the citation is appealed. The board uses these administrative tools for collecting outstanding fines.

44. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

It continues to be the Board's policy and practice to request full cost recovery for all of its criminal cases as well as those that result in administrative discipline.

If, as a result of the Board's investigation and prosecution, a licensees is disciplined through the administrative process, B & P Code §125.3 authorizes the Board to request reimbursement for costs incurred as a result of that investigation and prosecution.

The Board's request for recovery is made to the presiding Administrative Law Judge (ALJ) who decides how much of the Board's expenditures will be remunerated. The ALJ may award the Board full or partial cost recovery, or may reject the Board's request. In addition to cost recovery in cases that go to hearing, the Board also seeks cost recovery for its settlement cases.

When a Petition for Reinstatement is granted, and there are costs outstanding from the revocation or surrender proceeding, the ALJ may order full or partial recovery of costs for the Board.

45. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

As noted above, full cost recovery is always requested at the onset of administrative cases. In the case of revocations or surrenders, the ordered costs are pended by the Dental Board in the event the former licensee later returns and petitions for reinstatement. These outstanding costs may be ordered as a condition prior to reinstatement (if granted), or may be incorporated into a payment plan as a probationary condition.

Table 11. Cost Recovery (dollars in thousands)

	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Total Enforcement Expenditures	6,975	6,792	6,588	7,037
Potential Cases for Recovery *	106	111	97	91
Cases Recovery Ordered	50	67	46	64
Amount of Cost Recovery Ordered	3,907	4,579	3,222	6,819
Amount Collected	1,816	2,201	2,711	3,427

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

46. Are there cases for which the Dental Board does not seek cost recovery? Why?

The Board's authority only allows for cost recovery to be imposed against *licensees,* therefore, the Board is unable to seek cost recovery in Statement of Issues cases. A Statement of Issues case is initiated when the Board denies an applicant a license; and the applicant appeals the denial pursuant to B&P Code § 485.

47. Describe the Dental Board's use of Franchise Tax Board intercepts to collect cost recovery.

FTB Program for Cost Recovery- The Board has had success utilizing the Franchise Tax Board Intercept Program to collect cost recovery. However, due to limited staff resources, only a few licensees have ever been referred. The Board is currently working towards increasing our participation in this program and is identifying appropriate cases that can be enrolled. Challenges will remain in instances when the license has been surrendered or revoked, and the former licensee has employment challenges resulting in their inability to generate a taxable income.

48. Describe the Dental Board's efforts to obtain restitution for individual consumers, any formal or informal Board restitution policy, and the types of restitution that the Dental Board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the Dental Board may seek restitution from the licensee to a harmed consumer.

At present B&P Code section 129(c) provides for the Board's ability to request appropriate relief for a complainant, including the ability to meet and confer in order to mediate a complaint. However, the Dental Board does not have the regulatory authority to order restitution to consumers in administrative cases. In some instances, an Administrative Law Judge may impose restitution in addition to cost recovery and other conditions of a disciplinary order as seen in the table below. In these circumstances, when the licensee submits restitution payments, the Dental Board will track compliance and transfer the payments to designated parties.

In unlicensed activity cases, restitution may also be ordered as a part of the criminal penalty. The Board is unable to track how much is collected for the victims because the funds are paid directly to the court.

Table 12. Restitution (list dollars in thousands)

	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
# of Cases with Restitution Ordered	4	5	5	0
Amount Ordered	44	263	3164	0
Amount Collected	11	243	1802	N/A

Section 6
Public Information Policies

49. How does the Dental Board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the board's website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The Dental Board maintains an email list of all interested parties and sends out web-blasts to these individuals each time something new is posted on the website. All Board meeting materials are posted online at least one week prior to each meeting, along with draft minutes from the prior meeting. Meeting materials remain online indefinitely; final meeting minutes are posted as soon as the Board approves them and remain online indefinitely.

50. Does the Dental Board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long do webcast meetings remain available online?

The Dental Board has been webcasting all of the public Board and Committee meetings since 2012. The Dental Board plans to continue webcasting all of its public Board and Committee meetings. Webcasts are archived online for three years.

51. Does the Dental Board establish an annual meeting calendar, and post it on the board's web site?

The Dental Board establishes the following year's meeting dates at the August Board meeting and posts them on the website immediately.

52. Is the Dental Board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the Dental Board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

As the Board's mission is to protect the health and safety of California's consumers, it is committed to ensuring the public is provided with information related to enforcement actions against its licensees consistent with DCA's Consumer Complaint Disclosure policy as well as the Department's Guidelines for Access to Public Records. In addition to posting discipline documents on the licensee's verification page on the web site, the Board posts a monthly Hot Sheet that is a listing, by name, of all disciplinary actions or licensing denials initiated or finalized in that month.

53. What information does the Dental Board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

The Board provides on the internet, information on the current status of every license that has been issued, pursuant to B & P Code § 27. The public can view disciplinary history and can access disciplinary documents, including but not limited to accusations, suspensions, and revocations.

54. What methods are used by the Dental Board to provide consumer outreach and education?

The board has been restricted in its efforts to provide consumer outreach and education due to staffing issues and travel restrictions over the last few years. The board strives to provide as much information to California consumers as possible via its website. The board has informational items that are posted online including how to file a complaint and the board's enforcement process. In addition, the Board has developed a newsletter that is emailed to all subscribers, potential licentiates, and all interested parties on a quarterly basis. This newsletter includes all disciplinary action taken by the Board against its licensees and applicants for licensure.

The board also has a sign-up for its online e-mail list and has Frequently Asked Questions with answers, on its home page.

When the Department of Consumer Affairs sends a representative to the State or local county fairs, the Board participates by sending a staff representative, along with informational brochures, including licensing and permit application information for distribution.

Section 7
Online Practice Issues

55. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the Dental Board regulate online practice? Does the Board have any plans to regulate internet business practices or believe there is a need to do so?

The Board actively investigates and prosecutes violations of B&P Code § 4067 and § 2242.1, prohibit any person or entity from dispensing or furnishing any dangerous drug or device on the internet for delivery to any person in this state without a prescription issued pursuant to an appropriate prior examination and dental/medical indication. If an individual is not licensed in the State of California, the additional charge of B&P Code § 1701.1 (practicing dentistry without a license) will be sought. The Board regularly investigates inappropriate/illegal drug prescribing, although most is unrelated to internet sales.

More frequently, the dental board receives complaints regarding online advertising violations including licensees who are claiming superiority in their treatments and products. Such complaints are appropriately dealt with by the use of cease and desist letters and citations.

In advertising cases involving the use of neurotoxins or injectable fillers (Botox or Juvederm), the board investigates whether the products are offered for treatment of a bona fide dental condition (including TMJ, etc.), or offered for strictly cosmetic purposes. These cases may facilitate an undercover operation to confirm the illegitimate use which may result in a citation, administrative action against the licensee or criminal charges filed for unlicensed practice of dentistry or medicine.

The board has also received complaints of unlicensed denturists advertising to create dentures for customers without a prescription from a licensed dentist. These types of complaints may result in an undercover visit to confirm whether dentistry is taking place, which could result in furtherance of a search warrant, arrest and conviction, or merely an investigator confirming that the location is a legitimate dental lab.

Although these issues have been limited in volume, if the board were to identify a trend where problematic issues increase regarding dental practice on the internet, we would work with staff to develop a regulatory means to address it.

Section 8
Workforce Development and Job Creation

56. What actions has the board taken in terms of workforce development?

In response to the Dental Board's (DBC) Sunset Review Background Paper submitted to the Legislature in 2010, the Senate Business, Professions, and Economic Development Committee (Committee) indicated that the DBC should be looking at workforce issues and acting as an information source for the Committee and the Legislature on dental work force issues.

The Dental Board is currently participating in two legislatively mandated programs to gather work force data in order to address issues relating to access to care. The requirements for this data collection are found in two pieces of legislation which were signed into law in 2007: AB 269 (Chapter 262, Statutes of 2007) and SB 139 (Chapter 522, Statutes of 2007).

Assembly Bill 269

The Dental Board has been collecting workforce data, pursuant to the requirements outlined in AB 269 (Eng) (Chapter 262, Statutes of 2007) since January 1, 2009. It was the intent of the Legislature, at that time, to determine the number of dentists and licensed or registered dental auxiliaries with cultural and linguistic competency who are practicing dentistry in California. The bill further stated that "Collecting data on dentists and dental auxiliaries serving any given area allows for the consistent determination of the areas of California that are underserved by dentists and dental auxiliaries with cultural or linguistic competency." Ironically, the ethnic background and foreign language fluency questions on the survey are optional.

In accordance with AB 269, the Board developed a work force survey, which each licensee (dentist and registered dental assistant) is required to complete upon initial licensure and at the time of license renewal. The survey questions include:

- License Number
- License Type
- Employment Status (see attached survey for detail)
- Primary Practice Location (by zip code and number of hours worked at that location)
- Secondary Practice Location (by zip code and number of hours worked at that location)
- Postgraduate Training
- Dental Practice/Specialty and Board Certifications or Permits
- Ethnic Background (which is optional)
- Foreign Language Fluency, other than English (which is also optional).

The survey does not include questions related to earnings and benefits, job satisfaction, temporary departure from practice, or future plans of working licensees.

The on-line results of the survey are combined with the survey results that are manually inputted by staff into one data file. The Department downloads the raw data to the Board's website, per legislation, on or before July 1 of each year. The current report is approximately 299 pages and is posted on the website.

Senate Bill 139

In accordance with Senate Bill 139 (Chapter 522, Statutes of 2007), the Office of Statewide Health Planning and Development (OSHPD) established a health care workforce clearinghouse to serve as the central source of health care workforce and educational data in the state. The clearinghouse is responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations in California. The activities of the clearinghouse are funded by appropriations made from the California Health Data and Planning Fund in accordance with subdivision (h) of Section 127280.

OSHPD works with the Employment Development Department's Labor Market Information Division, state licensing boards, and state higher education entities to collect, to the extent available, all of the following data:

- The current supply of health care workers, by specialty.
- The geographical distribution of health care workers, by specialty.
- The diversity of the health care workforce, by specialty, including, but not necessarily limited to, data on race, ethnicity, and languages spoken.
- The current and forecasted demand for health care workers, by specialty.
- The educational capacity to produce trained, certified, and licensed health care worker, by specialty and by geographical distribution, including, but not necessarily limited to, the number of educational slots, the number of enrollments, the attrition rate, and wait time to enter the program of study.

After the data is collected, OSHPD prepares an annual report to the Legislature that does all of the following:

- Identifies education and employment trends in the health care profession.
- Reports on the current supply and demand for health care workers in California and gaps in the educational pipeline producing workers in specific occupations and geographic areas.
- Recommends state policy needed to address issues of workforce shortage and distribution.

The Dental Board, along with six other DCA healing arts boards, participated in the Clearinghouse Database design phase of the project (data collection). An MOU was

entered into between the Board and OSHPD in December 2011 and data is being collected, the results of which can be found in the OSHPD Facts Sheets for Dentists, Registered Dental Assistants, and Registered Dental Hygienists that are available at http://www.oshpd.ca.gov/hwdd/hwc/.

In addition, the board has had some preliminary discussions relative to increasing workforce capacity in the light of Federal Healthcare Reform. Those discussions always include the need to increase capacity in underserved and rural areas because those are the places where there is consistently a need. Last year we revised the Board's Strategic Plan and did two things: (1) highlighted access to quality care in our vision statement and (2) included diversity in our values.

We want our vision and values to be reflective of the consumers and professionals in the state and as such they are always a work in progress. We left our strategic plan open-ended so that we could revisit and expand on it. That work will be accomplished in future meetings.

Additionally, Health Care reform can provide the Board with opportunities to increase access to care through our strategic goals of being proactive about legislative solutions, and conducting outreach programs to discuss public policy issues on health care. In these, we see an opportunity to impact dental health.

The Board has worked with interested parties on workforce issues such as the Healthcare Manpower Pilot Project, and has developed new pathways to licensure such as licensure by residency and licensure by credential. Most recently the Board sponsored legislation that will allow students attending a California dental school an alternate pathway to licensure, referred to as the portfolio pathway. The board recently implemented new regulations that allow for greater utilization of dental assistants. The Board would like to work closely with the Select Committee on Health Workforce and the various legislative caucuses as well as other interested parties, for-profit, non-profit and stakeholder organizations, to find solutions and reach the goal of a workforce that reflects our state.

57. Describe any assessment the board has conducted on the impact of licensing delays.

The Dental Board is fortunate to not have experienced any licensing delays. The board is currently issuing licenses within 30 days of receipt of a complete application package.

58. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

The Dental Board provides outreach presentations every year at the dental schools, professional conferences and to local dental societies. When the Board conducts presentations we educate the student population, faculty and dental community about the

laws related to the profession, the Dental Board, and its composition, purpose and the various licenses, permits and certifications the Board issues.

The Dental Board also sends email blasts to the public and dental industry offering information that pertains to potential licensees (students) regarding the examination process and licensure. The Board has also been able to network with professional organizations such as CDA, CALAMOS, Council on Dental Assisting and the California Association of Orthodontists. The Board meets with the Deans of the dental schools on a regular basis to discuss the new portfolio pathway to licensure.

In addition, the Dental Board staffs an informational booth at the California Dental Association (CDA) annual convention which is held twice per year. At the conference, the Board has staff on hand to answer questions from licensees, students and applicants on the licensure pathways and the laws related to the profession.

The Dental Board has partnered with the Dental Hygiene Committee of California (DHCC) where we have conducted several outreach lectures at the local colleges and Universities. We discuss the makeup of the Board, its function, licensure requirements, and the licensing process.

Additionally, the Dental Board posts updates pertaining to licensing requirements and the licensing process on the webpage, as well as having a link to this information. The Dental Board has developed a newsletter that is emailed to all subscribers, potential licentiates, and all interested parties on a quarterly basis.

59. Provide any workforce development data collected by the board, such as:

a. Workforce shortages

The Dental Board monitors reports from the Office of Statewide Health Planning and Development (OSHPD) Workforce Clearinghouse data and information provided by the industry on possible workforce shortages. The Dental Board believes it can enhance its efforts on diversity and workforce shortages in part through the collaboration it will seek to assist in the implementation of the Federal Health Care Reform. The Board also has formed the Access to Care committee to review the studies and work in collaboration with the Select Committee on Health Workforce and the various legislative caucuses as well as other interested parties, for-profit, non-profit and stakeholder organizations can bring increased diversity in the dental profession.

b. Successful training programs.

The Board does not currently have staff or the funding available to provide any training programs for our licensees.

Section 9
Current Issues

60. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

Uniform Standards for Substance Abusing Licensees

Effective April 1, 2014, the Board implemented the provisions of Senate Bill 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) by adopting the *Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders, New February 28, 2013*. These standards will be used by administrative law judges in disciplinary proceedings after a licensee has been determined to be abusing substances. The standards relate to:

1. Notification to Employer;
2. Supervised Practice;
3. Drug and Alcohol Testing;
4. Abstention from the Use of Alcohol, Controlled Substances, and Dangerous Drugs;
5. Facilitated Group Support Meetings;
6. Clinical Diagnostic Evaluations; and,
7. Drug or Alcohol Abuse Treatment Program

To ensure its successful implementation, the board's enforcement staff have taken the following
actions:

1. Provided the Attorney General liaison with the *Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders, New February 28, 2013* to be distributed to their offices statewide. The information was also provided to the Office of Administrative Hearings.

2. Written additional probation guidelines to address the seven new monitoring conditions. This included development of additional probation forms and correspondence templates.

3. Provided staff training: Supervisors and managers have met with staff to familiarize them with the new requirements and implementation

4. Identified statewide resources lists that meet the conditions set forth for Facilitated Group Support Meetings, Clinical Diagnostic Evaluation, and Drug or Alcohol Abuse Treatment Programs.

61. What is the status of the Dental Board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

Consumer Protection Enforcement Initiative (CPEI) Regulations

In July 2009, the *Los Angeles Times* published an article indicating that the Board of Registered Nursing often takes years to take disciplinary action on complaints of egregious misconduct, while the licensees were still practicing. These articles exposed the need for healing arts boards within the Department of Consumer Affairs (Department) to improve the enforcement process to ensure patient safety.

As a result of the article, the Department held an informational hearing and investigated the problems that were addressed in the *Los Angeles Times* article. The Department developed a report (*Department of Consumer Affairs "Consumer Protection Enforcement Initiative BCP Independent Verification & Validation Report, March 2010"*) regarding the existing enforcement problems and made recommendations for improving the enforcement programs of the healing arts boards. The Department also sponsored legislation, Senate Bill 1111 (Negrete McLeod), during the 2009-2010 Legislative Session to codify many of the recommendations contained within the report. However, the bill failed to be enacted.

When the bill failed to be enacted into law, the Department encouraged the healing arts boards to pursue regulatory action to assist the boards with investigating and prosecuting complaints in a timely manner, and to provide the boards with tools to improve the enforcement process and ensure patient safety. In response to this, the Dental Board of California (Board) reviewed proposed regulatory amendments that would improve the Board's enforcement process in an effort to address public concern and have promulgated three (3) rulemaking proposals.

The first rulemaking proposal became effective on March 9, 2012. Specifically, these regulations:

(1) Specified that the following acts constitute unprofessional conduct:

a. Failure to provide records requested by the Board within 15 days,
b. Failure of a licensee to report an indictment within 30 days,
c. Failure of a licensee to report a felony charge within 30 days,
d. Failure of a licensee to report a conviction within 30 days, and
e. Failure of a licensee to report disciplinary action taken by another professional licensing entity or other agency within 30 days; and

(2) Authorized the Board to require an examination of an applicant who may be impaired by a physical or mental illness affecting competency.

The second rulemaking proposal was promulgated in February 2014 and is pending approval from the Office of Administrative Law. This rulemaking amends California Code of Regulations, Title 16, Section 1018 to require an Administrative Law Judge (ALJ) to order revocation of a license when issuing a proposed decision that contains any findings of fact that: (1) a licensee engaged in any act of sexual contact with a patient, client, or customer; or, (2) the licensee has been convicted of or committed a sex offense. This proposal would prohibit the proposed decision issued by the ALJ under such circumstances from containing an order staying the revocation of the license or placing the licensee on probation. Furthermore, this proposal specifies that the terms "sexual contact" has the same meaning as defined in Business and Professions Code Section 729(c) and the term "sex offense" has the same meaning as defined in Education Code Section 44010.

The third rulemaking proposal was promulgated in May 2014. The initial rulemaking documents are being drafted for submission to the Office of Administrative Law. This rulemaking amends California Code of Regulations, Title 16, Section 1001 to authorize the Board's Executive Officer to approve settlement agreements for the revocation, surrender, or interim suspension of a license.

The Board already had statutory or regulatory authority for the following provisions; therefore, regulatory action was not necessary:

- §720.12 – Denial of application for registered sex offender: Require the Board to deny a license to an applicant or revoke the license of a licensee who is registered as a sex offender.
- §720.16(d) and (f) – Failure to provide documents and 718(d) – Failure to comply with court order:
- §726(a) & (b) – Sexual misconduct: Currently defined in B&P Code §726. Recommend: Define in regulation that sexual misconduct is unprofessional conduct.

Additionally, on January 1, 2013, Business and Professions Code Section 143.5 (AB 2570, Chapter 561, Statutes of 2012) became effective and prohibits a licensee who is regulated by the Department of Consumer Affairs or various boards, bureaus, or programs, or an entity or person acting as an authorized agent of a licensee, from including or permitting to be included a provision in an agreement to settle a civil dispute that prohibits the other party in that dispute from contacting, filing a complaint with, or cooperating with the department, board, bureau, or program, or that requires the other party to withdraw a complaint from the Department, board, bureau, or program, except as specified.

62. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

The Dental Board has been included in Release 2 of the BreEZe project, which is currently underway. The Dental Board is fully committed to the success of the project and has assigned one Staff Services Manager full time as the Single Point of Contact (SPOC) for the board's business integration. Additional staff have been designated as subject matter leads in different program areas, and several retired annuitants have been maintained in anticipation of the forthcoming resource demands while the system is tested, data migration is validated, and training of full time staff is conducted.

The Dental Board has been reporting project updates at its quarterly board meetings, and providing staff with quarterly reports as well.

There are several challenges that the Dental Board is anticipating before successful implementation. Most critical is the Board's ability to schedule written and practical exams for the Registered Dental Assistant license at various times and locations throughout California. The existing Commercial-off-the-shelf (COTS) product that BreEZe is developed from did not contain this functionality. Secondly, the Dental Board will be one of the first boards to use the Inspection module to track its inspection cases separate from enforcement cases. Release 1 boards chose not to use this feature. Third, although planned for Release 3, Release 2 will not have an Activity Tracking component to track Investigator time (and costs) as originally intended. Dental Board enforcement staff will need to continue to use the Investigative Activity Report (IAR) to log their case activity. The IAR (owned and supported by the Medical Board of California or MBC) has been a useful workaround, but may not continue to be supported if MBC resources are redirected.

Section 10
Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the dental board.
2. Short discussion of recommendations made by the Committees/Joint Committee during prior sunset review.
3. What action the dental board took in response to the recommendation or findings made under prior sunset review.
4. Any recommendations the dental board has for dealing with the issue, if appropriate.

BOARD ADMINISTRATION ISSUES

ISSUE #1: (CHANGE COMPOSITION OF DBC.) Should the composition of DBC be changed to include more public member representation?

Senate BPE Staff Recommendation: ***To ensure the continued commitment of DBC to protect the public, the composition of DBC should be changed to include more public members. This could be accomplished by replacing one of the dentists appointed by the Governor with a public member and giving the Governor an additional public member appointment. This would bring the total of DBC to 15 members: 7 dentists, 1 RDA, 1 RDH and 6 public members.***

DBC Response: Senate Bill 540 (Price,Chapter 385, Statutes of 2011) changed the membership of the Board to include one additional public member who is appointed by the Governor. The Board currently consists of eight practicing dentists, one registered dental assistant, one registered dental hygienist, and five public members for a total of 15 members.
All 15 positions on the Board have been filled for over one year and there are currently no vacancies.

ISSUE #2: (STRATEGIC PLAN UPDATE NEEDED.) Should DBC's Strategic Plan include action items and realistic target dates for how its goals and objectives will be met?

Senate BPE Staff Recommendation: ***DBC should develop and publish a detailed action plan with specific action items and realistic target dates for how each of the objectives will be met. Additionally, the Board should be given a written status report on the action plan at each board meeting.***

DBC Response: In the fall of 2012, the Board updated its Strategic Plan (Plan) to include eight goals and 36 objectives. Action items and deliverable dates were identified for each

objective. Initially adopted as a three year plan in December 2012, due to unanticipated delays in implementation of a new computer system (BreEZe), the hiring of new Executive Officer, and the appointment of new members to the Board, the duration of the Plan was changed to four years, therefore extending the plan through the sunset review period. The Board receives strategic plan updates during its quarterly meetings in written report form and through the Executive Officer's report.

ISSUE #3: (LACK OF PERSONNEL EVALUATION.) Should DBC implement annual personnel performance evaluations or appraisals?

Senate BPE Staff Recommendation: ***DBC should explain to the Committee its system of work performance evaluations and ensure that these evaluations or appraisals are completed by staff on a timely basis.***

DBC Response: Government Code Sections 19992 – 19992.4 and the Department of Personnel Administration Rule 599.798 require supervisors to complete written evaluations and discuss overall work performance with permanent employees on an annual basis. DBC managers strive to complete these evaluations on a timely basis.

ISSUE #4: (CLARIFICATION OF THE AUTHORITY OF DBC OVER THE DENTAL HYGIENE COMMITTEE AND DENTAL ASSISTANTS.) Is there some clarification needed regarding the authority which DBC has over the Dental Hygiene Committee and the Dental Assisting Forum?

Senate BPE Staff Recommendation: ***It would appear as if the intent of the Legislature was that the Dental Hygiene Committee was created so that it could make independent decisions on issues related to the regulation of the hygienist profession unless it involved scope of practice changes which would need to be worked out between both the dentistry and hygienist professions. Clarification may be needed to assure that the Dental Hygiene Committee maintains its independence over that of DBC. Additionally, the Committee should ask DBC to explain the purpose for establishing two groups to deal with dental assisting issues, and consider merging the DAC and DAF into one entity.***

DBC Response: Since its formation in 2009, the Dental Hygiene Committee of California (DHCC) falls within the jurisdiction of the Board ONLY on issues dealing with scope of practice for registered dental hygienists, registered dental hygienists in extended functions, and registered dental hygienists in alternative practice. All other aspects of the DHCC are independent of the Board, including the DHCC's development of its own practice act and promulgation of regulations relating to dental hygiene. The DBC and the DHCC have worked to keep the lines of communication open and collaborate on issues of mutual concern. The relationship is a work in progress. There remains a question about authority over the process of promulgating regulations for scope of practice issues relating to registered dental hygienists, registered dental hygienists in extended functions, and registered dental hygienists in alternative practice; and whether or not clear guidelines

exist in order to ensure that if the DHCC promulgates these regulations, that they do no conflict with regulations promulgated by the Board.

With regard to establishment of a dental assisting forum, Senate Bill 540 (Price) (Chapter 385, Statutes of 2011) created a Dental Assisting Council which is comprised of seven members appointed by the Board: the registered dental assistant member of the Board, another member of the Board, and five registered dental assistants representing as broad a range of dental assisting experience and education as possible. The mandate of the Council is to consider all matters relating to dental assistants in the state, on its own initiative or upon the request of the Board, and to make appropriate recommendations to the board and the standing committees of the board relating to examinations, licensure, educational programs, courses, and continuing education; duties settings and supervision levels; appropriate standards of conduct and enforcement for dental assistants; and requirements regarding infection control. The appointments to the Council were made in February 2012.

Most of the registered dental assistants serving as DAC members possess little to no experience working as a member of an appointed council. Their combined political acumen is nonexistent and it has been challenging to educate the members about the legislative and regulatory process. Board staff conducted a one day workshop on the regulatory process in an effort to assist DAC members with the learning curve. Members are enthusiastic about participating on the DAC, but there is little to no discussion on the dental assisting issues that come before them at the meetings.

DENTAL WORKFORCE AND DIVERSITY ISSUES

ISSUE #5: (IMPACT OF FEDERAL HEALTH CARE REFORM ON THE DENTAL WORKFORCE?) Will California meet the increased demand for dental services with the enactment of the Federal Health Care Reform, and what can DBC do to assist in the implementation of the Federal Health Care Reform?

Senate BPE Staff Recommendation: ***The Committee should ask DBC whether it has assessed the impact of, and planned for, implementation of the Patient Protection and Affordable Care Act (PPACA); how DBC is looking at the dental workforce capacity in light of implementation of the PPACA, given that millions of additional Californians, especially children, will gain dental coverage when the PPACA is implemented. Additionally, DBC should continue in its efforts to increase the dental workforce in California, explore approaches and work collaboratively with for-profit and non-profit organizations and other stakeholders to address the increased demand for oral healthcare as a result of the PPACA. Additionally, DBC should be proactive in finding ways to increase access to dental programs especially for socio-economic disadvantaged students.***

DBC Response: During the prior sunset review period, the Senate Business & Professions Committee indicated that the Board should be looking at workforce issues and be acting as an information source for the Committee and the Legislature on dental work

force issues. The Board has been collecting workforce data for dentists and dental assistants pursuant AB 269 (Eng, Chapter 262, Statutes of 2007) since January 1, 2009. Licensees are required to complete a survey upon initial licensure and at each biennial renewal. The purpose of the survey is to determine the number of dentists and RDAs, and their cultural and linguistic competencies. This workforce survey project is ongoing.

In addition, the Board is a participant in the California Office of Statewide Health Planning and Development (OSHPD) project to create a health care workforce clearinghouse in accordance with SB 139 (Scott, Chapter 522, Statutes of 2007). The clearinghouse is responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations in California. The data included in the OSHPD project is fairly comprehensive and will allow OSHPD to deliver a report to the Legislature that addresses employment trends, supply and demand for health care workers, gaps in the educational pipeline, and recommendations for state policy needed producing workers in specific occupations and geographic areas to address issues of workforce shortage and distribution.

In 2012, the Board updated its strategic plan to include the goal of maintaining awareness of the changes and challenges within the dental community and to serve as a resource to the dental workforce. One objective is to identify areas where the Board can assist with workforce development, including the dental loan repayment program, and publicize such programs to help underserved populations.

Lastly, the Board established an Access to Care Committee to monitor the implementation of the PPACA and to ensure that the goals and objectives outlined in its strategic plan are carried out.

ISSUE #6: (IS THERE A LACK OF DIVERSITY IN THE DENTAL PROFESSION?)Should DBC enhance its efforts to increase diversity in the dental profession?

Senate BPE Staff Recommendation: ***DBC should enhance its efforts on diversity issues, and increase its collaboration efforts with dental schools, dental associations, other state and local agencies, and for-profit and non-profit organizations.***

DBC Response: The Board accepts accreditation of the California dental schools by the Commission on Dental Accreditation (CODA) of the American Dental Association (ADA). CODA accreditation standards require dental schools to have policies and procedures that promote diversity among its students, faculty and staff. CODA believes that "diversity in education is essential to academic excellence. A significant amount of learning occurs through informal interactions among individuals who are of different races, ethnicities, religions, and backgrounds; come from cities, rural areas and from various geographic regions; and have a wide variety of interests, talents, and perspectives. These interactions allow students to directly and indirectly learn from their differences, and to stimulate one another to reexamine even their most deeply held assumptions about themselves and their

world. Cultural competence cannot be effectively acquired in a relatively homogeneous environment. Programs must create an environment that ensures an in-depth exchange of ideas and beliefs across gender, racial, ethnic, cultural and socioeconomic lines."

Students attending California dental schools are being educated and trained to recognize issues relating to diversity through the following CODA standards:

- The dental education program **must** have a stated commitment to a humanistic culture and learning environment that is regularly evaluated.
- The dental school **must** have policies and practices to: 1) achieve appropriate levels of diversity among its students, faculty and staff, 2) engage in ongoing systematic and focused efforts to attract and retain students, faculty and staff from diverse backgrounds, and 3) systematically evaluate comprehensive strategies to improve the institutional climate for diversity.
- Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communication skills to function successfully in a multicultural work environment.
- Admission policies and procedures **must** be designed to include recruitment and admission of a diverse student population.

DENTAL PRACTICE ISSUES

ISSUE #7: (DIFFICULT TO DETERMINE SPECIALTY AREAS OF DENTAL PRACTICE.) Should DBC be responsible for determining and reviewing areas of specialty education and accreditation requirements for those specialized areas of Dentistry?

Senate BPE Staff Recommendation: ***Adopt the recommendation of DBC to delete B & P Code Section 651(h)(5)(A)(i) through Section 651(h)(5)(A)(iii).***

DBC Response: The Board has historically taken the view that it is a licensing body and does not have the authority or staff to determine and review areas of education and accreditation requirements for specialized areas of dentistry. The Committee staff recommended deletion of sections in statute in order to prevent future lawsuits filed against the Board related to advertising of specialty credentials. This was accomplished in Senate Bill 540 (Price) (Chapter 385, Statutes of 2011) when Section 651(h)(5)(A)(i) through Section 651(h)(5)(A)(iii) was removed from the B & P Code.

EXAMINATION ISSUES

ISSUE #8: (LENGTHY PROCESSING TIME FOR EXAMINATION APPLICATIONS.) Currently DBC is averaging up to five months to process examination applications.

Senate BPE Staff Recommendation: ***DBC should explain further the reasons for the delays in processing examination application averages and whether these delays are attributable to DBC.***

DBC Response: The Board currently utilizes an outside vendor to administer an examination in Law & Ethics for dentists, registered dental assistants, and registered dental assistants in extended functions, and the written examination for registered dental assistants, and registered dental assistants in extended functions. Board staff administers a practical examination for registered dental assistants, and registered dental assistants in extended functions. There have been no backlogs or delays in processing examination applications, either in dental assisting or dental licensing units since the last sunset review period. Examination applications for dentists applying to take the Western Regional Examination (WREB) take approximately 48 hours to process; applications for the registered dental assistants, and registered dental assistant in extended functions examinations are processed within ten days.

ISSUE #9: (RANDOMIZATION OF DENTAL AND RDA LAW AND ETHICS EXAMINATIONS NEEDED.) Are there sufficient safeguards to avoid, if not limit, examination compromises and ensure that testing reflect current laws and regulations? Should the California Law and Ethics examination questions for dentists and RDAs be randomized and reflect current laws and regulations?

Senate BPE Staff Recommendation: ***To avoid examination compromises and ensure that the examination questions reflect current law and regulations, DBC should require that OPES randomize (scramble) California law and ethics examinations for dentists and RDAs. Additionally, dentists should be required to certify that examination content will not be released.***

DBC Response: The Board periodically reviews and updates the test questions for both California Law and Ethics examinations (dentists and RDAs) to reflect current laws and regulations through a contract with the Office of Professional Examinations. The examinations are computer based and administered by an outside vendor (PSI); and test questions are scrambled in order to avoid examination compromises. All applicants are required to certify that the contents of the examination will not be released.

ISSUE #10: (RDA WRITTEN EXAMINATION PASS RATE IS LOW.) Should DBC explore pathways to improve the pass rates of RDAs taking the written examinations if the low pass rate trend continues?

Senate BPE Staff Recommendation: ***If in fiscal year 2010/2011, the RDA examination pass rate remains low, DBC should explore approaches to improve the passage rate of RDAs***.

DBC Response: When the Board assumed responsibility for the Dental Assisting Program on July 1, 2009, the written examination pass rate was 53%. Since implementation of the new RDA examination on January 1, 2010, the pass rate is fluctuating between 62% and 70% depending on the candidate pool. The candidates graduating from board-approved registered dental assisting programs appear to be passing the examination at a higher rate than those candidates who are on the job trained.

CONTINUING COMPETENCY ISSUES

ISSUE #11: (LACK OF CONTINUING EDUCATION AUDITS.) DBC suspended audits of continuing education prior to 2009, and does not audit RDAs.

Senate BPE Staff Recommendation: *DBC should explain to the Committee its current policy on continuing education audits for dentists and the reasons for suspension of the audits prior to 2009. DBC should also explain why it does not audit CE for RDAs and describe plans, if any, to implement audit for RDA CE.*

DBC Response: Radom Continuing Education audits for dentists were temporarily suspended in July 2009 due to workload in other areas of the Board and the need to redirect staff. The random audit program resumed with the February 2011 renewals. Staff has been auditing 5% of all dentists who renew on a two-year renewal cycle each month. Dentists who are not able to provide any proof of continuing education units are issued a citation and fine. Additionally, staff developed written procedures for the auditing process. Audits for Registered Dental Assistants cannot take place until additional staff is hired to assume those duties.

ENFORCEMENT ISSUES

ISSUE #12: (DISCIPLINARY CASE MANAGEMENT TIMEFRAME STILL TAKING ON AVERAGE 2 ½ YEARS OR MORE.) Will DBC be able to meet its goal of reducing the average disciplinary case timeframe from 2 ½ years or more, to 12 to 18 months?

Senate BPE Staff Recommendation: *In order to improve case processing and case aging, and to meet its goal of reducing the timeframe for the handling of its*

disciplinary cases, the following recommendations from the Monitor and Assessment Report should be considered by DBC:

1) ***Continue to reduce the amount of time to process and close complaints.***
2) ***A Guideline for case assignments must be established, taking into consideration the skills or experience level of staff and other factors.***
3) ***Making Case Processing and Aging a major focus of DBC's improvement planning.***
4) ***Prioritize the review of aged cases.***
5) ***Establish reasonable elapsed time objectives for each step of the case processing.***
6) ***Monitor Performance by establishing regular oversight of case progress and staff productivity.***
7) ***A policy or procedures for supervisory staff in performing case reviews should be established.***

Additionally, the Committee should give consideration to auditing both the Investigation Unit of DBC and the Licensing Section of the AG's Office to determine whether improvements could be made to the investigation and prosecution of disciplinary cases.

DBC Response: The Board's Enforcement program is committed to process improvement and has established several policies and procedures in response to the Enforcement Assessment 2009 and the committee's recommendations. With the additional staffing provided by the Consumer Protection Enforcement Initiative (CPEI), the Board has made improvements to processing times. The Complaint Unit reduced the average number of days to close a complaint from 435 days to 100 days (a 77% decrease). The implementation of quarterly case reviews has focused on case closures and closing the oldest investigations.

With the implementation of the Investigator Activity Report (IAR) system, the Board is gathering data associated with specific investigative functions to be able to establish time objectives for various case types. This data combined with the case reviews is being used by managers to monitor case progress and staff productivity.

Case review procedures along with case assignment guidelines have been developed and are included in the recently updated Enforcement Program manual.

Additionally, the Enforcement Program has implemented a number of internal procedures to address case handling; from receipt of complaint through investigation to closure. Specifically:

1) Case assignment guidelines were established in March 2011. These guidelines take into consideration the employee classification (skills, knowledge and abilities), case complexity and whether criminal components are present which would require assignment to sworn investigators.

2) Case reviews between first-line supervisor and assigned staff occur on a quarterly basis. As quoted from the Enforcement Procedure Manual, "case reviews assist in

case reconciliation, provide timely supervisory assistance, help prioritize the investigators' workload, identify training needs, and can identify and address problems early on."

3) Reductions in case aging. With the exception of the most egregious circumstances, working the oldest cases first continues to be the Enforcement program's primary goal.

Case Age	FY 10/11	FY 11/12	FY 12/13	FY 13/14
0 – 1 Year Old	589	497	351	426
1 – 2 Years Old	271	249	268	324
2 – 3 Years Old	123	63	93	70
3+ Years Old	9	18	21	17

ISSUE #13: (DISCIPLINARY CASE TRACKING SYSTEM INADEQUATE.)

Should DBC continue to monitor the quality of enforcement data and ensure that investigative activities are tracked? Additionally, should DBC adopt guidelines for the completion of specific investigative functions to establish objective expectations?

Senate BPE Staff Recommendation: ***Although all the boards and bureaus within the DCA will transition into the BreEZe system, this process is several years out. In the meantime, DBC should continue to monitor the quality of enforcement data and tracking of investigative services. Moreover, although DBC had transitioned to the IAR utilized by the MBC, DBC should ensure that the IARs are consistent and completed. Additionally, as the Enforcement Assessment recommended, guidelines should be established for the completion of specific investigative functions to establish objective expectations. Lastly, DBC should continue in its role to work collaboratively with the DCA's Office of Information Services project staff, as well as with any vendor, to assist in creating an efficient and user-friendly integrated computer system.***

DBC Response: The Board developed internal reports as well as reasonable time objectives to track administrative case referrals for timely handling at the Attorney General's Office (AGO). Presently, enforcement staff monitors timeframes between the following benchmarks:

1) Referral to assignment (benchmark – 30 days maximum)
2) Assignment to accusation (benchmark – 90 days maximum)
3) Hearing conclusion to receipt of written Disciplinary Order (benchmark – 30 days)

Staff are taking the initiative and contacting the AGO for follow-up and to ensure the case handling is made a priority. These efforts have resulted in greater accountability and reductions to case aging.

It should be noted that some case aging issues are beyond the control of board staff and will continue to cause disciplinary cases to exceed the current Performance expectations. These include delays caused by opposing counsel, suspensions while criminal matters are pending, and difficulty in scheduling hearing dates with the Office of Administrative Hearings (three months out for a one to two day hearing, 8 months out for 4 or more day hearings).

ISSUE #14: (PROTRACTED PROCESS TO SUSPEND LICENSE OF A DENTIST.) DBC must go through a cumbersome process to suspend the license of a licensee who may pose an immediate threat to patients or who have committed a serious crime and may even be incarcerated.

Senate BPE Staff Recommendation: ***Extend the time constraints placed on the AG to file an accusation thus allowing the AG to utilize the ISO process without having to have their accusation prepared within a very limited time frame (15 days). Pursuant to Section 494 of the B&P Code, DBC does not have to always rely on an ALJ to conduct the ISO hearing, DBC also has authority to conduct the hearing and could do so more expeditiously where serious circumstances exist regarding the suspension of a dentist's license. Provide for automatic suspension of a dental license if the dentist is incarcerated and mandatory revocation of a license if a dentist is convicted of acts of sexual exploitation of a patient.***

DBC Response: The Board is utilizing a number of tools to suspend a practitioner's license when necessary, including:

- Penal Code Section 23 motions to temporarily suspend practice on criminal allegations which have the potential for public harm
- Business and Professions Code Section 1687 provides for the revocation on convicted sexual offenders
- Business and Professions Code Section 315.2 (effective January 1, 2011), which authorizes the Board to order a licensee to cease practice if they test positive for any substance that is prohibited under the terms of the licensee's probation.

In addition, in concert with Senate Bill 1111, in May 2014 the Board approved proposed regulatory language to delegation to the Executive Office the authority to adopt a stipulated settlement if an action to revoke a license has been filed and the licensee agrees to surrender the license without requiring the Board to vote to adopt the settlement.

ISSUE #15: (DIFFICULTY COLLECTING CITATIONS AND FINES FOR CERTAIN TYPES OF VIOLATIONS AND COST RECOVERY.) Should DBC contract with a collection agency to improve its cost recovery and cite and fine functions?

Senate BPE Staff Recommendation: ***In order to improve cost recovery and fine collection efforts, DBC should be allowed to procure a contract with a collection agency for the purpose of collecting outstanding fees, fines, or cost recovery amounts. According to the DCA, most of the boards within DCA are struggling to***

collect cost recovery amounts, outstanding fees, citations or fines. If this is the case, the DCA may wish to procure a contract with one collection agency for all its boards.

DBC Response: Licensees who have been issued a citation or who are on probation are required to pay these fees in order to renew their license and continue practicing. Unrecovered costs are limited to those practitioners whose license is revoked. When a license is revoked, the individual's ability to secure gainful employment and reimburse the board is diminished significantly. Unless the practitioner wishes to reapply for licensure, there are limited mechanisms to require the licensee to meet their cost recovery obligation.

Currently the DBC participates with the Department's Franchise Tax Board program which allows the Board to collect outstanding cost recovery associated with enforcement actions. The process has been successful; however staff resources have limited our referrals. The DBC will consider submitting a BCP to add staff that can perform this function on an ongoing basis.

ISSUE #16: (PROBLEMS WITH PROBATION MONITORING.) Should DBC adopt written guidelines on how to make probation assignments and ensure that probationary and evaluation reports are conducted consistently and regularly as recommended by the Enforcement Assessment?

Senate BPE Staff Recommendation: ***As recommended in the Enforcement Assessment, DBC should adopt written guidelines on how to make probation assignments, and ensure that probationary and evaluation reports are conducted consistently and regularly.***

DBC Response: The Board's Enforcement Program has updated and revised its written guidelines for probation monitoring which also includes the language outlined in the uniform standards; and enforcement staff has been trained on the procedures so that there is statewide consistency in monitoring licensees on probation. In addition, modifications have been made to the Investigator Activity Report System (IAR) to allow for tracking the time spent on probation monitoring functions in addition to investigative tasks.

ISSUE #17: (NEED FOR ANNUAL REPORTING REQUIREMENTS.) Should DBC annually report specific licensing and enforcement information to its licensees and the Legislature?

Senate BPE Staff Recommendation: ***The Dental Practice Act should be amended to require DBC to report annually to the Legislature information required under Business and Professions Code Section 2313 that applies to dentists, including malpractice settlements and judgments, Section 805 reports, the total number of temporary restraining orders or interim suspension orders sought by DBC, and other licensing and enforcement information as specified. Staff recommends that***

annual reports should also be published in DBC's newsletter and made available on its Website.

DBC Response: The Board annually reports malpractice settlements and judgment information collected pursuant to Business and Professions Code Section 806. In addition, the Board reports annually to the Department in a number of categories consistent with the intent of Business and Professions Code Section 2313; including complaint totals and timeframes, arrest and conviction filings, cite and fine results, and disciplinary totals and benchmarks. On a quarterly basis, the Board reports on several Performance Measures to the Department of Consumer Affairs. These results (collected beginning in July 2010) are compared to established expectations and provide transparency of the Board's ongoing achievements and challenges. These reports are available on the Board's website.

ISSUE #18: (IMPLEMENT 2009 DBC ENFORCEMENT ASSESSMENT CORRECTIVE ACTION PLAN.) Should DBC implement the recommendations of a 2009 Enforcement Assessment of DBC's Enforcement Program?

Senate BPE Staff Recommendation: ***DBC should submit to this Committee a corrective action plan detailing how DBC intends to address and implement the recommendations contained in the 2009 Enforcement Assessment*.**

DBC Response: Below are the areas identified in the 2009 Enforcement Assessment report along with the action taken by the Board's Enforcement program to date:

Complaint & Compliance Unit (CCU) and Assignment Processes -COMPLETED

- Issue: Discrepancies between contracted dental consultant productivity and the in-house salaried dental consultant were discussed in the 2009 report. In response, several internal checks and balances were put in place. Individual productivity is tracked monthly and staff performance is rated and up-to-date.
- Issue: The Complaint & Compliance Unit needs an updated Procedure Manual. A comprehensive Intake manual has been drafted and is under final review. In addition, the CCU manager updates procedures on an ongoing basis as processes are affected by regulations process improvements are identified.

Non-Sworn Enforcement Processes -COMPLETED

- Issue: It was noted that probation monitors may have used DMV reports for probation monitoring outside of established procedure. This issue was addressed as a part of the new Probation Monitoring manual and training provided to all monitoring staff.

Inspection Services -COMPLETED

- Issue: Concern that Inspectors need to track their probation monitoring time when they monitor probationers. Capturing this time allows the board to collect more accurate monitoring data to establish probation monitoring fees. Inspectors were added to the IAR system after it was implemented. The Board can now track their time performing inspections and probation monitoring duties. However, following assignment guidelines, Inspectors are not typically assigned active probationers. Inspectors do manage probationers placed on a tolling status, which requires only a limited degree of interaction with staff.

Sworn Investigator Services – COMPLETED AND ONGOING

- Issue: Concern that Investigator vacancies are causing a backlog and case aging. Due in part to economic changes which increased the candidate pools, and more aggressive recruitment efforts by the Board, there have been no ongoing vacancies in several years.

  As illustrated in the Enforcement Program vacancy table (below and under Issue #25), both offices have remained at nearly full staff for the last full years. As a result, the Board has eliminated its backlog of cases. As noted at the Board's May 2014 Board meeting, staff caseloads (while still higher than Medical Board and Division of Investigation) are not unmanageable. In addition, cased in the oldest categories has decreased significantly over the past four years.

			Fiscal Year							
			10/11		11/12		12/13		13/14	
		Classification	Positions	Vacant	Positions	Vacant	Positions	Vacant	Positions	Vacant
Enforcement Program Staff	Mgmt.	Supervising Investigator II	1	0	1	0	1	0	1	0
		Supervising Investigator I	2	0	3	0	3	0	3	0
		Staff Services Manager	2	0	2	0	2	0	2	0
	Investigations	Investigator (sworn)	15	4	14	3.5	14	3.5	14	2.5
		Special Investigator (non-sworn)	1	0	4	0	4	0	4	0
		Inspector	2	0	2	0	2	0	2	0
		Analytical Staff	11.5	0	9.5	1	8.5	0	8.5	1
		Dental Consultant	2	1	2	1	2	1	2	1
		Enforcement Rep I	1	0	0	0	0	0	0	0
	Support	Discipline Analysts	2.5	0	2.5	0	2.5	0.5	2.5	0
		Office Technicians	4	1	4	0	4	0	4	0

Total Sworn Staff	20	4	20	3.5	20	3.5	20	2.5
Total Non-Sworn Staff	24	2	24	2	23	1.5	23	2
Total Enforcement APs	44	6	44	5.5	43	5	43	4.5

Investigator Activity Reporting (IAR) – UPGRADED AND IN USE

- Issue: The case activity tracking system that was in place was antiquated and not used by staff consistently. In 2010, the Board upgraded its tracking system and now uses a copy of the Medical Board's existing Investigator Activity Reporting (IAR) web-based time-tracking program. Enforcement managers are responsible for checking this system monthly to ensure staff are using the tool consistently.

  It should be noted that as Medical Board's staff have been integrated into the BreEZe database, they are no longer using IAR and are unable to provide the Board with the IT support. The Board anticipates time-tracking functionality in BreEZe will replace IAR in the next two years.

Law Enforcement Databases – RESOLVED

- Issue: The CURES computer has been kept in the evidence room and compromises the integrity of evidence safekeeping. The computer was removed from the evidence room. Presently, sworn staff are registered with the Department of Justice's CURES program and may access the database via a web-based portal. Access to the evidence room has been restricted to one Evidence Custodian and the Enforcement Chief.

Toxicology Services – RESOLVED

- Issue: Concern of a non-reliable vendor for toxicology screening. The Dental Board has joined along with several other DCA Boards on a master contract with Phamatech. Thus far, this vendor has met the Board's ongoing needs for random testing.

Evidence Funds – IN PLACE

- Issue: The Enforcement Program lacked an Evidence Fund for use by Sworn Investigators. The Enforcement Program has written policy and procedure for staff and established evidence funds for the Southern California and Northern California offices.

Administrative Cite and Fine Process – IN PLACE

- Issue: Concern that the Administrative Cite & Fine process was underutilized. Enforcement staff have increased their use of this enforcement tool more broadly than in the past. Citations are issued for a number of violations including:

    - Failure to comply with CE requirements,
    - Failure to comply with Student Loan requirements,
    - Failure to produce patient records within statutory requirements,
    - Inadequate record keeping,
    - Failure to report conviction within time requirements,
    - Fictitious Name Permit violations, and
    - False, misleading advertising violation.

Expert Review – IN PROCESS

- Issue: Concern that the current pool of Subject Matter Experts (SMEs) is insufficient to meet the Board's needs. Adequate administrative support may further assist in generating additional subject matter experts. Several efforts were implemented to recruit additional SMEs. CPEI staff were tasked with updating a brochure to attract licensees to participate in the program. In addition, the Board's website was updated, and eligibility criteria were established. An *Access* database was developed to catalog and track SME's in contract.

- Pending: SME training materials are in the process of being updated, and a new SME calibration training is in development.

Evidence and Storage -ADDRESSED

- Issue: The Evidence room is not secure and the evidence storage loses integrity with various individuals being allowed in the Evidence room. As noted above, access to the Evidence rooms in both offices have been limited to a primary Evidence Custodian and one back-up person. Evidence policies and procedures have been put in place, including a sign in/sign out sheet to document access in and out of the evidence room.

Enforcement Management and Oversight – COMPLETED

- Issue: Concern that the Enforcement Chief vacancy has led to a lack of regular oversight of cases progress and productivity. In July 2010, a full-time Enforcement Chief was hired. The Enforcement Chief has been responsible for implementing much of the improvement items noted in the Enforcement Assessment. In addition, the Chief runs monthly and quarterly reports to monitor case aging, caseloads and ongoing productivity. Regular case reviews, probation reports and IDP's are being completed on a timely basis.

Case Reviews and Audits – INITIATED AND ONGOING

- Issue: Concern that without regular and ongoing case reviews, staff issues may contribute to case aging and decreased productivity. As noted in other sections of Board's response, regular case reviews are being conducted and documented in the DCA case tracking system (CAS). Probation reports and Annual Reviews are also being completed in a more timely manner.

Criminal Prosecution – Need to establish Due Diligence -IN PLACE

- Issue: Concern that following a criminal filing, Investigators were not conducting follow-up with the District Attorney to ensure warrants were not outstanding. A Criminal Action Report form was developed to document filed criminal cases and trigger regular follow-up intervals. Administrative staff use calendaring tools to assist in tracking these warrant dates.

Administrative Discipline Processes – IN PLACE

- Issues: Concern that the Enforcement Program's administrative referrals are not handled timely at the AGO. The Board redirected a position to address the existing workload issues at the Discipline desk. Additionally, CPEI funds established a ½-time position to augment the CPEI increase in administrative referral workload. Between these two positions, the Board has accelerated its efforts to process administrative cases to the AGO. These staff are also responsible for tracking the referrals and conducting follow-up on perceived case delays.

Use of Enforcement Program Data for Management Oversight -ADDRESSED

- Issue: Only a limited number of DBC employees have access to certain screens on CAS. Licensing staff cannot view Enforcement screens and may be at a disadvantage when making licensing and renewal decisions. **BREEZE will resolve this issue.**

Reports and Tracking -COMPLETED

- Issue: Concern that management does not receive Enforcement reports to better assess the ongoing productivity of the staff. The Enforcement Chief has established procedures to collect monthly statistical data, which is used to produce a monthly Enforcement report for the management team every month. Managers can use this information to assess their program status, provide feedback on probationary employees and annual evaluations.

Data Integrity – NO CHANGE

- Issue: The current database (CAS) is limited in some of the report data it can provide to management. Staff have developed some work-arounds to obtain data and better assess trends, but with the exception one manager, cannot run "ad hoc" reports. Due to the complexity in running these specialized reports, additional access will not be granted while DCA's IT staff resources are dedicated elsewhere. It is anticipated that BreEZe will solve this issue.

PERSONNEL RESOURCES

Hiring Practices – NO LONGER AN ISSUE

- Issue: Concern that attracting well qualified peace officer applicants has been challenging. At the time of this report, the board was required to consider SROA candidates during the recruitment process. Although candidates may have been within an established salary range, there were few peace officer applicants. Currently, the Board has found numerous well qualified applicants in the absence of a SROA list.

Background Requirements -ADDRESSED

- Issue: Concern that a non-POST trained employee conducted a background investigation for a sworn applicant. Presently, the Board has several sworn staff with POST training to conduct background investigations as needed. If workload or other issues prevent the Board from completing a background promptly, we contract with Division of Investigation or Medical Board to conduct our backgrounds.

Probation Reports and Annual Evaluations -ADDRESSED

- Issue: Concern that probation reports and annual evaluations are not being conducted on a routine basis. Currently, personnel staff provides the management team with a monthly report with due dates. Managers are working to remain in compliance with these due dates.

PEACE OFFICER TRAINING REQUIREMENTS

Continuing Professional Training and Perishable Skills – IN COMPLIANCE

- Issue: Concern that Peace Officers are out of compliance with Perishable Skills requirements. The Dental Board has trained several of its staff to provide many of the required training courses. In addition, the Board now partners with the Medical Board and Division of Investigation to share resources and offer sufficient training dates to ensure all sworn staff remain in compliance.

Firearms Training – IN COMPLIANCE

- Issue: Concern that a POST certified Tactical Firearms course has not been developed. One of the Board's Firearms instructors has attended the POST course and received certification for our Tactical Firearms course. Staff have participated in and are now in compliance with this requirement.

Field Training Officer (FTO) Program – IN PLACE

- Issue: Concern that there is a lack of a FTO Program. The new Enforcement Chief developed a FTO program and the Enforcement Manual has been updated to reflect the FTO Program.

Racial Profiling – IN COMPLIANCE

- Issue: Some sworn staff had not attended this 5-year required course. All staff have been sent to the course and continue to meet the requirement.

Tracking and Accountability of POST Requirements– IN COMPLIANCE

- Issue: Concern that the lack of tracking of POST requirements has contributed to the compliance issues discovered. A sworn investigator has been assigned to track POST training requirements on a regular basis and report issues (well in advance) to management. Quarterly reminders are also sent out to staff with course opportunities to meet the 2-year training obligation.

Procedure Manuals – IN PROGRESS

- Issue: Concern that the Board's Policy & Procedure Manuals are outdated. Nearly all the Board's manuals have been updated within the past 2 years.

ISSUE #19: (CONTINUED USE OF THE DENTAL LOAN REPAYMENT PROGRAM.) The California Dental Corps Loan Repayment Program still has funds available to provide to dental students.

Senate BPE Staff Recommendation*: The California Dental Corps Loan Repayment Program should be extended until DBC distributes all the funds in the account. DBC should indicate to the Committee its efforts to inform students about the availability of the loan repayment program.*

DBC Response: Senate Bill 540 (Price) (Chapter 385, Statutes of 2011) extended the California Dental Corps Loan Repayment Program until all monies in the account are expended. There are currently three participants in the program and approximately $1.633 million left in the account. The DBC promotes this program on its website and includes this information in its presentation to senior students in California dental schools. In addition, the Board has worked with stakeholders and professional associations to distribute this information through their publications.

SUBSTANCE ABUSE AND DIVERSION PROGRAM ISSUES

ISSUE #20: (EFFECTIVENESS OF DIVERSION PROGRAM AND IMPLEMENTATION OF SB 1441 STANDARDS.) It is unknown how successful DBC's Diversion Program is in preventing recidivism of dentists who may abuse drugs or alcohol, and if the Diversion Program is effectively monitoring and testing those who participate in the program. Additionally, it is unclear when "Uniform Standards" for their Diversion Programs will be implemented.

Senate BPE Staff Recommendation: *The Committee should consider requiring an audit of DBC's Diversion Program in 2012, along with the other health boards which have Diversion Programs to assure that these programs are appropriately monitoring and treating participants and to determine whether these programs are effective in preventing further substance abuse. Additionally, the audit should also determine the value of utilizing DECS in a diversion program. DBC should also indicate to the Committee how the Uniform Standards are being implemented and if all Uniform Standards are being followed, and if not, why not; give a definite timeframe when disciplinary guidelines will be amended to include SB 1441 standards, whether formal training for DECS is necessary to ensure that standards are applied consistently, and the necessity of revising the Maximus diversion program recovery contract signed by a dentist who enters the diversion program to incorporate certain aspects of SB 1441 including the requirement that a dentist must undergo a clinical diagnostic evaluation to participate in the program; the practice*

restrictions that apply while undergoing a diagnostic evaluation; the requirement to provide the names and contacts of employers or supervisors for participants who continue to work; the frequency of drug testing; that collection of specimens shall be observed; that certain requirements exist for facilitators; what constitutes major or minor violations; and the consequences for major or minor violations.

DBC Response: The DCA Internal Audit Office (IAO) performed an audit of the DCA's contract with MAXIMUS, Inc. to fulfill the audit requirements outlined in Senate Bill 1441.The purpose of the audit was to review MAXIMUS' effectiveness, efficiency, and overall performance in managing diversion programs for substance abusing licensees.

The audit was performed in accordance with the Standards for the Professional Practice of Internal Auditing, in addition to the voluntary adoption of Government Auditing Standards for performance auditing. The objective of the audit was to provide DCA management, and the California legislature with an audit of the effectiveness, efficiency, and overall performance of the vendor chosen by the department to manage diversion programs for substance-abusing licensees of health care licensing boards, as required by Senate Bill 1441. The Senate Bill also requested the audit make recommendations regarding the continuation of the programs and a changes or reforms required to ensure that individuals participating in the programs are appropriately monitored, and the public is protected from health care practitioners who are impaired due to alcohol or drug abuse or mental or physical illness.

The audit scope was designed to closely follow the audit requirements set forth in SB1441, and was organized as follows:

- Description of the program, including percentages of self-referred, board-referred, and board-ordered participants; whether or not each board or committee uses a Diversion Evaluation Committee (DEC); describes in detail the diversion services provided by MAXIMUS, Inc. including bodily fluids testing, frequency, randomnicity, method of notice to participants, timing of tests, standard for specimen collectors, and procedures used by specimen collectors, group meeting attendance requirements, inpatient or outpatient treatment determination, and worksite monitoring.

SB1441 required the audit make recommendations regarding the continuation of the programs and any changes or reforms required to ensure that individuals participating in the programs are appropriately monitored. In general the audit found that MAXIMUS has established and is maintaining an effective and efficient program. They recommended the program be continued, for the following reasons:

- The Diversion program is the only program designed to protect the consumer from self-referred substance-abusing licensees. These are the licensees for whom there have been no formal complaints, arrests, or other matter coming to the attention of the department. If not for the Diversion program, under which a licensee can confidentially refer him or herself for treatment, while voluntarily refraining from clinical practice, these licensees; substance abuse problems could be driven underground with no one the wiser.

- The Board would like to emphasize that when a participant enters diversion they do not circumvent the enforcement system. The term *diversion* implies that enforcement has been somehow avoided. In fact, if a participant is not successful in the diversion program, MAXIMUS will immediately inform the Board of this fact so that they may decide what action to take next. If the licensee is in diversion as a condition of probation, the disciplinary action will continue. In some instances, disciplinary action continues whether or not the licensee enters diversion.

- The program is very economical for the Board. Most of the cost is paid by the participants. The Board pays only a monthly administrative fee, which is partially deferred by program participants. Participants pay for all drug tests, inpatient or outpatient treatment, therapy, support group costs, etc.

- The cost of the Diversion Evaluation Committees (DECs) that assist the Board is also very economical. The state pays only $100 per day worked for each DEC member. Each committee consists of three licensed dentists, one licensed dental auxiliary, one public member, and one licensed physician or psychologist. They are primarily volunteers, who provide this public service because they want to. Many are giving up their usual daily income to provide this service. DECs provide face to face monitoring by a committee of experienced health care professionals. This monitoring is much more effective than any one individual could be.

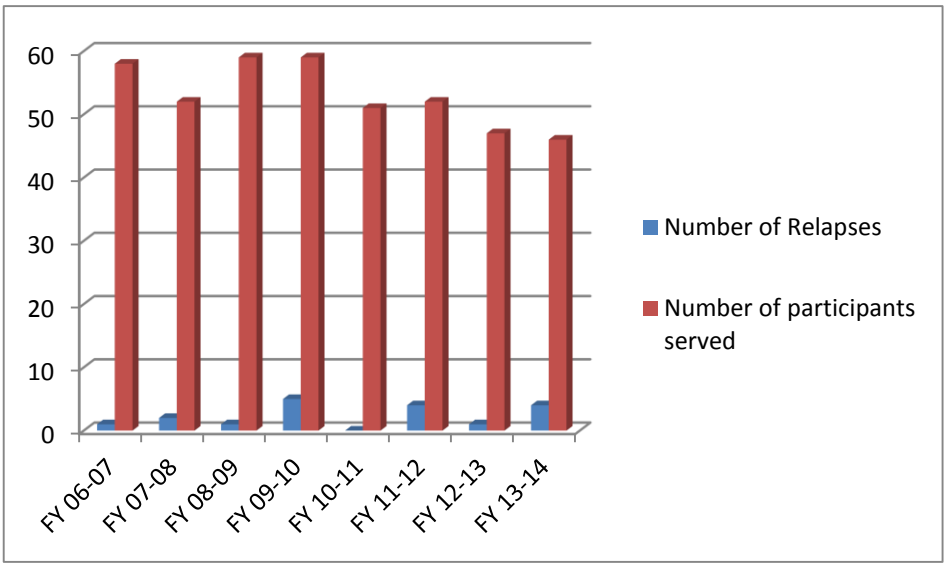
- The Diversion program also provides an additional layer of accountability that does not exist within voluntary peer support settings. If a participant is terminated from the program due to noncompliance, notice is immediately provided to the Board's enforcement program for follow-up action.

With respect to the SB 1441 requirements, the Board's rulemaking relating to Uniform Standards for Substance Abusing Licensees was approved by the Office of Administrative Law and filed with the Secretary of State on January 7, 2014. These standards amended the Board's Disciplinary Guidelines to use the uniform standards developed by the Substance Abuse Coordination Committee and to specify that it is the Diversion Evaluation Committee's duty and responsibility to consider the uniform standards contained within the Disciplinary Guidelines in creating treatment rehabilitation plans for licensees entering the Diversion Program. The amended Disciplinary Guidelines use the uniform standards that should be used in all cases in which a license is placed on probation due to a substance abuse problem. The uniform standards include (1) Clinical Diagnostic Evaluation; (2) Clinical Diagnostic Evaluation Report; (3) Facilitated Group Support Meetings; (4) Supervised Practice (Work Site Monitor Requirements); (5) Major and Minor Violations; and (6) Drug Testing Standards.

The SB 1441 mandates that were included without regulation were accomplished through a contract amendment which became effective on 02/01/2014.

The recidivism rate has remained substantially low throughout the last eight (8) fiscal years. Below are two (2) charts indicating the number of participants and the number of relapses during this time frame.

Number of Relapses	1	2	1	5	0	4	1	4
Number of participants served	58	52	59	59	51	52	47	46



ISSUE #21: (DBC CANNOT ACCESS RECORDS OF THE DIVERSION PROGRAM WHEN A DENTIST IS TERMINATED FOR NON-COMPLIANCE.) Should DBC be authorized to access diversion records for dentists who are terminated from the diversion program for non-compliance, which usually involves relapse?

Senate BPE Staff Recommendation: ***Amend the Dental Practice Act to authorize DBC to access any diversion records of a licensee who participates in a diversion program and is terminated for non-compliance, for purposes of investigation and imposition of a disciplinary action.***

DBC Response: Senate Bill 540 (Price) (Chapter 385, Statutes of 2011) amended the Dental Practice Act to authorize DBC to access any diversion records of a licensee who participates in a diversion program and withdraws or is terminated for non-compliance, for purposes of investigation and imposition of a disciplinary action.

CONSUMER NOTICE ISSUE

ISSUE #22: (NOTICE TO CONSUMERS THAT DENTISTS ARE REGULATED BY DBC.) Should DBC promulgate regulations pursuant to a statute enacted in 1999 to require dentists to inform patients that they are licensed by DBC?

Senate BPE Staff Recommendation: *Pursuant to Section 138 of the B & P Code, DBC should adopt regulations to require dentists to inform their patients that they are licensed by the DBC.*

DBC Response: Regulations were promulgated that required licensed dentists engaged in the practice of dentistry provide notice to each patient of the fact that the dentist is licensed and regulated by the Dental Board of California. In addition, the notice is required to include the Boards telephone number and internet address. This notice is required to be posted prominently in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services. The font size of the notice is required to be at least 48-point type. This regulation became effective November 28, 2012.

BOARD, CONSUMER AND LICENSEE USE OF THE INTERNET ISSUES

ISSUE #23: (NEED FOR CONTINUED ENHANCEMENT OF DBC's INTERNET SERVICES.) Should DBC continue to explore ways to enhance its Internet Services and Website to licensees and members of the public?

Senate BPE Staff Recommendation: *DBC should continue to explore ways to enhance its Internet Services to licensees and members of the public, including*

posting meeting materials, board policies, and legislative reports on the Internet and webcasting Board meetings.

DBC Response: Improving the web site is a board priority. The Board has recently hired staff with strong IT skills to implement this goal. We will continue to post meeting notices and materials, board policies, legislative and regulatory information, newsletters, and other information on our website. While the Board intends to webcast its meetings and has done so since 2011, it may not be possible to webcast the entire open meeting due to limitations on resources.

BUDGETARY ISSUES

ISSUE #24: (ARE RECENT LICENSING FEES SUFFICENT TO COVER DBC COSTS?)
Is DBC adequately funded to cover its administrative, licensing and enforcement costs and to make major improvements to its enforcement program?

Senate BPE *Staff Recommendation*: *DBC should assure the Committee that it will have sufficient resources to cover its administrative, licensing and enforcement costs and to provide for adequate staffing levels for critical program areas if appropriate staffing and funding is provided. Additionally, the Committee may consider amending Section 1725 of the B & P Code to instead require that any changes in licensing and permitting fees of dental assistants be established by regulations, instead of Board Resolutions as currently required.*

DBC Response:
Based on data from the past five (5) fiscal years, the DBC has calculated that with the addition of average estimated savings and reimbursements to the new fee of $525, the State Dentistry Fund will be able to sustain expenditures into BY 2017-18 before facing a deficit once again. The Board is currently undergoing a fee rate audit to determine the appropriate fee amounts to assess and will be providing that information as part of the Sunset Review process in 2015. The Board anticipates establishing new maximum fee ceilings in statute to provide the Board with the necessary authority to promulgate regulations to increase fees in FY 2017-18.

ISSUE #25: (LACK OF STAFF CONTINUES TO HAMPER DBC'S ENFORCEMENT PROCESS.) DBC should explain to the Committee the negative impact of enforcement program vacancies to its overall functions.

Senate BPE Staff Recommendation: *DBC should express to the Committee its frustration in being unable to meet the staffing needs of its various critical programs, especially that of its enforcement program, and the impact that it will have on its ability to address the problems identified by this Committee, especially*

as it concerns its goal to reduce the timeframe for the investigation and prosecution of disciplinary cases.

DBC Response:
Since the last report, the Board has been fortunate to be able to fill the majority of its sworn and non-sworn enforcement positions. Case closure rates climbed following the addition of CPEI positions and remain steady, averaging 968 cases/year, up from 651 cases/year four years ago.
As a result of these figures, the Board recognized the increase in clerical support tasks that resulted from the growth in enforcement staff and casework, and submitted a Budget Change Proposal (BCP) to add two full-time Office Technician positions to support these enforcement efforts.

Despite an augmentation in enforcement staffing levels from CPEI, the caseload per investigator continues to remain significantly higher than other programs within DCA. In addition to an investigation caseload, Dental Board investigators also carry a probation monitoring caseload averaging 10 per sworn investigator and up to 25 for Special Investigators. High caseloads can adversely affect performance when staff is diverted from their work by competing demands.

DCA – Enforcement Program	Average Caseload per Investigators
Division of Investigation	20-22 cases
Medical Board of California	20 cases
Dental Board of California	45-55 cases

			Fiscal Year							
			2010/11		2011/12		2012/13		2013/14	
		Classification	Positions	Vacant	Positions	Vacant	Positions	Vacant	Positions	Vacant
Enforcement Program Staff	Mgmt.	Supervising Investigator II	1	0	1	0	1	0	1	0
		Supervising Investigator I	2	0	3	0	3	0	3	0
		Staff Services Manager	2	0	2	0	2	0	2	0
	Investigations	Investigator (sworn)	15	4	14	3.5	14	3.5	14	2.5
		Special Investigator (non-sworn)	1	0	4	0	4	0	4	0
		Inspector	2	0	2	0	2	0	2	0
		Analytical Staff	11.5	0	9.5	1	8.5	0	8.5	1
		Dental Consultant	2	1	2	1	2	1	2	1
		Enforcement Representative I	1	0	0	0	0	0	0	0
	Support	Discipline Analysts	2.5	0	2.5	0	2.5	0.5	2.5	0
		Office Technicians	4	1	4	0	4	0	4	0
		Total Sworn Staff	20	4	20	3.5	20	3.5	20	2.5
		Total Non-Sworn Staff	24	2	24	2	23	1.5	23	2
		Total Enforcement APs	44	6	44	5.5	43	5	43	4.5

ISSUE #26: (IMPACT ON DBC OF THE UNPAID LOANS MADE TO THE GENERAL FUND.) Will the unpaid loan to the General Fund have an impact on the ability of DBC to deal with its case aging and case processing?

Senate BPE Staff Recommendation: ***No more loans from the reserve funds of the DBC to the General Fund. DBC should explain to the Committee what the impact will be to its overall Budget and its enforcement process if the outstanding loan is not repaid as soon as possible. This of course is if DBC is granted an exemption from the hiring freeze, otherwise new expenditures will not be necessary.***

DBC Response: The Board has received full repayment of the $10 million loan to the general fund.

CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT MEMBERS OF THE DENTAL BOARD OF CALIFORNIA

ISSUE #27: (CONSUMER SATISFACTION WITH DBC IS LOW.) A 2010/2011 Consumer Satisfaction Survey of DBC shows only about 30% of complainants are satisfied with the service provided by the Board. Additionally, DBC failed to disseminate a consumer satisfaction survey prior to 2010.

Senate BPE Staff Recommendation: ***DBC should explain to the Committee why a Consumer Satisfaction Survey was not implemented as recommended by the Monitor, and explain why it believes consumer satisfaction regarding its service is so low, and what other efforts DBC could take to improve its general service to the consumer. Does DBC believe that mediation could be used in certain circumstances to help resolve complaints from the general public regarding health care practitioners?***

DBC Response: The Board continues to survey consumers to learn about their experience with the complaint and enforcement process. However, participation remains low. Acting on the belief that consumers may be increasingly reluctant to participate in online surveys, staff have also provided self-addressed, postage paid survey cards in closure envelopes. This has not had any discernible effect to the participation rate.

The option of using a mediation format to resolve consumer complaints could potentially provide an increase in consumer satisfaction. Historically, the Dental Board receives a significant number of complaints that are focused on the desire to receive a partial or full refund of monies paid for services rendered or initiated. At present, many of these consumers are provided with resources to pursue their issue within the civil courts or peer review and the cases are closed as non-jurisdictional. Mediation could offer an alternative venue that allows both the consumer and licensee to have a voice in the process while potentially negotiating reimbursements where appropriate. While mediation is provided for

in B&P 129(c), the Board lacks the regulatory authority and resources to implement this program at this time.

ISSUE #28. (CONTINUED REGULATION OF DENTISTS BY DBC.) Should the licensing and regulation of the dental profession be continued, and be regulated by the current board membership?

Senate BPE Staff Recommendation: ***Recommend that the dental profession should continue to be regulated by the current DBC members in order to protect the interests of consumers and be reviewed once again in four years.***

DBC Response: Senate Bill 540 (Price) (Chapter 385, Statutes of 2011) extended the Board's sunset date to January 1, 2016.

Section 11
New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, legislative changes) for each of the following:

1. Issues that were raised under prior Sunset Review that have not been addressed.

Of the issues that were addressed in the prior Sunset Review, there are three issues that warrant additional discussion here:

a) Issue #11 discussed the Board's ability to conduct Continuing Education (CE) audits of Dental Auxiliary licensees. The Dental Board recognized that without additional staff resources, it is currently unable to perform regular CE audits on Registered Dental Assistants and Registered Dental Assistants in Extended Functions. The Board will consider requesting a Budget Change Proposal to augment its position authority to initiate regular and ongoing audits.
b) Issue #19 regarding the California Dental Corps Loan Repayment Program. The Board may wish to explore additional methods to advertise the program to prospective dental students to increase current participation rates.
c) Issue #27 - Lack of participation in the Consumer Satisfaction Survey. The Board is actively working with DCA in a focus group to seek new methods for consumer input.

2. New issues that are identified by the board in this report.

<u>Fee Caps</u>

Based on data from the past five (5) fiscal years, the DBC has calculated that with the addition of average estimated savings and reimbursements to the new fee of $525, the State Dentistry Fund will be able to sustain expenditures into BY 2017-18 before facing a deficit once again. The Board is currently undergoing a fee rate audit to determine the appropriate fee amounts to assess and will be providing that information as part of the Sunset Review process in 2015. The Board anticipates establishing new maximum fee ceilings in statute to provide the Board with the necessary authority to promulgate regulations to increase fees in FY 2017-18.

3. New issues not previously discussed in this report.

Authority to collect email addresses

In order to improve the Board's ability to communicate with licensees, the Board will be pursuing expanded authority to allow it to require email addresses on its applications and renewal forms.

Web-based communications will also reduce postage costs and provide a cost savings to the Board.

Regulatory Clarification regarding the filing of disciplinary actions

Through its enforcement efforts, the Board had identified where clarity is needed in further defining the action which indicates that an accusation (or other disciplinary action) has officially been filed. Currently, there are different working understandings of whether an action has been filed upon signature of the Executive Officer (or his/her designee), or when the signed charging document has been served upon the respondent and posted on the Board's website. The Board is seeking to implement language comparable to CCR 1356.5 [in place with the Medical Board of California] which states, "An accusation or petition to revoke probation shall be deemed "filed" on the date it is signed by the executive director or other person described in section 1356."

DHCC's Regulations Relationship with the Dental Board of California

Feasibility of using ADEX as a licensing examination

In August 2014, the Senate Business, Professions and Economic Development Committee (Committee) was contacted by Mercury, a company representing the North East Regional Board of Examiners (NERB), asking if the Committee would consider legislation to accept the ADEX examination as a pathway to licensure in California, similar to WREB. The Committee recommended Mercury contact the Dental Board (Board) to discuss the request for future consideration. Additionally, the Committee suggested that the Board review the issue of accepting the NERB examination and other regional board examinations as a pathway to licensure in California during the upcoming sunset review process.

Pursuant to B&P Code section 139, the Dental Board will need to conduct examination validation studies and an occupational analysis to assess the feasibility of accepting the additional exam pathway. In addition, any decision to accept an additional pathway would require legislative changes to the Dental Practice Act

Retention and Storage of Dental Records

The Dental Board will be seeking regulatory language that defines the responsible party (licensee) who maintains possession of dental treatment records, as well as a reasonable timeframe for maintaining and storage of records when the licensee is no longer in practice.

With the exception of H&S 11191 [which provides for the maintenance of records for three (3) years when the practitioner has prescribed or administered a controlled substance to their patient], the Dental Practice Act lacks the regulatory ability to set forth minimum timeframes before dental patient records can be destroyed, who maintains responsibility for the records when a practice is sold or a treating dentist transfers from one practice to another, as well as the unexpected death of a practicing licensee. Seeking regulation will hold licensees accountable for safeguarding patient information in instances when they have declared bankruptcy, deserted their practice, or failed to pay storage fees and have left patient records abandoned and exposed to identity theft or data mining.

Inclusion of Dental Board within B&P 149

The Dental Board's enforcement program has been addressing unlicensed activity on an ongoing basis through organized task forces as well as individual investigations. In many instances, investigative staff have found that many of the suspects are repeat offenders and have prior convictions. Additionally, to avoid apprehension the suspects are often transitory, relying on their cellular phones to direct potential and returning patients to a location for dental treatment.

Business and Professions Code section 149 provides for the ability of an agency to seek the disconnection of the cellular telephone number associated with the unlicensed practice. The Dental Board believes its inclusion within this statute will prove a very effective tool in its efforts to stop unlicensed activity in the future.

4. New issues raised by the Committees.

Guidelines for the prescribing of Controlled Substances

In May 2014, the Dental Board President and Enforcement Chief attended a Bay Area Prescription Drug Abuse Summit hosted by U.S. Attorney Melinda Haag in partnership with local city and county District Attorney offices, the Drug Enforcement Administration (DEA), Department of Justice (DOJ), and several other organizations involved in the battle against drug addiction. The Summit emphasized the devastating impact that prescription drug abuse is having in communities, and how dispensing practices along with accessibility has contributed to this epidemic.

In response to the growing efforts to curb the illegal use of controlled substances, the Dental Board is considering establishing guidelines for the prescribing of controlled substances. Guidelines will provide clear expectations to prescribers regarding their role

in deciding to prescribe opioids for pain control to their patients as well as follow-up after treatment has been provided.

The board will also be studying the expansion of CE requirements focused on pain management and prescription drug misuse, as well as the establishment of in-office dispensing protocols.

Section 12
Attachments

Please provide the following attachments:

A. Board's administrative manual.

B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).

C. Major studies, if any (cf., Section 1, Question 4).

D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 3, Question 15).

Table 1a. Attendance			
DENTAL BOARD			
Steve Afriat, Public Member			
Date Appointed: 07/21/10	**Reappointed: 12/20/2013**		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	07/26/10	Sacramento	**N**
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	**2/24-N** 2/25-Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	**N**
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	**N**
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	**N**
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-3/01/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Board Meeting 21	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	**N**

John Bettinger, DDS			
Date Appointed: 03/26/09	**Term Expired: 01/01/13**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y

Table 1a. Attendance- Dental Board, continued			
John Bettinger, DDS (continued)			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y

Fran Burton, Public Member			
Date Appointed: 06/03/09	**Reappointed: 01/31/13**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	**N**
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-3/1/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/9/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Table 1a. Attendance-Dental Board, continued			
Stephen Casagrande, DDS			
Date Appointed: 03/27/09	**Reappointed: 07/01/12**		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	**N**
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	**N**
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-03/1/13	San Diego	**N**
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	5/16 Y **5/17 N**
Teleconference	07/11/13	Various locations	**N**
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	**N**

Yvette Chappell-Ingram, Public Member			
Date Appointed: 04/17/13			
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	**N**
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Table 1a. Attendance-Dental Board, continued			
Katie Dawson, RDH			
Date Appointed: 04/11/13			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	**N**
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	**N**
Teleconference	04/09/14	Various locations	**N**
Quarterly Board Meeting	05/29-30/14	Oakland	**5/29 N** 5/30

Luis Dominicis, DDS			
Date Appointed: 03/26/09	**Reappointed: 01/03/13**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	**N**
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-03/1/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	**N**
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Table 1a. Attendance-Dental Board, continued			
Rebecca Downing, Public Member			
Date Appointed: 03/26/09	**Left Office: 01/01/13**		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	**N**
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	**N**
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y

Judith Forsythe, RDA			
Date Appointed: 03/26/09	**Reappointed: 04/20/2013**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	**N**
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	**N**
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	5/17 Y **5/18 N**
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	**N**
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-3/1/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y

Table 1a. Attendance-Dental Board, continued			
Judith Forsythe, RDA (continued)			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	**N**
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Kathleen King, Public Member			
Date Appointed: 02/4/13			
Quarterly Board Meeting	02/28-03/1/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	5/16 Y **5/17 N**
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	**N**
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Ross Lai, DDS			
Date Appointed: 02/26/13			
Quarterly Board Meeting	05/16-17/13	Oakland	5/16 Y **5/17 N**
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	**N**
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Table 1a. Attendance-Dental Board, continued			
Huong Le, DDS			
Date Appointed: 03/26/09	**Reappointed: 01/01/11**		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-8/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-03/1/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Suzanne McCormick, DDS			
Date Appointed: 03/26/09	**Left Office: 04/01/13**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	**N**
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y

Table 1a. Attendance-Dental Board, continued			
Suzanne McCormick, DDS, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Quarterly Board Meeting	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-03/01/13	San Diego	2/28 Y **3/1 N**

Meredith McKenzie, Esq., Public Member			
Date Appointed: 04/15/13			
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	**N**
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	**N**
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Steven Morrow, DDS			
Date Appointed: 08/17/10	**Reappointed: 06/09/14**		
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-03/01/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y

Table 1a. Attendance-Dental Board, continued			
Steven Morrow, DDS, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	**N**
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Thomas Olinger, DDS			
Date Appointed: 03/26/09	**Left Office: 01/01/13**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/7-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	2/23 Y **2/24 N**
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y

Thomas Stewart, DDS			
Date Appointed: 02/28/13			
Quarterly Board Meeting	02/28-03/01/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y

Table 1a. Attendance-Dental Board, continued			
Thomas Stewart, DDS, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Bruce Whitcher, DDS			
Date Appointed: 03/26/09	**Reappointment Date: 01/01/2011**		
Quarterly Board Meeting	07/26/10	Sacramento	Y
Quarterly Board Meeting	09/16/10	Sacramento	Y
Quarterly Board Meeting	11/04-05/10	Los Angeles	Y
Teleconference	12/14/10	Various locations	Y
Quarterly Board Meeting	02/24-25/11	San Diego	Y
Quarterly Board Meeting	05/19-20/11	San Francisco	Y
Quarterly Board Meeting	08/11-12/11	Sacramento	Y
Quarterly Board Meeting	11/07-08/11	Burbank	Y
Teleconference	12/12/11	Various locations	Y
Quarterly Board Meeting	02/23-24/12	San Diego	Y
Teleconference	04/11/12	Various locations	Y
Quarterly Board Meeting	05/17-18/12	San Francisco	Y
Quarterly Board Meeting	08/16-17/12	Sacramento	Y
Teleconference	10/24/12	Various locations	Y
Quarterly Board Meeting	12/03-04/12	Los Angeles	Y
Quarterly Board Meeting	02/28-03/1/13	San Diego	Y
Quarterly Board Meeting	04/04/13	Sacramento	Y
Quarterly Board Meeting	05/16-17/13	Oakland	Y
Teleconference	07/11/13	Various locations	Y
Quarterly Board Meeting	08/26-27/13	Sacramento	Y
Teleconference	10/09/13	Various locations	Y
Quarterly Board Meeting	11/21-22/13	Burbank	Y
Quarterly Board Meeting	02/27-28/14	San Diego	Y
Teleconference	03/12/14	Various locations	Y
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Table 1a. Attendance-Dental Board, continued			
Debra Woo, DDS, continued			
Date Appointed: 01/29/14			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Quarterly Board Meeting	02/27-28/14	San Diego	**N**
Teleconference	03/12/14	Various locations	**N**
Teleconference	04/09/14	Various locations	Y
Quarterly Board Meeting	05/29-30/14	Oakland	Y

Table 1a. Attendance, continued			
BOARD COMMITTEE ATTENDANCE			
Elective Facial and Cosmetic Surgery Permit Credentialing Committee (EFCS)			
Louis Gallia, DMD, MD			
Date Appointed: 06/20/2011			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
EFCS Committee Meeting	10/12/11	Teleconference	Y
EFCS Committee Meeting	01/18/12	Orange, CA	**N**
EFCS Committee Meeting	04/18/12	Cancelled	N/A
EFCS Committee Meeting	07/11/12	Teleconference	Y
EFCS Committee Meeting	10/03/12	Teleconference	Y
EFCS Committee Meeting	01/16/13	Teleconference	Y
EFCS Committee Meeting	04/17/13	Teleconference	Y
EFCS Committee Meeting	07/10/13	Cancelled	N/A
EFCS Committee Meeting	10/02/13	Teleconference	Y
EFCS Committee Meeting	04/16/14	Teleconference	Y

Robert Gramins, DDS			
Date Appointed: 07/02/2009			
EFCS Committee Meeting	01/19/11	Sacramento	Y
EFCS Committee Meeting	04/27/11	Teleconference	Y
EFCS Committee Meeting	07/13/11	Cancelled	N/A
EFCS Committee Meeting	10/12/11	Teleconference	Y
EFCS Committee Meeting	01/18/12	Orange	Y
EFCS Committee Meeting	04/18/12	Cancelled	N/A
EFCS Committee Meeting	07/11/12	Teleconference	Y
EFCS Committee Meeting	10/03/12	Teleconference	Y
EFCS Committee Meeting	01/16/13	Teleconference	Y
EFCS Committee Meeting	04/17/13	Teleconference	Y
EFCS Committee Meeting	07/10/13	Cancelled	N/A
EFCS Committee Meeting	10/02/13	Teleconference	Y
EFCS Committee Meeting	04/16/14	Teleconference	Y

Nestor Karas, MD, DDS			
Date Appointed: 03/19/2007	**Resigned: 2/1/2011**		
EFCS Committee Meeting	01/19/11	Sacramento	Y

Table 1a. Attendance-Board Committees, continued			
Anil Punjabi, MD, DDS			
Date Appointed: 07/07/2009			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
EFCS Committee Meeting	01/19/11	Sacramento	Y
EFCS Committee Meeting	04/27/11	Teleconference	Y
EFCS Committee Meeting	07/13/11	Cancelled	N/A
EFCS Committee Meeting	10/12/11	Teleconference	Y
EFCS Committee Meeting	01/18/12	Orange	Y
EFCS Committee Meeting	04/18/12	Cancelled	N/A
EFCS Committee Meeting	07/11/12	Teleconference	Y
EFCS Committee Meeting	10/03/12	Teleconference	Y
EFCS Committee Meeting	01/16/13	Teleconference	Y
EFCS Committee Meeting	04/17/13	Teleconference	**N**
EFCS Committee Meeting	07/10/13	Cancelled	N/A
EFCS Committee Meeting	10/02/13	Teleconference	Y
EFCS Committee Meeting	04/16/14	Teleconference	**N**

Peter Scheer, DDS			
Date Appointed: 07/20/209			
EFCS Committee Meeting	01/19/11	Sacramento	**N**
EFCS Committee Meeting	04/27/11	Teleconference	Y
EFCS Committee Meeting	07/13/11	Cancelled	N/A
EFCS Committee Meeting	10/12/11	Teleconference	Y
EFCS Committee Meeting	01/18/12	Orange	Y
EFCS Committee Meeting	04/18/12	Cancelled	N/A
EFCS Committee Meeting	07/11/12	Teleconference	Y
EFCS Committee Meeting	10/03/12	Teleconference	Y
EFCS Committee Meeting	01/16/13	Teleconference	Y
EFCS Committee Meeting	04/17/13	Teleconference	Y
EFCS Committee Meeting	07/10/13	Cancelled	N/A
EFCS Committee Meeting	10/02/13	Teleconference	Y
EFCS Committee Meeting	04/16/14	Teleconference	Y

Table 1a. Attendance-Board Committees, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Brian Wong, MD			
Date Appointed: 01/18/2012			
EFCS Committee Meeting	01/18/12	Orange	Y
EFCS Committee Meeting	04/18/12	Cancelled	N/A
EFCS Committee Meeting	07/11/12	Teleconference	Y
EFCS Committee Meeting	10/03/12	Teleconference	Y
EFCS Committee Meeting	01/16/13	Teleconference	**N**
EFCS Committee Meeting	04/17/13	Teleconference	Y
EFCS Committee Meeting	07/10/13	Cancelled	N/A
EFCS Committee Meeting	10/02/13	Teleconference	Y
EFCS Committee Meeting	04/16/14	Teleconference	**N**

Table 1a. Attendance, continued			
NORTHERN DIVERSION EVALUATION COMMITTEE (N-DEC)			
James Frier, DDS			
Date Appointed: 08/28/13			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
N-DEC Meeting	09/05/13	Sacramento	Y
N-DEC Meeting	12/05/13	Sacramento	Y
N-DEC Meeting	03/06/14	Sacramento	Y
N-DEC Meeting	06/05/14	Sacramento	Y

Dina Gillette, RDH, BA			
Date Appointed: 11/08/09	**Reappointed: 03/06/14**		
N-DEC Meeting	11/16/10	Sacramento	Y
N-DEC Meeting	12/02/10	Sacramento	Y
N-DEC Meeting	03/02/11	Sacramento	Y
N-DEC Meeting	06/02/11	Sacramento	Y
N-DEC Meeting	09/01/11	Sacramento	Y
N-DEC Meeting	12/01/11	Sacramento	Y
N-DEC Meeting	03/01/12	Sacramento	**N**
N-DEC Meeting	06/07/12	Sacramento	Y
N-DEC Meeting	09/06-07/12	Sacramento	Y
N-DEC Meeting	11/29/12	Sacramento	Y
N-DEC Meeting	03/07/13	Sacramento	Y
N-DEC Meeting	06/06/13	Sacramento	Y
N-DEC Meeting	9/5/2013	Sacramento	Y
N-DEC Meeting	12/05/13	Sacramento	Y
N-DEC Meeting	03/06/14	Sacramento	Y
N-DEC Meeting	06/05/14	Sacramento	Y

Mark Grecco, DMD			
Date Appointed: 02/01/02	**Reappointed: 03/06/08**	**Separated: 06/06/13**	
N-DEC Meeting	11/16/10	Sacramento	Y
N-DEC Meeting	12/02/10	Sacramento	Y
N-DEC Meeting	03/02/11	Sacramento	**N**
N-DEC Meeting	06/02/11	Sacramento	Y
N-DEC Meeting	09/01/11	Sacramento	**N**
N-DEC Meeting	12/01/11	Sacramento	Y
N-DEC Meeting	03/01/12	Sacramento	**N**
N-DEC Meeting	06/07/12	Sacramento	Y
N-DEC Meeting	09/06-07/12	Sacramento	9/06-Y **9/07-N**

Table 1a. Attendance-Board Committees, continued			
Mark Grecco, DMD, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
N-DEC Meeting	11/29/12	Sacramento	Y
N-DEC Meeting	03/07/13	Sacramento	Y
N-DEC Meeting	06/06/13	Sacramento	Y

Carrie Jaffe, MD/PhD/Psychologist			
Date Appointed: 05/18/05	**Term Ended: 05/19/14**		
N-DEC Meeting	11/16/10	Sacramento	**N**
N-DEC Meeting	12/02/10	Sacramento	Y
N-DEC Meeting	03/02/11	Sacramento	**N**
N-DEC Meeting	06/02/11	Sacramento	Y
N-DEC Meeting	09/01/11	Sacramento	Y
N-DEC Meeting	12/01/11	Sacramento	**N**
N-DEC Meeting	03/01/12	Sacramento	**N**
N-DEC Meeting	06/07/12	Sacramento	**N**
N-DEC Meeting	09/06-07/12	Sacramento	Y
N-DEC Meeting	11/29/12	Sacramento	Y
N-DEC Meeting	03/07/13	Sacramento	**N**
N-DEC Meeting	06/06/13	Sacramento	Y
N-DEC Meeting	09/05/13	Sacramento	**N**
N-DEC Meeting	12/05/13	Sacramento	**N**
N-DEC Meeting	03/06/14	Sacramento	Y

Steve Leighty, DDS			
Date Appointed: 05/18/05	**Reappointed: 05/18/09**	**Separated: 03/06/14**	
N-DEC Meeting	11/16/10	Sacramento	Y
N-DEC Meeting	12/02/10	Sacramento	Y
N-DEC Meeting	03/02/11	Sacramento	Y
N-DEC Meeting	06/02/11	Sacramento	Y
N-DEC Meeting	09/01/11	Sacramento	Y
N-DEC Meeting	12/01/11	Sacramento	Y
N-DEC Meeting	03/01/12	Sacramento	Y
N-DEC Meeting	06/07/12	Sacramento	Y
N-DEC Meeting	09/06-07/12	Sacramento	Y
N-DEC Meeting	11/29/12	Sacramento	Y
N-DEC Meeting	03/07/13	Sacramento	Y
N-DEC Meeting	06/06/13	Sacramento	Y
N-DEC Meeting	09/05/13	Sacramento	Y

Table 1a. Attendance-Board Committees, continued			
Steve Leighty, DDS, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
N-DEC Meeting	12/05/13	Sacramento	Y
N-DEC Meeting	03/06/14	Sacramento	Y

Gregory Pluckhan, DDS			
Date Appointed: 03/02/13			
N-DEC Meeting	03/07/13	Sacramento	Y
N-DEC Meeting	06/06/13	Sacramento	Y
N-DEC Meeting	09/05/13	Sacramento	**N**
N-DEC Meeting	12/05/13	Sacramento	Y
N-DEC Meeting	03/06/14	Sacramento	Y
N-DEC Meeting	06/05/14	Sacramento	**N**

Kathleen Shanel, DDS			
Date Appointed: 06/04/04	**Reappointed: 03/06/08**	**Separated: 11/29/12**	
N-DEC Meeting	11/16/10	Sacramento	Y
N-DEC Meeting	12/02/10	Sacramento	Y
N-DEC Meeting	03/02/11	Sacramento	Y
N-DEC Meeting	06/02/11	Sacramento	Y
N-DEC Meeting	09/01/11	Sacramento	Y
N-DEC Meeting	12/01/11	Sacramento	Y
N-DEC Meeting	03/01/12	Sacramento	Y
N-DEC Meeting	06/07/12	Sacramento	**N**
N-DEC Meeting	09/06-07/12	Sacramento	9/06 Y **9/07 N**
N-DEC Meeting	11/29/12	Sacramento	Y

Janis Thibault, Public Member			
Date Appointed: 05/18/12	**Resigned: 12/17/13**		
N-DEC Meeting	06/07/12	Sacramento	**N**
N-DEC Meeting	09/06-07/12	Sacramento	**N**
N-DEC Meeting	11/29/12	Sacramento	**N**
N-DEC Meeting	03/07/13	Sacramento	**N**
N-DEC Meeting	06/06/13	Sacramento	**N**
N-DEC Meeting	09/05/13	Sacramento	**N**
N-DEC Meeting	12/05/13	Sacramento	**N**

Table 1a. Attendance-Board Committees, continued			
Lynn Zender, Public Member			
Date Appointed: 11/08/09	**Reappointed: 03/06/14**		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
N-DEC Meeting	11/16/10	Sacramento	Y
N-DEC Meeting	12/02/10	Sacramento	Y
N-DEC Meeting	03/02/11	Sacramento	Y
N-DEC Meeting	06/02/11	Sacramento	Y
N-DEC Meeting	09/01/11	Sacramento	Y
N-DEC Meeting	12/01/11	Sacramento	Y
N-DEC Meeting	03/01/12	Sacramento	Y
N-DEC Meeting	06/07/12	Sacramento	Y
N-DEC Meeting	09/06-07/12	Sacramento	Y
N-DEC Meeting	11/29/12	Sacramento	Y
N-DEC Meeting	03/07/13	Sacramento	Y
N-DEC Meeting	06/06/13	Sacramento	Y
N-DEC Meeting	09/05/13	Sacramento	Y
N-DEC Meeting	12/05/13	Sacramento	Y
N-DEC Meeting	03/06/14	Sacramento	Y
N-DEC Meeting	06/05/14	Sacramento	**N**

Table 1a. Attendance-Board Committees, continued			
SOUTHERN DIVERSION EVALUATION COMMITTEE (S-DEC)			
Anca Severin, Public Member			
Date Appointed: 03/14/14			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
S-DEC Meeting	04/02/14	Los Angeles	Y

Alan Schroeder, MD			
Date Appointed: 04/16/04	**Reappointed: 04/17/08**		
S-DEC Meeting	11/15/10	Los Angeles	Y
S-DEC Meeting	07/06-07/11	Los Angeles	Y
S-DEC Meeting	10/05/11	Los Angeles	Y
S-DEC Meeting	01/04-05/12	Los Angeles	Y
S-DEC Meeting	04/04/12	Los Angeles	Y
S-DEC Meeting	07/11-12/12	Los Angeles	**N**
S-DEC Meeting	10/03/12	Los Angeles	Y

Thomas Specht, MD/PhD/Psychologist			
Date Appointed: 08/01/09	**Reasppointed: 03/20/14**		
S-DEC Meeting	11/15/10	Los Angeles	Y
S-DEC Meeting	07/06-07/11	Los Angeles	Y
S-DEC Meeting	10/05/11	Los Angeles	Y
S-DEC Meeting	01/04-05/12	Los Angeles	Y
S-DEC Meeting	04/04/12	Los Angeles	**N**
S-DEC Meeting	07/11-12/12	Los Angeles	Y
S-DEC Meeting	10/03/12	Los Angeles	Y
S-DEC Meeting	01/08-09/13	Los Angeles	Y
S-DEC Meeting	04/03-04/13	Los Angeles	Y
S-DEC Meeting	07/10-11/13	Los Angeles	Y
S-DEC Meeting	10/02/13	Los Angeles	Y
S-DEC Meeting	01/15/14	Los Angeles	Y
S-DEC Meeting	04/02/14	Los Angeles	Y

Table 1a. Attendance-Board Committees, continued			
Steven Supancic, DDS, MD			
Date Appointed: 08/01/09	**Reappointed: 08/01/13**		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
S-DEC Meeting	11/15/10	Los Angeles	Y
S-DEC Meeting	07/06-07/11	Los Angeles	Y
S-DEC Meeting	10/05/11	Los Angeles	Y
S-DEC Meeting	01/04-05/12	Los Angeles	**N**
S-DEC Meeting	04/04/12	Los Angeles	Y
S-DEC Meeting	07/11-12/12	Los Angeles	Y
S-DEC Meeting	10/03/12	Los Angeles	Y
S-DEC Meeting	01/08-09/13	Los Angeles	Y
S-DEC Meeting	04/03-04/13	Los Angeles	Y
S-DEC Meeting	07/10-11/13	Los Angeles	Y
S-DEC Meeting	10/02/13	Los Angeles	Y
S-DEC Meeting	01/15/14	Los Angeles	Y
S-DEC Meeting	04/02/14	Los Angeles	Y

James Tracy, DDS			
Date Appointed: 08/04/06			
S-DEC Meeting	11/15/10	Los Angeles	Y
S-DEC Meeting	07/06-07/11	Los Angeles	Y
S-DEC Meeting	10/05/11	Los Angeles	Y
S-DEC Meeting	01/04-05/12	Los Angeles	Y
S-DEC Meeting	04/04/12	Los Angeles	Y
S-DEC Meeting	07/11-12/12	Los Angeles	7/11-Y **7/12- N**
S-DEC Meeting	10/03/12	Los Angeles	Y
S-DEC Meeting	01/08-09/13	Los Angeles	Y
S-DEC Meeting	04/03-04/13	Los Angeles	Y
S-DEC Meeting	07/10-11/13	Los Angeles	7/10- Y **7/11- N**
S-DEC Meeting	10/02/13	Los Angeles	Y
S-DEC Meeting	01/15/14	Los Angeles	Y
S-DEC Meeting	04/02/14	Los Angeles	Y

Table 1a. Attendance-Board Committees, continued			
Curtis Vixie, DDS			
Date Appointed: 08/24/07	**Reappointed: 08/24/11**		
S-DEC Meeting	11/15/10	Los Angeles	Y
S-DEC Meeting	07/06-07/11	Los Angeles	Y
S-DEC Meeting	10/05/11	Los Angeles	Y
S-DEC Meeting	01/04-5/12	Los Angeles	1/4-Y **1/5- N**
S-DEC Meeting	04/04/12	Los Angeles	Y
S-DEC Meeting	07/11-12/12	Los Angeles	Y
S-DEC Meeting	10/03/12	Los Angeles	Y
S-DEC Meeting	1/8-9/13	Los Angeles	Y
S-DEC Meeting	4/3-4/13	Los Angeles	Y
S-DEC Meeting	07/10-11/13	Los Angeles	Y
S-DEC Meeting	10/02/13	Los Angeles	Y
S-DEC Meeting	01/15/14	Los Angeles	Y
S-DEC Meeting	04/02/14	Los Angeles	Y

Table 1a. Attendance-Board Committees, continued			
DENTAL ASSISTING COUNCIL MEMBERS' ATTENDANCE (DAC)			
Anne Contreras, RDA			
Date Appointed: 03/26/12			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
DAC Meeting	05/17-18/12	San Francisco	Y
DAC Meeting	08/16-17/12	Sacramento	Y
DAC Meeting	12/03-04/12	Los Angeles	Y
DAC Meeting	2/28-3/01/13	San Diego	Y
DAC Meeting	04/04/13	Sacramento	Y
DAC Meeting	5/16-17/13	Oakland	Y
DAC Meeting	8/26-27/13	Sacramento	Y
DAC Meeting	11/21-22/13	Burbank	Y
DAC Meeting	2/27-28/14	San Diego	Y
DAC Meeting	5/29-30/14	Oakland	Y

Pamela Davis-Washington, RDA			
Date Appointed: 03/19/12			
DAC Meeting	05/17-18/12	San Francisco	Y
DAC Meeting	08/16-17/12	Sacramento	Y
DAC Meeting	12/03-04/12	Los Angeles	Y
DAC Meeting	2/28-3/01/13	San Diego	Y
DAC Meeting	04/04/13	Sacramento	Y
DAC Meeting	5/16-17/13	Oakland	Y
DAC Meeting	8/26-27/13	Sacramento	Y
DAC Meeting	11/21-22/13	Burbank	Y
DAC Meeting	2/27-28/14	San Diego	Y
DAC Meeting	5/29-30/14	Oakland	Y

Michele Jawad, RDA, Faculty			
Date Appointed: 04/17/13			
DAC Meeting	05/17-18/12	San Francisco	Y
DAC Meeting	08/16-17/12	Sacramento	Y
DAC Meeting	12/03-04/12	Los Angeles	Y
DAC Meeting	2/28-3/01/13	San Diego	Y
DAC Meeting	04/04/13	Sacramento	Y
DAC Meeting	5/16-17/13	Oakland	Y

Table 1a. Attendance-Board Committees, continued			
Michele Jawad, RDA, Faculty, continued			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
DAC Meeting	8/26-27/13	Sacramento	Y
DAC Meeting	11/21-22/13	Burbank	Y
DAC Meeting	2/27-28/14	San Diego	Y
DAC Meeting	5/29-30/14	Oakland	Y

Teresa Lua, RDAEF			
Date Appointed: 03/16/12			
DAC Meeting	05/17-18/12	San Francisco	Y
DAC Meeting	08/16-17/12	Sacramento	Y
DAC Meeting	12/03-04/12	Los Angeles	Y
DAC Meeting	2/28-3/01/13	San Diego	Y
DAC Meeting	04/04/13	Sacramento	Y
DAC Meeting	5/16-17/13	Oakland	Y
DAC Meeting	8/26-27/13	Sacramento	Y
DAC Meeting	11/21-22/13	Burbank	Y
DAC Meeting	2/27-28/14	San Diego	Y
DAC Meeting	5/29-30/14	Oakland	Y

Emma Ramos, RDA, Faculty			
Date Appointed: 03/19/12			
DAC Meeting	05/17-18/12	San Francisco	Y
DAC Meeting	08/16-17/12	Sacramento	Y
DAC Meeting	12/03-04/12	Los Angeles	Y
DAC Meeting	2/28-3/01/13	San Diego	Y
DAC Meeting	04/04/13	Sacramento	Y
DAC Meeting	5/16-17/13	Oakland	Y
DAC Meeting	8/26-27/13	Sacramento	Y
DAC Meeting	11/21-22/13	Burbank	Y
DAC Meeting	2/27-28/14	San Diego	Y
DAC Meeting	5/29-30/14	Oakland	Y

Table 1a. Attendance-Board Committees, continued			
Denise Romero, RDA, Faculty			
Date Appointed: 03/29/12			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
DAC Meeting	05/17-18/12	San Francisco	Y
DAC Meeting	08/16-17/12	Sacramento	Y
DAC Meeting	12/03-04/12	Los Angeles	Y
DAC Meeting	2/28-3/01/13	San Diego	Y
DAC Meeting	04/04/13	Sacramento	Y
DAC Meeting	5/16-17/13	Oakland	Y
DAC Meeting	8/26-27/13	Sacramento	Y
DAC Meeting	11/21-22/13	Burbank	Y
DAC Meeting	2/27-28/14	San Diego	Y
DAC Meeting	5/29-30/14	Oakland	Y

Member Name	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type
Afriat, Steven	07/21/10	12/20/13	01/01/17	Assembly Speaker	Public
Bettinger, John	03/26/09	n/a	01/01/13	Governor	Licensee
Burton, Fran	06/03/09	01/31/13	01/01/17	Senate Rules	Public
Casagrande, Stephen	02/10/06	07/01/12	07/16/16	Governor	Licensee
Chappell-Ingram, Yvette	04/17/13	n/a	01/01/16	Governor	Public
Dawson, Katie	04/11/13	n/a	01/01/17	Governor	RDH
Dominicis, Luis	03/26/09	01/03/13	01/01/16	Governor	Licensee
Downing, Rebecca	03/26/09	n/a	01/01/12	Governor	Public
Forsythe, Judith	03/26/09	04/20/13	01/01/17	Governor	RDA
King, Kathleen	02/04/13	n/a	01/01/14	Governor	Public
Lai, Ross	02/26/13	n/a	01/01/17	Governor	Licensee
Le, Huong	03/26/09	01/02/11	01/01/15	Governor	Non-Profit Community Clinic/Licensee
McCormick, Suzanne	03/26/09	n/a	01/01/13	Governor	Licensee
McKenzie, Meredith	04/15/13	n/a	01/01/16	Governor	Public
Morrow, Steven	08/17/10	06/09/14	01/01/18	Governor	Licensee/Faculty
Olinger, Thomas	03/26/13	n/a	01/01/13	Governor	Licensee
Stewart, Thomas	02/28/13	n/a	01/01/17	Governor	Licensee
Whitcher, Bruce	03/26/09	01/02/11	01/01/15	Governor	Licensee
Woo, Debra	01/24/14	n/a	01/01/17	Governor	Licensee

the pleasure of the Board.					
Louis Gallia, DMD, MD	06/20/11	n/a	n/a	Dental Board	Professional
Robert Gramins, DDS	07/02/09	n/a	n/a	Dental Board	Professional
Nestor Karas, MD, DDS	03/19/07	n/a	n/a	Dental Board	Professional
Anil Punjabi, MD, DDS	07/07/09	n/a	n/a	Dental Board	Professional
Peter Scheer, DDS	07/20/09	n/a	n/a	Dental Board	Professional
Brian Wong, MD	01/18/12	n/a	n/a	Dental Board	Professional

Table 1b. Board/Committee Member Rosters, continued					
Member Name	**Date First Appointed**	**Date Re-appointed**	**Date Term Expires**	**Appointing Authority**	**Type**
Northern Diversion Evaluation Committee Members					
Frier, James	08/28/13	n/a	08/27/17	Dental Board	Dentist
Gillette, Dina	11/08/09	03/06/14	03/05/17	Dental Board	Auxiliary
Grecco, Mark	12/01/02	03/06/08	03/07/12	Dental Board	Dentist
Jaffe, Carrie	05/18/05	05/18/09	05/19/13	Dental Board	Psychologist
Leighty, Steve	05/18/05	05/18/09	05/17/13	Dental Board	Dentist
Pluckan, Gregory	03/02/13	n/a	03/01/17	Dental Board	Dentist
Shanel, Kathleen	06/04/04	03/06/08	03/07/12	Dental Board	Psychologist
Thibault, Janis	05/18/12	n/a	resigned	Dental Board	Public
Zender, Lynn	11/08/09	03/06/14	03/01/17	Dental Board	Public
Southern Diversion Evaluation Committee Members					
Schroeder, Alan	04/16/04	04/17/08	04/16/12	Dental Board	Doctor
Severin, Anca	03/14/14	n/a	03/13/18	Dental Board	Auxiliary
Specht, Thomas	08/01/09	03/20/14	03/19/17	Dental Board	Doctor
Supancic, J. Steven	08/01/09	08/01/13	03/21/17	Dental Board	Dentist
Tracy, James	08/04/06	08/04/10	08/03/14	Dental Board	Dentist
Vixie, Curtis	08/24/07	08/24/11	08/23/15	Dental Board	Dentist
Vacant				Dental Board	Public
Dental Assisting Council Members					
Contreras, Anne	03/26/12	03/17/14	03/16/18	Dental Board	RDA
Davis-Washington, Pamela	03/19/12	n/a	03/18/15	Dental Board	RDA
Jawad, Michele	04/17/13	n/a	resigned	Dental Board	Faculty
Lua, Teresa	03/16/12	n/a	03/15/16	Dental Board	RDAEF
McNealy, Tamara	06/13/14	n/a	06/12/17	Dental Board	Faculty
Ramos, Emma	03/19/12	n/a	03/19/15	Dental Board	Faculty
Romero, Denise	03/29/12	n/a	03/28/13	Dental Board	Faculty

Dental Board of California

Policy and Procedure Manual

Adopted by the Board
2/28/2014

Dental Board of California
2005 Evergreen Street, Ste 1550
Sacramento, CA 95815-3831
www.dbc.ca.gov

Table of Contents

CHAPTER 1. INTRODUCTION

Overview

The Dental Board of California (DBC) was created by the California Legislature in 1885. Today the DBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), Business, Consumer Services, and Housing Agency. DBC's highest priority is protection of the public while exercising its licensing, regulatory, and disciplinary functions. If protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

The DBC is presently comprised of 15 members. The composition of the Board is defined in Business and Professions Code Sections 1601 and 1603 and includes eight dentists appointed by the Governor, one of whom must be a member of a faculty of any California dental college and one shall be a dentist practicing in a nonprofit community clinic; five public members, three appointed by the Governor, one by the Speaker of the Assembly and one by the Senate Rules Committee; one licensed dental hygienist appointed by the Governor; and one licensed dental assistant appointed by the Governor. Board members may serve up to two four-year terms. Board members serve without a salary, but are compensated $100 per day for each meeting day and are reimbursed for travel expenses (B&P Code § 103).

This policy and procedure manual is provided to Board members as a reference for important laws, regulations, DCA policies, and Board policies to help guide the actions of the Board members and ensure Board effectiveness and efficiency.

Definitions:

BPC	Business and Professions Code
CCR	California Code of Regulation
CLEAR	Council on Licensure Enforcement and Regulations
DCA	Department of Consumer Affairs
EO	Executive Officer
SAM	State Administrative Manual
President	Where the term "President" is used in this manual, it will be assumed to include "his or her designee"

General Rules of Conduct:

Board members shall not speak or act for the Board without proper authorization**.**

Board members shall maintain the confidentiality of confidential documents and information.

Board members shall commit the time necessary to prepare for Board responsibilities.

Each Board member shall recognize the equal role and responsibilities of all Board members.

Board members shall act fairly, be nonpartisan, impartial and unbiased in their role of protecting the public.

Board members shall treat all applicants and licensees in a fair and impartial manner.

Board members' actions shall serve to uphold the principle that the Board's primary mission is to protect the public.

Board members shall not use their positions on the Board for personal, familial or financial gain.

CHAPTER 2. BOARD MEETING PROCEDURES

Frequency of Meetings
(BPC Section 101.7)

Boards shall meet at least three times each calendar year. Boards shall meet at least once each calendar year in Northern California and once each calendar year in southern California in order to facilitate participation by the public and its licensees.

Special meetings may be held at such times as the board may elect or on the call of the president of the board, or of not less than four members thereof. (BPC Section 1608)

Notice of each meeting and the time and place thereof shall be given in accordance with the Bagley-Keene Open Meeting Act (Gov. Code § 11120 et seq).

Board Member Attendance at Board Meetings
(Board Policy)

Board members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President or the Executive Officer and request to be excused from the meeting.

Board Meetings
(Government Code Section 11120 et seq.)

Meetings are subject to all provisions of the Bagley-Keene Open Meeting Act. This act governs meetings of the state regulatory boards and meetings of committees of those boards where the committee consists of more than two members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included in the agenda.

Communications
(Bagley-Keene Open Meeting Act – 2013)

A majority of the members of a state body shall not, outside of a meeting, use a series of communications of any kind, directly or through intermediaries, to discuss, deliberate, or take action on any item of business that is within the subject matter of the state body.

Committees
(Board Policy, BPC 1601.1)

The Board shall be organized into standing committees pertaining to examinations, enforcement, and other subjects the Board deems appropriate.

Committees meet when they have issues to be considered in order to make recommendations to the full Board.

Dental Assisting Council
(BPC Section 1742)

The Dental Assisting Council (Council) will consider all matters relating to dental assistants in California and will make appropriate recommendations to the Board and the standing Committees of the Board. The members of the Council shall include the registered dental assistant member of the Board, another member of the Board, and five registered dental assistants.

Public Participation
(Board Policy)

Public participation is encouraged throughout the public portion of the meetings. The chairs of the respective committees, as well as the Board President, acknowledge comments from the audience during general discussion of agenda items. In addition, each Board agenda includes public comment as a standing item of the agenda. This standing agenda item allows the public to request items to be placed on future agendas.

If the agenda contains matters that are appropriate for closed session, the agenda shall cite the particular statutory section and subdivision authorizing the closed session.

Quorum
(BPC Section 1610)

Eight Board members constitute a quorum of the Board for the transaction of business.

Agenda Items
(Board Policy)

Board meetings generally involve:
- Board policy
- Legislation that may be relevant to the practice of dentistry
- Content and administration of examinations
- Adoption or deletion of regulations
- Approval of fee schedules
- Appeals of Board actions

Board Procedures/Operations
- Enforcement issues such as, acceptance/denial of Administrative Law Judge decisions, stipulations and advancement of cases to the Office of Administrative Hearings
- Committee meetings
- Acceptance or rejection of committee recommendations

Any Board member may submit, for consideration, items for a Board meeting agenda to the Board President and Executive Officer 30 days prior to the

meeting. The Board President and Executive Officer, in consultation with legal counsel, will review and approve items submitted for consideration.

Notice of Meetings
(Government Code Section 11120 et seq.)

According to the Open Meeting Act, meeting notices must include the agenda and shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include a staff person's name, work address and work telephone number who can provide further information prior to the meeting.

Notice of Meetings to be Posted on the Internet
(Government Code Section 11125)

Notice and the agenda shall also be made available on the Internet at least 10 days in advance of the meeting, and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices are available.

Record of Meetings
(Board Policy)

The minutes are a summary, not a transcript, of each Board meeting. They shall be prepared by Board staff and submitted for review by the Board members at the next Board meeting. Board minutes shall be approved at the next scheduled meeting of the Board. When approved, the minutes shall serve as the official record of the meeting.

Board meetings are webcast in real time when webcasting resources are available. Archived copies of the webcast are available on the Board's website approximately 30 days after the meeting is held.

Recording
(Board Policy)

Public meetings are recorded for staff purposes. Recordings may be erased upon Board approval of the minutes or 30 days after the recording. CD copies are available, upon request, for Board members not able to attend a meeting.

Meeting Rules
(16 CCR § 1002)

Board meetings are conducted following Robert's Rules of Order, to the extent that it does not conflict with state law (e.g., Bagley-Keene Open Meeting Act), as a guide when conducting the meetings.

Use of Electronic Devices During Meetings
(Bagley-Keene)

Board members should not text or email one another during a meeting on any matter within the Board's jurisdiction. Using electronic devices to communicate secretly in such a manner would violate the Open Meeting Act. Where laptop computers or tablets are used by the Board members at the meeting because the Board provides materials electronically, the Board President shall make an announcement at the beginning of the meeting as to the reason for the use of laptop computers or tablets.

CHAPTER 3. TRAVEL AND SALARY POLICIES AND PROCEDURES

Travel Approval
(DCA Memorandum 96-01)

Board members shall have Board President approval for all travel except for regularly scheduled Board and committee meetings to which the Board member is assigned.

Travel Arrangements
(Board Policy)

Board members are encouraged to coordinate with the Executive Assistant on travel arrangements and lodging accommodations.

Out-of-State Travel
(SAM Section 700 et seq.)

For out-of-state travel, Board members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled and must be approved by the Governor's Office.

Travel Claims
(SAM Section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Assistant maintains these forms and completes them as needed. It is advisable for Board members to submit their travel expense forms immediately after returning from a trip and not later than two weeks following the trip.

In order for the expenses to be reimbursed, Board members shall follow the procedures contained in DCA Departmental Memoranda which are periodically disseminated by the Director and are provided to Board members.

Per Diem Salary
(BPC Section 103)

BPC Section 103 regulates compensation in the form of per diem salary and reimbursement of travel and other related expenses for Board members. This section provides for the payment of per diem salary for Board members "for each day actually spent in the discharge of official duties," and provides that the Board member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Per Diem Salary
(Board Policy)

The following general guidelines shall apply to the payment of per diem salary, or reimbursement for travel:

1. No per diem salary or reimbursement for travel-related expenses shall be paid to Board members except for attendance at official Board or committee meetings. Attendance at gatherings, events, hearings, conferences or meetings other than official Board or committee meetings shall be approved in advance by the Board President. The Executive Officer shall be notified of the event and approval shall be obtained from the Board President prior to Board member's attendance.

2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board meeting or committee meeting to the conclusion of that meeting.

   Where it is necessary for a Board member to leave early from a meeting, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

   For Board-specified work, Board members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorized attendance at gatherings, events, meetings, hearings, or conferences, and committee work. That work does not include preparation time for Board or committee meetings. Board members cannot claim per diem salary for time spent traveling to and from a Board or committee meeting.

CHAPTER 4. SELECTION OF OFFICERS AND COMMITTEE/LIAISON APPOINTMENTS

Officers of the Board
(BPC Section 1606)

The Board shall elect from its members a President, a Vice President, and a Secretary.

Election of Officers
(Board Policy)

It is board policy to elect officers at the final meeting of the calendar year for service during the next calendar year, unless otherwise decided by the board. The newly elected officers shall assume the duties of their respective offices on January 1st of the New Year.

Officer Vacancies
(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers shall then serve the remainder of the term.

Committee/Liaison Appointments
(Board Policy)

The President shall establish committees, whether standing or special, as he or she deems necessary. The composition of the committees and the appointment of the members shall be determined by the Board President in consultation with the Vice President, Secretary and the Executive Officer. When committees include the appointment of non-Board members, all affected parties should be considered. The Board President shall strive to appoint board members to a minimum of one standing committee.

Attendance at Committee Meetings
(Board Policy)

If a Board member wishes to attend a meeting of a committee of which he or she is not a member, that Board member cannot participate or vote during the committee meeting, and must not sit on the Dais.

Roles and Responsibilities of Board Officers/Committee Chairs/Liaisons
(Board Policy)

President

- Acts as spokesperson for the Dental Board (attends legislative hearings and testifies on behalf of the Board, attends meetings with stakeholders and

Legislators on behalf of Board, talks to the media on behalf of the Board, and signs letters on behalf of the Board).

- Meets and/or communicates with the Executive Officer (EO) on a regular basis.
- Provides oversight to the Executive Officer in performance of the EO duties.
- Approves leave requests, verifies accuracy and approves timesheets, approves travel and signs travel expense claims for the EO.
- Coordinates the EO annual evaluation process including contacting DCA Office of Human Resources to obtain a copy of the Executive Officer Performance Evaluation Form, distributes the evaluation form to members, and collates the ratings and comments for discussion.
- Authors a president's message for every board meeting and published newsletters.
- Approves Board Meeting agendas.
- Chairs and facilitates Board Meetings.
- Chairs the Executive Committee.
- Signs specified full board enforcement approval orders.
- Establishes Committees and appoints Chairs and members.
- Establishes 2-Person subcommittees and /or task forces to research policy questions when necessary.
- Attends Dental Hygiene Committee of California meetings

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee.
- Coordinates the revision of the Board's Strategic Plan.

Secretary

- Calls the roll at each Board meeting and reports that a quorum has been established.
- Is a member of Executive Committee.

Committee Chair

- Reviews agenda items with EO and Board President prior to Committee meetings.
- Approves the Committee agendas.
- Chairs and facilitates Committee meetings.
- Reports the activities of the Committee to the full Board.

Liaisons

- Members acting as liaisons to Committees are responsible for keeping the Board informed regarding emerging issues and recommendations made at the Committee level.

Creation of Task Forces
(Board Policy)

It is the policy of the Board that:

1) task forces will be appointed sparingly as the exception rather than the rule and only when the Board finds it cannot address a specific and well defined issue through the existing committee structure;

2) task force members may be appointed by the Board President but must be approved by the full Board;

3) the charge given to the task force will be clear, specific, in writing and presented to the Board at the time of appointment;

4) task forces, of three or more members, appointed by the Board are subject to the same open meeting laws as the Board (as required by Government Code Section 11121);

5) all task forces shall give staff at least 20 days advance notice of the time, place and general agenda for any task force meeting;

6) task forces will meet and report regularly and provide the Board with minutes after every meeting;

7) no task force recommendation will be the basis for Board action in the absence of a formal written report from the task force to the Board.

CHAPTER 5. BOARD ADMINISTRATION AND STAFF

Board Administration
(DCA Reference Manual)

Board members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Officer.

Board Budget
(Board Policy)

The Executive Officer shall serve as the Board's budget liaison with staff and shall assist staff in the monitoring and reporting of the budget to the Board. The Executive Officer or the Executive Officer's designee will attend and testify at legislative budget hearings and shall communicate all budget issues to the Administration and Legislature.

Strategic Planning
(Board Policy)

The Executive Committee shall have overall responsibility for the Board's Strategic Planning Process. The Vice President shall serve as the Board's strategic planning liaison with staff and shall assist staff in the monitoring and reporting of the strategic plan to the Board. The Board will conduct periodic strategic planning sessions and may utilize a facilitator to conduct the strategic planning process.

Legislation
(Board Policy)

When time constraints preclude Board action, the Board delegates the authority to the Executive Officer and the Chair of the Legislative Committee to take action on legislation that would change the Dental Board of California's Dental Practice Act, or which impacts a previously established Board policy or affects the public's health, safety or welfare. Prior to taking a position on legislation, the Executive Officer shall consult with the Board President and Legislative Committee Chair. The Board shall be notified of such action as soon as possible.

Communications with Other Organizations and Individuals
(Board Policy)

The official spokesperson for the Dental Board of California is the President. The President may designate the Executive Officer, the Chief of Enforcement, other board members, or staff to speak on behalf of the Board.

It is the policy of the Dental Board of California to accommodate speaking requests from all organizations, schools, consumer groups, or other interested groups, whenever possible. If the Board representative is addressing a dental school or group of potential candidates for licensure, the program must be open to all interested parties. The President may authorize board members to speak to schools, organizations, consumer groups, or other interested groups upon request by members or written requests from said schools, organizations or groups.

Media Inquiries
(Board Policy)

If a member of the Board receives a media call, the Member should promptly refer the caller to the Department of Consumer Affairs Public Information Officer who is employed to interface with all types of media on any type of inquiry. It is required that members make this referral as the power of the Board is vested in the Board itself and not with an individual Board Member. Expressing a personal opinion can be misconstrued as a Board policy or position and may be represented as a position that the Board has taken on a particular issue when it has not.

A Board Member who receives a call should politely thank the caller for the call, but state that it is the Board's policy to refer all callers to the Public Information Officer. The Board Member should then send an email to the Executive Officer indicating they received a media call and relay any information supplied by the caller.

Service of Lawsuits
(Board Policy)

Board Members may receive service of a lawsuit against themselves and the Board pertaining to a certain issue (e.g. a disciplinary matter, a complaint, a legislative matter. etc.). To prevent a confrontation, the Board Member should accept service. Upon receipt, the Board Member should notify the Executive Officer of the service and indicate the name of the matter that was served and any pertinent information. The Board Member should then mail the entire package that was served to the Executive Officer as soon as possible. The Board's legal counsel will provide instructions to the Board Members on what is required of them once service has been made. The Board Members may be required to submit a request for representation to the Board to provide to the Attorney General's Office.

Executive Officer Evaluation
(Board Policy)

The Board shall evaluate the performance of the Executive Officer annually.

Board Staff
(DCA Reference Manual)

Employees of the Board, with the exception of the Executive Officer, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Officer. Consequently, the Executive Officer shall solely be responsible for all day-to-day personnel transactions.

Business Cards
(Board Policy)

Business cards will be provided to each Officer of the Board with the Board's office address, telephone and fax number, and Web site address. A Board Officer's business address, telephone and fax number, and e-mail address may be listed on the card at the member's request.

CHAPTER 6. OTHER POLICIES AND PROCEDURES

Mandatory Training
(DCA Policy)

State law requires board members within the Department of Consumer Affairs to complete training in several important areas, including ethics, conflict of interest laws, sexual harassment prevention and Board Member Orientation Training.

Ethics Orientation
http://www.dcaboardmembers.ca.gov/training/ethics_orientation.shtml
(Government Code §53234)

California law requires all appointees to take an ethics orientation within the first six months of their appointment and to repeat this ethics orientation every two years throughout their term.
The training includes important information on activities or actions that are inappropriate or illegal. For example, generally public officials cannot take part in decisions that directly affect their own economic interests. They are prohibited from misusing public funds, accepting free travel and accepting honoraria. There are limits on gifts.
An online, interactive version of the training is available on the Attorney General's Web site at http://oag.ca.gov/ethics. An accessible, text-only version of the materials is also available at the Attorney General's Web site.

Conflict of Interest
http://www.dcaboardmembers.ca.gov/member_info/conflict_interest.shtml
(Government Code §81000)(California Code of Regulations, §18730)

The Department of Consumer Affairs will make and retain a copy of the statements from members of the boards, commission, committees and subcommittees and make them available for public inspection. It will forward the original statement to the Fair Political Practices Commission.
Information on specific topics can be found at:
http://www.dcaboardmembers.ca.gov/member_info/conflict_interest.shtml

Sexual Harrassment Prevention
http://www.dcaboardmembers.ca.gov/training/harassment_prevention.shtml
(Government Code §12950.1)

All new board members are required to attend at least two hours of classroom or other interactive training and education regarding sexual harassment prevention within six months of their appointment. The Equal Employment Opportunity (EEO) Office is responsible for ensuring that all board members complete their required training. A copy of your certificate of proof of training must be sent to the EEO Office. Please identify which Board/Committee/Commission you serve on.

For information on how to receive Sexual Harrassment Prevention Training contact:

Equal Employment Opportunity Office
1625 N. Market Blvd, Ste N330
Sacramento, CA 95834
(916) 574-8280 (916) 574-8604 Fax

Board Member Orientation
(BPC Section 453)

Every newly appointed board member is required to complete a training and orientation program offered by the Department of Consumer Affairs (DCA) within one year of assuming office. The training covers the functions, responsibilities and obligations that come with being a member of a DCA board.

For more information and assistance with scheduling training, please contact:

SOLID Training Solutions
1747 North Market Blvd, Ste. 270
Sacramento, CA 95834
(916) 574-8316
SOLID@dca.ca.gov

Board Member Disciplinary Actions
(Board Policy)

The Board may censure a member if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as President of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members
(BPC Section 1605)

The Governor has the power to remove from office at any time any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct. The Governor may also remove from office a Board member whom directly or indirectly discloses examination questions to an applicant for examination for licensure. That member would also be subject to a misdemeanor violation (B&P Code 123).

Resignation of Board Members
(Government Code Section 1750)

In the event that it becomes necessary for a Board member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. State law requires written notification. A copy of this letter shall also be sent to the director of the Department, the Board President, and the Executive Officer.

Conflict of Interest
(Government Code Section 87100)

No Board member may make, participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board member who has a financial interest shall disqualify him or herself from making or attempting to use his or her official position to influence the decision. Any Board member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Officer, or the Board's legal counsel.

Contact with Candidates
(Board Policy)

Board members shall not intervene on behalf of a candidate for licensure for any reason. They should forward all contacts or inquiries to the Executive Officer or Board staff.

Gifts from Candidates
(Board Policy)

Gifts of any kind to Board members or the staff from candidates for licensure with the Board shall not be permitted.

Request for Records Access
(Board Policy)

No Board member may access the file of a licensee or candidate without the Executive Officer's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the DB~~O~~C's office.

Ex Parte Communications
(Government Code Section 11430.10 et seq.)

The Government Code contains provisions prohibiting *ex parte* communications. An "ex parte" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

> "While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication."

Board members are prohibited from an *ex parte* communication with Board enforcement staff while a proceeding is pending.

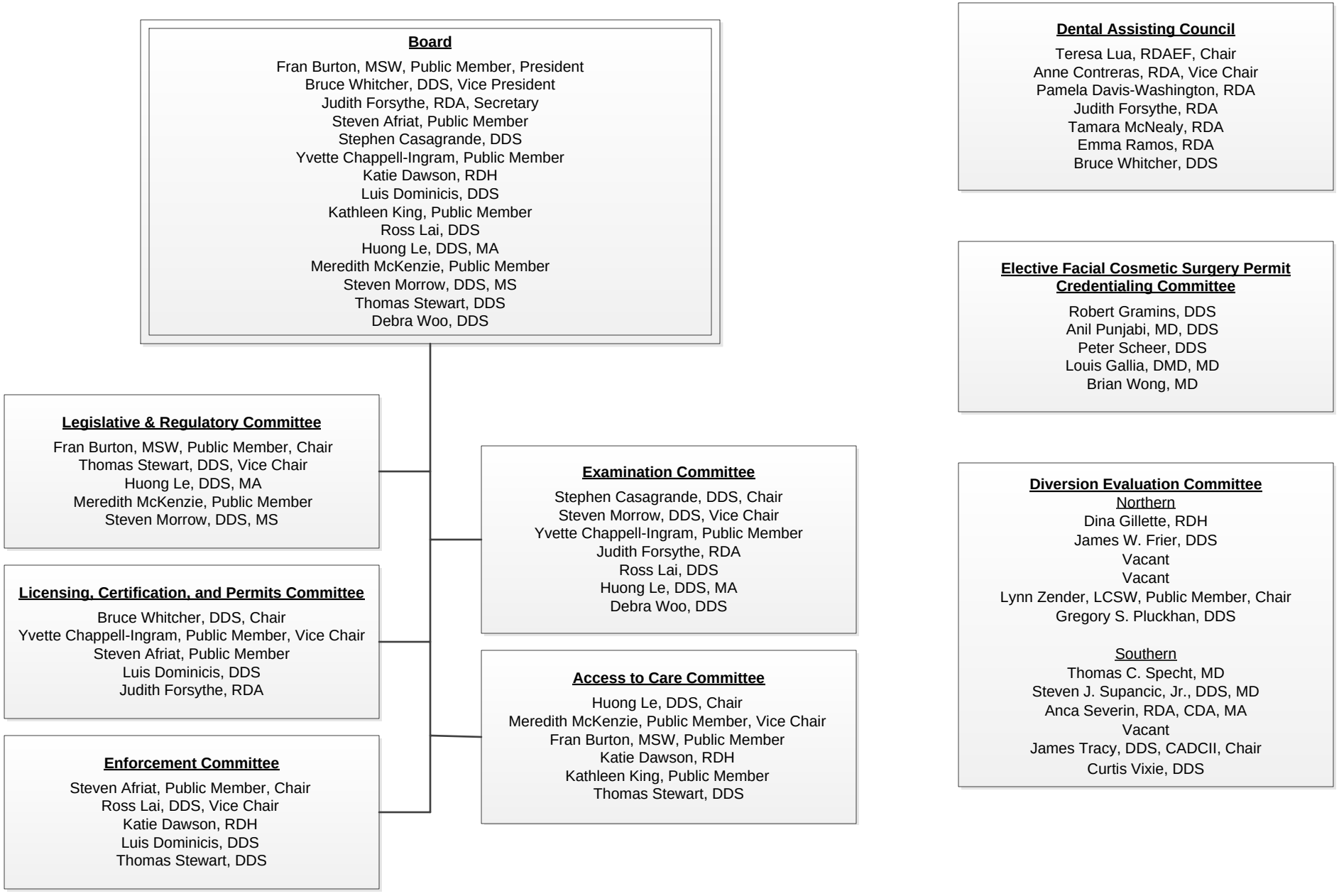
Occasionally an applicant who is being formally denied licensure, or a licensee against whom disciplinary action is being taken, will attempt to directly contact Board members. If the communication is written, the person should read only far enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, they should reseal the documents and send them to the Chief of Enforcement.

If a Board member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person they cannot speak to them about the matter. If the person insists on discussing the case, he or she should be told that the Board member would be required to excuse him or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the agency's assigned Legal Office attorney.

Org Chart
Board/Committee
2014

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL BOARD OF CALIFORNIA



DENTAL BOARD OF CALIFORNIA

REVIEW OF THE

WESTERN REGION EXAMINATION BOARD

GENERAL DENTISTRY EXAMINATIONS

Prepared by

OFFICE OF PROFESSIONAL EXAMINATION SERVICES
CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

DENTAL BOARD OF CALIFORNIA

REVIEW OF THE

WESTERN REGION EXAMINATION BOARD

GENERAL DENTISTRY EXAMINATIONS

This report was prepared and written by
Office of Professional Examination Services
California Department of Consumer Affairs

November 2013

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STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

EXECUTIVE SUMMARY

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs being used in the California licensure process comply with psychometric and legal standards. The California Dental Board (Board) requested that the DCA, Office of Professional Examination Services (OPES), complete a comprehensive review of the Western Region Examination Board's (WREB) licensing examination program. The purpose of the OPES review was to evaluate the suitability of the WREB examinations for continued use in California and to identify if there are areas of California dental practice not covered by the WREB examinations.

OPES received and reviewed documents provided by WREB. Follow-up phone communications were held to clarify WREB procedures and practices. A comprehensive evaluation of the documents was made to determine whether (a) job analysis, (b) examination development, (c) passing scores, (d) test administration, (e) examination performance, and (f) test security procedures met professional guidelines and technical standards. OPES found that the procedures used to establish and support the validity and defensibility of the WREB examination program components listed above meet professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing (Standards)* and the California Business and Professions Code section 139.

OPES convened a panel of licensed California dentists to serve as subject matter experts (SMEs) to review the WREB examination content and to compare the content to the description of practice determined for California dentists. The SMEs were selected by the Board based on their geographic location, experience, and practice specialty.

The SMEs were asked to review the scope of practice for dentists as determined by the 2005 California General Dentist Occupational Analysis, performed by OPES (OPES, 2005), and link it with the examination content for WREB as determined by the 2007 General Dentist Practice Analysis performed by WREB. The results of the SMEs' linkage indicate that the clinical competencies assessed in the WREB examinations are relevant to dental practice in California.

The SMEs were also asked to link the job task and knowledge statements that make up the examination outline for the California Dentistry Law and Ethics Examination with the content for the WREB examination. This linkage was performed to identify if there are areas of California dental practice not covered by the WREB examination. The California Dentistry Law and Ethics Examination is structured into two content areas. The examination outline (Table 2) specifies the job tasks related to California laws and regulations a dentist is expected to master at the time of licensure. The results of the subject matter experts' linkage indicate that there are areas of California dental practice not covered by the WREB examination. These areas were found to be covered by the California Dentistry Law and Ethics Examination (CDLEE).

The content areas for the WREB examination and the California Dentistry Law and Ethics Examination are provided in Tables 1 and 2 below, respectively.

TABLE 1 – CONTENT AREAS OF WREB EXAMINATION

Content Area	Content Area Description	Relative Weight
I. Operative	Candidates choose two procedures from the following options: Direct Posterior Class II Amalgam Restoration, Direct Posterior Class II Composite Restoration, Direct Anterior Class III Composite Restoration, and Indirect Posterior Class II Cast Gold Restoration.	52%
II. Periodontal	Candidates submit a patient for approval, then root planing and scaling are completed and the patient is submitted for grading.	10%
III. Endodontics	Candidates perform an endodontic treatment on two extracted teeth: one anterior tooth and one canal on a posterior multi-canal tooth. Access and condensation are graded.	10%
IV. Prosthodontics	Using medical and dental history, intra-oral photographs, radiographs, and periodontal examination records, candidates are required to assess periodontal factors and answer multiple choice questions regarding periodontal assessment, diagnosis, prognosis, appropriate treatment, and follow-up care.	18%
V. Patient Assessment and Treatment Planning	Candidates prepare a treatment plan for the assigned patient case.	10%
TOTAL		**100**

TABLE 2 – CONTENT AREAS FOR CALIFORNIA DENTISTRY LAW AND ETHICS EXAMINATION (CDLEE)

Content Area	Content Area Description	Percent Weight
I. Ethics	This area assesses the candidate's ability to comply with ethical standards for dentistry, including scope of practice and professional conduct. A. Treatment Planning Protocol (24%) B. Treatment Accessibility (10%)	34%
II. Law	This area assesses the candidate's ability to comply with legal obligations, including patient confidentiality, professional conduct, and information management. A. Confidentiality Obligations (9%) B. Professional Conduct (33%) C. Information Management (24%)	66%
TOTAL		**100**

DEVELOPMENT AND VALIDATION OF A PORTFOLIO EXAMINATION FOR INITIAL DENTAL LICENSURE

Submitted to:

Dental Board of California
2005 Evergreen Street
Suite 1550
Sacramento, California 95815

Date:

May 1, 2013

Prepared by:

PSI Services LLC
2950 North Hollywood Way
Suite 200
Burbank, California 91505

EXECUTIVE SUMMARY

This report describes major aspects of the Portfolio Examination that are essential to implementation for six subject matter areas: oral diagnosis and treatment planning, direct restoration, indirect restoration, removable prosthodontics, endodontics and periodontics.

The report includes the procedures used to define the competencies to be tested, provides background research that underlies the Portfolio Examination, describes the establishment of minimum clinical experiences and development of clinical competency examinations. Because the portfolio is an examination, it must meet the Standards for Educational and Psychological Testing (1999) to ensure that it is fair, unbiased, and legally defensible. The purpose of applying the Standards to the validation process is to ensure that the Portfolio Examination can provide evidence that entry level dentists possess the minimum competencies necessary to protect public health and safety.

The most important step in establishing the validity of the Portfolio Examination was to define the competencies to be tested in the examination. Separate focus groups of key faculty from six Board approved dental schools were convened to identify minimum clinical experiences and clinical competency examination content for oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, endodontics, and periodontics. Basically, focus group participants identified the competencies to be assessed in a systematic way beginning with an outline of major competency domains and ending with detailed rating (grading) scales for evaluating candidate performance. All participants provided input in a systematic, iterative fashion, until consensus is achieved. The competencies identified from this process served as the framework for the training and calibration procedures for examiners and audit procedures for evaluating the efficacy of the process.

- Section 6 lists the major competencies and the subcomponents within each competency.

- Section 7 describes basis for the evaluation system and procedures required to design it.

- Sections 8, 9, 10, 11, 12, and 13 describe the minimum clinical experiences, patient parameters and scoring (rating) criteria.

- Section 14 describes the procedures for training and calibrating examiners.

- Section 15 describes procedures that for establishing audit procedures for ensuring that the examination accomplishes its objectives.

The foundation of the Portfolio Examination is already in place at the dental schools. All six dental schools---University of Pacific, University of California San Francisco, Loma

Linda, University of Southern California, University of California Los Angeles and Western University of Health Sciences---had a great deal of consistency in their evaluation system. The schools use similar criteria to evaluate students' performance and use similar procedures to calibrate their faculty according to performance criteria. This finding had important implications for the implementation of the Portfolio Examination because the evaluation systems currently used by the dental schools will not require major changes.

The only difference between the current systems and the Portfolio Examination is that the competencies and the system to evaluate them would be standardized across schools. Therefore, the Portfolio Examination process will be implemented within the dental schools without additional resources. It is anticipated that the students will find the Portfolio Examination as a reasonable alternative pathway for initial licensure.

In summary, the dental schools reached consensus in identifying critical competencies to be measured in the Portfolio Examination, thereby standardizing the competencies to be measured, providing the framework for the evaluation (grading) system, training and calibration procedures for examiners, and audit procedures for evaluating the efficacy of the process.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

SECTION 1 – INTRODUCTION

OVERVIEW

The Portfolio Examination captures the strength of traditional portfolios used to assess learning progress and has the additional advantage of being integrated within the current educational process and within the context of a treatment plan of a patient of record. Instead of developing a traditional portfolio and having it evaluated, the Portfolio Examination requires documentation of clinical cases which are competency evaluations of required procedures assembled in either paper or electronic format. Candidates are evaluated in real time during the normal course of patient treatment and normal course of clinical training.

The Portfolio Examination was approached with the understanding that the outcome would directly impact predoctoral dental education at every dental school in California and could provide the framework for evaluating predoctoral dental competencies in dental schools across the nation.

The overarching principle for development of the Portfolio Examination pathway was consumer protection. The consultants worked closely with dental school faculty to derive the framework and content of the examination; moreover, procedures were conducted in an objective and impartial manner with the public's health, safety, and welfare as the most important concern.

First, consultants met with deans and dental school faculty who represented major domains of practice as well as legislative sponsors from the California Dental Association to present the Portfolio Examination concept and answer faculty questions regarding impact on their respective programs. Second, consultants conducted separate face-to-face meetings with representative faculty from each of the Board approved dental schools to individually present the concept and discuss their concerns. Third, consultants conducted discipline-specific focus groups of faculty[1], e.g., oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, periodontics, and endodontic, to develop the content for the examination.

From these meetings, consultants gained an understanding of the predoctoral dental competencies that were critical to development of the Portfolio Examination and creating supporting documentation that would be used in the formulation of Assembly Bill 1524. The consultants also conducted an extensive review of written documentation of each school's competency examinations to gain insights into the procedures used in competency examinations and associated scoring systems.

[1] Face-to-face focus groups were conducted at the University of the Pacific, the University of California San Francisco, the University of Southern California, and Western University of Health Sciences.

UTILIZATION OF EXPERTS

Committees of subject matter experts knowledgeable in the six subject areas, including section chairs, department chairs and/or other faculty who were knowledgeable in the six subject areas of interest, were consulted throughout the process to provide expertise regarding the competencies acquired in their respective programs and the competencies that should be assessed in the examination.

PSYCHOMETRIC STANDARDS

The Standards for Educational and Psychological Testing (1999) set forth by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education serve as the benchmark for evaluating all aspects of credentialing, including professional and occupational credentialing. The Standards are used by the measurement profession as the psychometric standards for validating all examinations, including licensing and certification examinations.

Whenever applicable, specific Standards will be cited as they apply to definition of examination content, rating scales, calibration of raters, and auditing procedures to link the particulars of the Portfolio Examination to psychometric practice.

LEGAL STANDARDS

Because the Portfolio Examination is a state licensure examination, it must also meet legal standards as explicated in Sections 12944 of the California Government Code and Section 139 of the California Business and Professions Code. Section 12944 relates to establishment of qualifications for licensure that do not adversely affect any class by virtue of race, creed, color, national origin/ancestry, sex, gender, gender identity, gender expression, age, medical condition, genetic information, physical disability, mental disability, or sexual orientation. Section 139 of the California Business and Professions Code states occupational licensure examination programs must be based upon occupational (job/practice) analyses and examination validation studies.

SECTION 2 – HISTORY

EXISTING PATHWAYS

The Dental Board of California (hereafter, the Board) currently offers two pathways that predoctoral dental students may choose to obtain initial licensure:

- A clinical and simulation examination administered by the Western Regional Examining Board, or,

- A minimum of 12 months of a general practice residency (GPR) or advanced education in general dentistry (AEGD) program approved by the American Dental Association's Commission on Dental Accreditation.

All applicants are required to successfully complete the written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations and an examination in California law and ethics.

AUTHORIZATION OF THE PORTFOLIO EXAMINATION PATHWAY

Assembly Bill 1524, introduced in February 2009, eliminated the clinical and written examination offered by the Board. Provisions of the bill allow the Board to offer the portfolio examination as an alternative to initial licensure for general dentists in addition to other pathways available to students graduating from dental schools in California, i.e., the Western Regional Examining Board (WREB) examination and "Licensure by Credential" (PGY-1).

> *"…The bill would abolish the clinical and written examination administered by the Board. The bill would replace the examination with an assessment process in which an applicant is assessed while enrolled at an in-state dental school utilizing uniform standards of minimal clinical experiences and competencies and at the end of his or her dental program."*

REQUIREMENTS FOR PORTFOLIO EXAMINATION

Section 3 of the Business and Professions Code is amended to read:

> *1632. (a) The Board shall require each applicant to successfully complete the written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.*

1632. (b) The Board shall require each applicant to successfully complete an examination in California law and ethics developed and administered by the Board. The Board shall provide a separate application for this examination…..the only other requirement for taking this examination shall be certification from the dean of the qualifying dental school attended by the applicant that the applicant has graduated, or will graduate, or is expected to graduate.

1632. (c) The Board shall require each applicant to have taken and received a passing score ……on the portfolio assessment (examination) of the applicant's fitness to practice dentistry while the applicant is enrolled in a dental school program at a Board approved school in California. This assessment shall utilize uniform standards minimal clinical experiences and competencies. The applicant shall pass a final assessment at the end of his or her dental school program.

OTHER REQUIREMENTS

Students who participate in the portfolio examination pathway must:

(a) Be in good academic standing in their institution at the time of portfolio examination and be signed off by the dean of their respective schools.

(b) Have no pending ethical issues at the time of the portfolio examination and must be signed off by the dean of their respective schools.

SECTION 3 – BACKGROUND RESEARCH

PSYCHOMETRIC ISSUES

Use of Portfolio as an examination. Portfolio assessment can provide a powerful approach to assessing a range of curriculum outcomes not easily assessed by other methods and provides a more in-depth picture of student competence than the snapshot obtained in a traditional examination (Davis, Friedman Ben-David, Harden, Howie, Ker, McGhee, Pippard & Snadden, 2001, p. 364). Furthermore, the real value of portfolio assessment is that it provides a basis for judgment of the student's professional fitness to practice (p. 364).

Some researchers comment that if portfolios are used for *summative* (examination) rather than formative (learning) purposes, the portfolios must meet stringent psychometric requirements including standardization, rater training with structured guidelines for making decisions, and large numbers of examiners to average out rater effects (Driessen, van der Vleuten, Schuwirth, Tartwijk & Vermunt, 2005, p. 215). Davis and Ponnamperuma (2005, p. 282) note that the one of the advantages of portfolio is that it can be standardized and used in summative assessment.

Validity of inferences made. Friedman Ben-David, Davis, Harden, Howie, Ker, and Pippard (2001) note that the validity of the inferences made about the portfolio depend on the reliability of the test. If the test scores or ratings suffer from low interrater agreement or poor sampling, inferences cannot be made. Moreover, there should be a clear definition of the purpose of the portfolio and identification of the competencies to be assessed. Webb, Endacott, Gray, Jasper, McMullan and Scholes (2003) and McMullan (2003) cite several criteria that should be used to evaluate portfolio assessments, namely, explicit grading criteria, evidence from a variety of sources, internal quality assurance processes, and external quality assurance processes.

Content validation by job analysis. Content validity is important in developing an examination for initial licensure (Chambers, 2004) such that there should be a validation process that inquires whether tasks being evaluated should be representative of tasks critical to safe and effective practice. A recent paper by Patterson, Ferguson, and Thomas (2008) calls for validation by using a job analysis to identify core and specific competencies.

Use in dental licensure. A recent paper entitled "Point/Counterpoint: Do portfolio assessments have a place in dental licensure?" addresses many of these issues specifically as they pertain to the purpose of licensure rather than education (Hammond & Buckendahl, 2006; Ranney & Hambleton, 2006).

Hammond and Buckendahl do not support the use of portfolios for dental licensure. They cite two issues as important in considering the use of portfolio assessments for licensure purposes. First, standardizing the training and evaluation across a broad range of locations would be difficult. Second, demonstrations of abilities in past records would need to be verified so that there is an evaluation of the current range of competencies. These authors contend that the portfolio does not provide an assessment of minimum skills that is administered ***independent*** of the training program to support licensure decisions; and therefore, provides no external validation and verification of the students' competence. Moreover, there may be measurement error, or low reliability, within the system as a result of errors in content sampling, number of observations of performance, number of examiners rating the student's performance, assumptions of unidimensional relationships between items, lack of interrater agreement, and reliance on pairs rather than triads of examiners for all students.

In an opposing point of view in the same article, Ranney and Hambleton (2006), support the use of portfolios for dental licensure. According to these authors, testing agencies have published little or no data to allow an assessment of reliability of validity of their examinations. Variability in the reliability of clinical licensure examinations and pass rates among testing agencies may reflect lack of reliability or validity in the examination process, and, omission of skills necessary to practice safely at the entry level, not just changes in student populations. The authors recognize that several criteria would need to be met before portfolio assessment could be implemented. The most important of these criteria are: administration by independent parties, inclusion of a full continuum of student competencies for comprehensive evaluation, and, evaluating competence within the context of a treatment plan designed to meet the patient's oral health care needs. In their discussion, the authors believe that portfolio assessments could work if the developers considered which tasks to measure, how the tasks would be scored, calibration protocols for examiners, and how performance expectations would be set.

INITIAL LICENSURE REQUIREMENTS IN OTHER JURISDICTIONS

According to the American Association of Dental Examiners "Composite" issued in January 2009, virtually all states and U. S. territories require applicants to pass an examination administered by the National Board of Dental Examiners.

- Forty-seven jurisdictions accepted a regional clinical examination, e.g., WREB, SRTA, CRDTS or national clinical, e.g., ADEX, ADLEX.
- Four jurisdictions, other than California, administered a state clinical examination.
- Forty-three jurisdictions administered a jurisprudence examination.
- Four states, other than California, granted licensure after completion of an accredited, 12-month, postgraduate residency program.
- Six states allow applicants to take any state or regional clinical examination. Virginia explicitly states that the clinical examination must use live patients.

- Two states (Montana and Utah) accept California's (former) clinical examination.

Table 1 – Summary of existing requirements for initial licensure[2]

State	National Board	Regional clinical	State clinical	Jurisprudence	Other
AL	Y	N	Y	Y	
AK	Y	Y (WREB)	N	Y	
AZ	Y	Y (WREB)	N	Y	
AR	Y	Y (SRTA)	N	Y	
CA	Y	Y (WREB)	Y	Y	PGY-1
CO	Y	Y (CRTDS)	N	Y	
CT	Y	Y (NERB OR DSCE)	N	N	PGY-1
DE	Y	N	Y	Y	DOR
District of Columbia	Y	Y	Y	Y	
FL	Y	N	Y	Y	
GA	Y	Y (CRDTS)	N	Y	
HI	Y	N	N	N	ADEX
ID	Y	Y (WREB, CRDTS)	N	Y	ADEX
IL	Y	N	N	N	ADEX
IN	Y	Y (WREB, SRTA, CRDTS, NERB)	N	Y	
IA	Y	Y (CRDTS, WREB)	N	Y	ADEX
KS	Y	Y (WREB, SRTA, CRDTS, NERB, CITA)	Y	Y	
KY	Y	Y (SRTA, WREB, CRDTS, NERB)	N	Y	ADEX not accepted
LA	Y	Y (CITA, CRDTS, NERB, SRTA, WREB)	N	Y	ADEX
ME	Y	Y (NERB)	N	Y	
MD	Y	Y (NERB)	N	Y	
MA	Y	Y	N	Y	
MI	Y	Y (NERB, DSCE)	--	--	
MN	Y	Y (NDEB, WREB)	N	Y	PGY-1, ADLEX, ADEX
MS	Y	Y	N	Y	
MO	Y	Y (Any state or regional examination)	N	Y	
MT	Y	Y (WREB, CRDTS, WREB, SRTA, NERB)	N	Y	State clinical examinations from CA, DE, FL, and NV

[2] Examination acronyms for states which specified regional examinations: ADEX = American Board of Dental Examiners; ADLEX = American Dental Licensing Examination; CITA = Council of Interstate Testing Agencies; CRTDS = Central Regional Dental Testing Service; DOR = Dental Operating Rooms at Naval dental facilities; DSCE = Dental Simulated Clinical Examination; NERB = North East Regional Board; NDEB = National Dental Examining Board of Canada; SRTA = Southern Regional Testing Agency; WREB = Western Regional Examining Board

State	National Board	Regional clinical	State clinical	Jurisprudence	Other
NE	Y	Y (CRDTS, NERB)	N	Y	
NV	Y	N	--	Y	ADEX; no licensure by credential
NH	Y	Y (NERB)	N	Y	
NJ	Y	Y (NERB)	N	Y	ADEX
NM	Y	Y (WREB, CRDTS)	N	Y	
NY	Y	N	N	N	CDA approved residency; one-time jurisprudence examination
NC	Y	Y (CITA)	N	Y	Sterilization/infection control examination
ND	Y	Y (NERB, CRDTS)	N	Y	ADEX
OH	Y	Y (CRDTS, SRTA, WREB, NERB)	N	Y	
OK	Y	Y (WREB)	N	Y	
OR	Y	Y	N	Y	Accepts any state or regional examination
PA	Y	Y (NERB)	N	N	ADLEX
Puerto Rico	Y	CITA	Y	Y	CITA in lieu of state clinical examination
RI	Y	Y (NERB)	N	N	
SC	Y	Y (SRTA, CRDTS)	N	Y	ADLEX
SD	Y	Y (CRDTS, WREB)	N	Y	Accepts any state or regional examination for licensure by credential
TN	Y	Y (SRTA, WREB)	N	N	
TX	Y	Y	--	Y	Accepts any state or regional examination for licensure by credential
UT	Y	Y (WREB, SRTA, NERB, CRDTS)	N	N	California state examination, Hawaii examination
VT	Y	Y (NERB, WREB, SRTA, CRDTS, CITA)	N	Y	
VA	Y	Y (SRTA, WREB, DRDTS, NERGE, CITA)	--	Y	Accepts any state or regional examination for licensure by credential (only if live patients used)
U. S. Virgin Islands	--	--	--	--	

State	National Board	Regional clinical	State clinical	Jurisprudence	Other
WA	Y	Y	N	Y	PGY-1; Accepts any state or regional examination
WV	Y	Y	N	Y	Any state or regional examination
WI	Y	Y (CRDTS, WREB, NERB)	N	Y	ADEX I and II
WY	Y	Y (CRDTS, WREB, NERB)	N	Y	Part IV of ADEX

COMPARISON OF REQUIREMENTS IN THE U.S. AND CANADA

In their 2001 review of dental education and licensure, the Council on Dental Education of the American Dental Association (ADA) compared practices for initial dental licensure in the United States and Canada. Their findings indicate that initial licensure in the United States and Canada are very similar; however, Canada relies on the use of the Objective Structured Clinical Examination (OSCE), which requires students to answer multiple-choice questions about radiographs, case histories, and/or models in a series of stations. In the OSCE, simulated patients (manikins) rather than actual patients are used as subjects for examination procedures.

Table 2 – Comparison of practices in U. S. and Canada for initial licensure

Requirement	United States	Canada
Graduation from an accredited program	Yes; program is accredited by the ADA Commission on Dental accreditation	Yes; program is accredited by the Commission on Dental Accreditation of Canada
Written examination	Yes: National Dental Board Examinations (NDBE) Parts I and II	Yes; National Dental Examining Board of Canada Written Examination (NDEB)
Clinical examination	• Regionally administered clinical examinations Central Regional Testing Services (CRTS); Northeast Regional Examining Board (NERB), Southern Regional Testing Agency (SRTA), Western Regional Examining Board (WREB) offered once to multiple times, depending on the testing agency • 10 states (CA, DE, FL, HI, IN, LA, MS, NC, NV plus Puerto Rico and the Virgin Islands) offer state administered examinations • Each state determines which clinical examination results are accepted for the purpose of licensure • All states require completion of both written and clinical examinations before being eligible for licensure • Some states also require additional criteria such as proof of malpractice insurance, certification in Basic Life Support, or a jurisprudence examination	• OSCE offered three times a year • Quebec requires an NDEB certificate or a provincial examination. • Some provinces require completion of an ethics examination

EXISTING COMPETENCY EXAMINATIONS

As expected, all of the California schools included competencies which met minimum standards set forth by the Commission on Dental Accreditation for predoctoral dental education programs (2008, Standard 2-25, p. 15): "At a minimum graduates must be competent in providing oral health care with the scope of general dentistry, as defined by the school, for the child, adolescent, adult, and geriatric patient, including:

a) Patient assessment and diagnosis;
b) Comprehensive treatment planning;
c) Health promotion and disease prevention;
d) Informed consent;
e) Anesthesia, and pain and anxiety control;
f) Restoration of teeth;
g) Replacement of teeth;
h) Periodontal therapy;
i) Pulpal therapy;
j) Oral mucosal disorders;
k) Hard and soft tissue surgery;
l) Dental emergencies;
m) Malocclusion and space management; and,
n) Evaluation of the outcomes of treatment."

Key faculty from five Board approved schools[3] were interviewed regarding the clinical dimensions of practice assessed in competency examinations within their predoctoral programs. All of the schools provided a list of the clinical competencies assessed during predoctoral training. A list of each school's competency examination is presented in the Tables 3, 4, 5, 6 and 7.

Table 3 – Competency examinations: Loma Linda University

Comprehensive diagnosis and treatment planning	• Oral diagnosis examination • Radiology interpretation (FMX pathology) • Radiology interpretation (normal and errors) • Radiology techniques
Direct restoration	• Class II composite resin • Class II amalgam • Class III composite
Indirect restoration	• Full gold crown, partial coverage crown, full coverage ceramic crown, fixed partial denture *or* multiple tooth restoration
Removable prosthodontics	• Rest seat preparation • RPD design • CD setup
Periodontics	• Preclinical OSCE (5) • Scaling and root planning (2) • Oral health care (2)
Endodontics	• Endodontic qualifying examination (to treat patients in clinic) • Endodontic section of Fall mock board • Endodontic qualifying examination (to take WREB)

[3] When the Portfolio process began, there were five Board approved dental schools.

Table 4 – Competency examinations: University of California Los Angeles

Comprehensive diagnosis and treatment planning	• Oral diagnosis • Head and neck examination • Treatment planning • Caries management by risk assessment
Direct restoration	• Class II amalgam (2) • Class II composite (1) • Class III composite or Class V composite (2) • Two buildups (core, pin, prefabricated post and core, *or* dowel core)
Indirect restoration	• Two restorations (PFM, bonded ceramic, full gold crown *or* partial veneer crown)
Removable prosthodontics	• Complete denture • Immediate full denture • Removable partial denture • Reline
Periodontics	• Periodontal diagnosis and treatment plan • Periodontal instrumentation • Re-evaluation of Phase I therapy • Periodontal surgery
Endodontics	• Endodontic case portfolio

Table 5 – Competency examinations: University of California San Francisco

Comprehensive diagnosis and treatment planning	• Medical/dental history taking • Infection control • Practice management • Oral diagnosis and treatment planning OSCE • Caries risk assessment • Complete oral examination/treatment planning • Radiology • Emergency • Baseline skills attainment • Pediatric comprehensive oral examination • Outcomes of care
Direct restoration	• Class I composite or preventive resin restoration • Class I amalgam • Class II amalgam • Class II composite • Class III or IV composite • Class V composite, glass ionomer *or* amalgam • Pediatric restorative
Indirect restoration	• Mounted diagnostic cast • Die trimming • Casting (PFM, all gold, *or* all ceramic crown)
Removable prosthodontics	• Removable prosthodontics (partial *or* full denture)
Periodontics	• Instrument sharpening • Instrument identification and adaptation • Scaling and root planning
Endodontics	• Single-root root canal • Multi-root root canal on typodont

Table 6 – Competency examinations: University of the Pacific

Comprehensive diagnosis and treatment planning	• Oral diagnosis and treatment planning
Direct restoration[4]	• Class I resin • Class II resin • Class II amalgam • Class III resin • Class V resin
Indirect restoration	• All cases evaluated for case management, buildup (if needed), preparation and temporization • Crown preparation and crown (FVM, PFM *or* all ceramics) • CIMOE (cementation) • Impression
Removable prosthodontics	• Complete denture, immediate complete denture *or* other removable prosthestic device
Periodontics	• Periodontal oral diagnosis and treatment planning • Periodontal diagnostic competency • Calculus detection and root planing • Instrument sharpening • Periodontal re-evaluation
Endodontics	• Endodontic radiographic technique • Cleaning and shaping (single canal) • Coronal access anterior • Coronal access posterior • Obturation (single canal)

[4]All direct restoration cases are evaluated for case management, preparation and restoration. Typically Class III and Class V resins are performed in the anterior segments; several posterior Class II restorations are completed including a mandatory mock board scenario—mixed between amalgam and resin

Table 7 – Competency examinations: University of Southern California

Competency domain	Specific competencies
Comprehensive diagnosis and treatment planning	• Oral radiology (OSCE in radiology) • Physical evaluation • Ultrasonic instrumentation/ultrasonic scaler • OSCE in vital signs, extra- and intraoral examination and infection control
Direct restoration	• Class II amalgam • Composite restoration (Class II, III, IV, *or* V)
Indirect restoration	• Crown preparation (PFM, full gold, partial veneer gold, *or* ceramic) • Crown cementation (PFM, full gold, partial veneer gold, *or* ceramic)
Removable prosthodontics	• Preliminary Impression • Outline tray(s)/ custom tray(s) • Final impression(s) • Final survey • Framework try-in (retention/occlusion) • Jaw record(s)/ tooth selection • Teeth try-in/ remount jig • Prosthesis placement/ clinical remount • Final adaptation and articulation
Periodontics[5]	• Diagnosis and comprehensive treatment planning • Ultrasonic instrumentation for scaling and root planning • Scaling and root planning • Mock board examination (WREB compatible)
Endodontics	• Access • Instrumentation • Obturation

CALIBRATION OF CLINIC EXAMINERS IN SCHOOLS

During visits to the dental school clinics and interviews with faculty, it was clear that the dental schools did an exceptional job in calibrating their examiners and were consistent in their methodology to ensure that common criteria were used to evaluate students' performance on competency examinations. The faculty were calibrated and re-calibrated to ensure consistency in their evaluation of the student competencies and the processes used by the dental schools for assessing competencies was very similar. In every case, minimum competency was built into the rating scales used to evaluate the students in their competency examinations.

The general rule was that two examiners must concur on failing grades. If there is disagreement between the two examiners, a third examiner was asked to grade the student. One school specifically mentioned that examiners were designated full-time faculty who were familiar with the grading criteria and the logistics of competency examinations. Other schools mentioned that their examiners (part-time and full-time faculty) were provided extensive materials to read and review prior to hands-on training with experienced examiners. These materials included detailed examiner training manuals, detailed slide

[5] Diagnosis and comprehensive treatment planning, ultrasonic instrumentation, scaling and root planing are performed in the junior year; mock board examination performed in the senior year

presentations (Powerpoint), sample cases, and sample documentation. Hands-on training and calibration sessions were conducted to ensure that the examiners understood the evaluation system and how to use it.

SECTION 4 – THE PORTFOLIO EXAMINATION

DEFINITION

Albino, Young, Neumann, Kramer, Andrieu, Henson, Horn, and Hendricson (2008, p. 164) define clinical competency examinations as performance examinations in which students perform designated tasks and procedures on a patient without instructor assistance. The process of care and the products are assessed by faculty observers typically guided by rating scales.

Here, the Portfolio Examination can be conceptualized as a series of examinations administered in a multiple patient encounters in six subject areas. Candidates are rated according to standardized rating scales by faculty examiners who are formally trained in their use.

The Portfolio Examination is a performance examination that assesses skills in commonly encountered situations, which includes components of the clinical examination administered by a traditional testing agency. Performance is measured during competency evaluations conducted in the schools by calibrated examiners who are members of the dental school faculty. Thus, the Portfolio Examination involves hands-on performance evaluations of clinical skills as evaluated within the candidate's program of dental education.

PREMISE

The Portfolio Examination is an alternative examination that each individual school may elect at any time to implement or decline to implement.

The Portfolio Examination allows candidates to build a portfolio of completed clinical experiences and clinical competency examinations in six subject areas over the normal course of clinical training. Both clinical experiences and clinical competency examinations are performed on patients of record within the normal course of treatment. The primary difference between clinical experiences and clinical competency examinations is that the clinical competency examinations are performed independently without faculty intervention unless patient safety issues are imminent.

The Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a California Board approved dental school. A student may elect to begin the Portfolio Examination process during the clinical training phase of their dental education, with the approval of his/her clinical faculty.

The Portfolio Examination follows a similar structure for candidate evaluation that currently exists within the schools to assess minimum competence. The faculty observes the treatment provided and evaluates candidates according to

standardized criteria developed by a consensus of key faculty from all of the dental schools. Each candidate prepares and submits a portfolio of documentation that provides proof of completion of competency evaluations for specific procedures in six subject areas: oral diagnosis and treatment planning, direct restoration (amalgam/composite), indirect restoration (fixed prosthetics), removable prosthodontics, endodontics and periodontics.

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

DISTINGUISHING CHARACTERISTICS

There are 10 distinguishing characteristics of the Portfolio Examination:

- *First*, the Portfolio Examination is considered a performance examination that assesses candidates' skills in commonly encountered clinical situations. Consequently, the Portfolio Examination must meet legal standards (Sections 12944 of the Government Code, Section 139 of the Business and Professions Code) and psychometric standards set forth by the Standards for Educational and Psychological Testing.

- *Second*, the Portfolio Examination is a ***summative*** assessment of a candidate's competence to practice independently. Therefore, candidates perform clinical procedures without faculty intervention in the competency examinations. If a candidate commits a critical error at any time during a competency examination, the examination is terminated immediately in the interests of patient safety.

- *Third*, it includes components of clinical examinations similar to other clinical examinations, ***and***, is administered in a manner that is similar to other clinical examinations encountered in the candidates' course of study. The multiple clinical examinations allow for an evaluation of the full continuum of competence. No additional resources are required from candidates, schools or the Board.

- *Fourth*, treatments for candidates' clinical experience and competency examinations are rendered on patients of record. This means that candidates' competence is not evaluated in an artificial or contrived situation, but on patients who require dental interventions as a normal course of treatment and

their progress can be monitored beyond the scope of the clinical experiences or competency examinations.

- *Fifth*, candidates must complete a minimum number of clinical experiences as required for each of six competency domains.

- *Sixth*, readiness for the Portfolio competency examinations is determined by the clinical faculty at the institution where the candidate is enrolled.

- *Seventh*, each of the schools will designate faculty as Portfolio competency examiners and is responsible for administering a Board approved standardized calibration training course for said examiners. The schools are also responsible for the calibration of Portfolio examiners' performance to ensure consistent implementation of the examination and a standardized examination experience for all candidates.

- *Eighth*, candidates' performance is measured according to the information provided in competency evaluations conducted in the schools by clinical faculty within the predoctoral program of education.

- *Ninth*, it produces documented data for outcomes assessment of results, thereby allowing for verification of validity evidence. The data provides the foundation of periodic audits of each school conducted by the Board to ensure that each school is implementing the Portfolio Examination according to the standardized procedures.

- *Tenth*, there are policies and procedures in place to treat candidates fairly and professionally, with timely and complete communication of examination results.

RE-EXAMINATION

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

ROLE OF THE BOARD

Oversight of the Portfolio Examination is maintained by the Board. The Portfolio Examination includes a mechanism to administer the program and grant the

license, as well as maintain authority to monitor school compliance with the standardized examination process.

ROLE OF THE SCHOOLS

Schools are responsible for selection and calibration of Portfolio examiners. Faculty who wish to become a Portfolio examiner will be required to submit credentials to document their qualifications and experience in conducting examinations in an objective manner. Faculty who are selected as Portfolio examiners are required to participate in Board approved calibration training courses for the competency domain of interest, e.g., oral diagnosis and treatment planning, endodontics, etc.

Schools are also responsible to maintaining the calibration of Portfolio examiners by regularly providing opportunities for re-calibration as needed.

SECTION 5 – CONTENT VALIDATION PROCESS

APPLICABLE STANDARDS

Since criterion related evidence is generally not available for use in making licensure decisions, validation of licensure and certification tests rely mainly on expert judgments that the test adequately represents the content domain of the occupation or specialty. Here, content related validity evidence from a job analysis supports the validity of the Portfolio Examination as a measure of clinical competence. The Standards contain extensive discussion of validity issues.

> *"Test design generally starts with an adequate definition of the occupation or specialty, so that persons can be clearly identified as engaging in the activity." (p. 156)*

> *"Often a thorough analysis is conducted of the work performed by people in the profession or occupation to document the tasks and abilities that are essential to practice. A wide variety of empirical approaches is used, including delineation, critical incidence techniques, job analysis, training needs assessments, or practice studies and surveys of practicing professionals. Panels of respected experts in the field often work in collaboration with qualified specialists in testing to define test specifications, including the knowledge and skills needed for safe, effective performance, and an appropriate way of assessing that performance." (p. 156)*

> *"Credentialing tests may cover a number of related but distinct areas. Designing the testing program includes deciding what areas are to be covered, whether one or a series of tests is to be used, and how multiple test scores are to be combined to reach an overall decision." (p. 156-157)*

There are also specific standards that address the use of job analysis to define the competencies to be tested in the Portfolio Examination.

Standard 14.8 "Evidence of validity based on test content requires a thorough and explicit definition of the content domain of interest. For selection, classification, and promotion, the characterization of the domain should be based on a job analysis." (p. 160)

Standard 14.14

"The content domain to be covered by a credentialing test should be defined clearly and justified in terms of the importance of the content for credential-worthy performance in an occupation or profession. A rationale should be provided to support the claim that the knowledge or skills being assessed are required for credential-worthy performance in an occupation and are consistent with the purpose for which the licensing or certification program was instituted" (p. 161)

METHODOLOGY

The methodology used to validate the content of the competency examinations comprising the Portfolio Examination is a commonly used psychometric procedure called job (aka practice) analysis. Job analysis data is typically obtained through multiple sources including interviews, observations, survey questionnaires, and/or focus groups.

This methodology has been used extensively in the measurement field and is described in detail in many publications in the psychometric literature as a "table-top job analysis," e.g., Department of Energy (1994). Basically, focus groups identify the competencies to be assessed in a systematic way beginning with an outline of major competency domains and ending with a detailed account of major and specific competencies organized in outline fashion. All participants provide input in a systematic, iterative fashion, until consensus is achieved.

PROCESS

Separate focus groups of subject matter experts from six Board approved dental schools were convened to define the content for the Portfolio Examinations for six competency domains to be assessed in the Portfolio Examination: oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, endodontics, and periodontics.

The content was developed at two levels of analysis. The first level of analysis was to develop a consensus at a broad level regarding the major competencies to be assessed. The faculty indicated that the competencies were acceptable to the schools as the basis for the Portfolio Examination. They further understood that the major competencies were likely to be included in proposed legislation in order to implement the Portfolio Examination.

The second level of analysis produced detailed procedures for measuring specific subcomponents within each of the six competency domains. The detailed procedures were used to develop the Portfolio Examination.

PROCEDURE

The procedure was conducted systematically in several steps:

Step 1 ***Orient focus group***	• Present participants with an outline of topics to be covered for a given competency domain • Orient participants as to the goal of the process and how the results will be used
Step 2 ***Review subject matter***	• Have participants explain how their program currently conducts competency examinations • Review the topics involved in a given competency domain, e.g., periodontics, endodontics, etc.
Step 3 ***Identify major competencies***	• Identify major competencies to be assessed • Discuss implications of the competencies at each participant's program until consensus is reached
Step 4 ***Identify specific competencies***	• Identify specific competencies within each content domain to be assessed • Discuss implications of the competencies at each participant's program until consensus is reached
Step 5 ***Sequence competencies***	• Sequence the competencies until consensus is reached
Step 6 ***Develop competency statements***	• Rephrase each competency in terms of a consistent format that includes an action verb and direct object (c. f., Chambers & Gerrow, 1994)
Step 7 ***Refine competencies***	• Make final edits to the wording of the competencies until consensus is reached
Step 8 ***Re-evaluate competencies***	• Discuss the list of major and specific competencies until consensus is reached

SECTION 6 – MAJOR COMPETENCIES ASSESSED

The Portfolio Examination is comprised of performance examinations in six competency domains identified by the focus groups using a "table-top job analysis" methodology described in Section 5. The competencies and their subcomponent competencies provide the most fundamental type of validity evidence for the Portfolio Examination, that is, *content validity*. The subcomponents of each major competency domain are presented below.

Table 8 – Major competencies and subcomponents to be assessed

ORAL DIAGNOSIS AND TREATMENT PLANNING	I. Medical issues that impact dental care II. Treatment modifications based on medical conditions III. Patient concerns/chief complaint IV. Dental history V. Significant radiographic findings VI. Clinical findings VII. Risk level assessment VIII. Need for additional diagnostic tests/referrals IX. Findings from mounted diagnostic casts X. Comprehensive problem list XI. Diagnosis and interaction of problems XII. Overall treatment approach XIII. Phasing and sequencing of treatment XIV. Comprehensiveness of treatment plan XV. Treatment record
DIRECT RESTORATION	I. Case presentation II. Outline and extensions III. Internal form IV. Operative environment V. Anatomical form VI. Margins VII. Finish and function
INDIRECT RESTORATION	I. Case presentation II. Preparation III. Impression IV. Provisional V. Candidate evaluation of laboratory work VI. Pre-cementation VII. Cementation and finish

REMOVABLE PROSTHODONTICS	I. Patient evaluation II. Treatment plan and sequencing III. Preliminary impressions IV. RFP design (if applicable) V. Tooth modification (if applicable) VI. Border molding and final impressions VII. Framework try-in VIII. Jaw relation records IX. Trial dentures X. Insertion of removable prosthesis XI. Post insertion (1 week) XII. Laboratory services for prosthesis
ENDODONTICS	I. Pretreatment clinical testing and radiographic imaging II. Endodontic diagnosis III. Endodontic treatment plan IV. Anesthesia and pain control V. Caries removal, removal of failing restorations, evaluation of restorability, site isolation VI. Access opening VII. Canal preparation technique VIII. Master cone fit IX. Obturation technique X. Completion of case
PERIODONTICS	I. Review medical and dental history II. Radiographic findings III. Comprehensive periodontal data collection IV. Evaluate periodontal etiology/risk factors V. Comprehensive periodontal diagnosis VI. Treatment plan VII. Calculus detection VIII. Effectiveness of calculus removal IX. Periodontal re-evaluation

SECTION 7 – EVALUATION SYSTEM

A standardized evaluation system was developed to evaluate candidates' performance in the competency examinations. The competencies and their subcomponents defined in Section 6 provided the framework for the evaluation system that assesses the candidates' competencies in the procedures. Faculty from six Board approved dental schools were involved in the process so that the final evaluation system represented rating criteria applicable to candidates regardless of predoctoral programs.

The evaluation system is designed to be used for ***summative*** decisions (high stakes, pass/fail decisions) rather than formative decisions (compilation of daily work with faculty feedback for learning purposes). The evaluation system provides quantitative validity evidence for determining clinical competence in terms of numeric scores.

APPLICABLE STANDARDS

The evaluation system must meet psychometric criteria to provide the measurement opportunity for success for all candidates.

Standard 3.20 "The instructions presented to test takers should contain sufficient detail so that test takers can respond to a task in the manner that the test developer intended. When appropriate, sample material, practice or sample questions…should be provided to test takers prior to the administration of the test or included in the testing material as part of the standard administration instructions." (p. 47)

Standard 3.22 "Procedures for scoring and, if relevant, scoring criteria should be presented by the test developer in sufficient detail and clarity to maximize the accuracy of scoring. Instructions for using rating scales or for deriving scores obtained by coding, scaling, or classifying constructed responses should be clear." (p. 47)

Standard 14.17 "The level of performance required for passing a credentialing test should depend on the knowledge and skills necessary for acceptable performance in the occupation or profession and should not be adjusted to regulate the number or proportion of persons passing the test." (p. 162)

BEHAVIORALLY ANCHORED RATING SCALES

Behaviorally anchored rating scales have unique measurement properties which have been used extensively in medical and dental education as a tool to assess performance. They rely on critical incidents of behavior which may be classified into dimensions unique and independent of each other in their meaning. Each performance dimension is arrayed on a continuum of behaviors and examiners must select the behaviors that most closely describe the candidate's performance.

There were several steps to develop behaviorally anchored rating scales for the Portfolio Examination evaluation system:

1. Use the competencies and their associated subcomponents defined by the table-top job analysis discussed in Section 5 as the framework for the evaluation system, e.g., comprehensive oral diagnosis and treatment planning, direct restoration, indirect restoration, removable prosthodontics, endodontics, periodontics.

2. Generate critical incidents of ineffective and effective behavior.

3. Create performance dimensions that describe the qualities of groups of critical incidents (Flanagan, 1954).

4. Define performance dimensions in terms of numeric ratings, e.g., 1 to 5, 1 to 7, 1 to 9.

5. Retranslate (reclassify) the critical incidents to ensure that the incidents describe the performance dimensions.

6. Identifying several incidents for each performance dimension.

7. Refine standardized criteria for each of the competency domains and their subcomponent competencies.

8. Establish minimum acceptable competence criteria (passing criteria) for competency examinations.

MINIMUM COMPETENCE

The passing standard for all of the competency examinations is built into the rating scales when the grading criteria are developed. The rating criteria for minimum competence was developed by representative faculty who have a solid conceptual understanding of standardized rating criteria and how the criteria will be applied in an operational setting.

SECTION 8 – ORAL DIAGNOSIS /TREATMENT PLANNING

PURPOSE

The competency examination for oral diagnosis and treatment planning (ODTP) is designed to assess the candidate's ability to identify and evaluate patient data and clinical findings; formulate diagnoses; and plan treatment interventions from a multidisciplinary perspective.

MINIMUM CLINICAL EXPERIENCES

The documentation of oral diagnosis and treatment planning clinical experiences will include a minimum of 20 patient cases.

Clinical experiences for ODTP include:

- Comprehensive oral evaluations,
- Limited (problem-focused) oral evaluations, and,
- Periodic oral evaluation

Each examination, ODTP clinical experience requires medical and dental history, identified problem(s), diagnoses, treatment plans, and informed consent.

OVERVIEW

- Fifteen (15) scoring factors.
- Initiation and completion of one (1) multidisciplinary Portfolio competency examination.
- Treatment plan must involve at least three (3) of the following six disciplines:

  > Periodontics
  > Endodontics
  > Operative (direct and indirect restoration)
  > Fixed and removable prosthodontics
  > Orthodontics
  > Oral surgery

PATIENT PARAMETERS

- Maximum of ASA II.
- Missing or will be missing two or more teeth, NOT including third molars.
- At least moderate periodontitis (probing depths of 5 mm or more).

SCORING

Scoring points for ODTP are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

ELEMENTS OF THE ODTP PORTFOLIO

The ODTP portfolio may include, but is not limited to the following:

a) Medical history for dental treatment provided to patients. The medical history must include: an evaluation of past illnesses and conditions, hospitalizations and operations, allergies, family history, social history, current illnesses and medications, and their effect on dental condition.

b) Dental history for dental treatment provided to clinical patients. The dental history must include: age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts.

c) Documentation of a comprehensive examination for dental treatment provided to patients includes:

    (1) Interpretation of radiographic series
    (2) Performance of caries risk assessment
    (3) Determination of periodontal condition
    (4) Performance of a head and neck examination, including oral cancer screening.
    (5) Screening for temporomandibular disorders
    (6) Assessment of vital signs
    (7) Performance of a clinical examination of dentition
    (8) Performance of an occlusal examination

d) Documentation the candidate evaluated data to identify problems. The documentation of the data evaluation includes:

    (1) Chief complaint
    (2) Medical problem
    (3) Stomatognathic problems
    (4) Psychosocial problems

e) Documentation the candidate worked up the problems and developed a tentative treatment plan. The documentation of the work-up and tentative treatment plan includes:

(1) Problem definition, e.g., severity/chronicity and classification
(2) Determination if additional diagnostic tests are needed
(3) Development of a differential diagnosis
(4) Recognition of need for referral(s)
(5) Pathophysiology of the problem
(6) Short term needs
(7) Long term needs
(8) Determination interaction of problems
(9) Development of treatment options
(10) Determination of prognosis
(11) Patient information regarding informed consent

f) Documentation the candidate developed a final treatment plan. The documentation includes:

(1) Rationale for treatment.
(2) Problems to be addressed, or any condition that puts the patient at risk in the long term.
(3) Determination of sequencing with the following framework:

- Systemic: medical issues of concern, medications and their effects, effect of diseases on oral condition, precautions, treatment modifications
- Urgent: Acute pain/infection management, urgent esthetic issues, further exploration/additional information, oral medicine consultation, pathology
- Preparatory: Preventive interventions, orthodontic, periodontal (Phase I, II), endodontic treatment, caries control, other temporization
- Restorative: operative, fixed, removable prostheses, occlusal splints, implants
- Elective: esthetic (veneers, etc.) any procedure that is not clinically necessary, replacement of sound restoration for esthetic purposes, bleaching
- Maintenance: periodontic recall, radiographic interval, periodic oral examination, caries risk management

ODTP SCORING CRITERIA

FACTOR 1: MEDICAL ISSUES THAT IMPACT DENTAL CARE

4	3	2	1	0
• Identifies and evaluates all medical issues • Explains dental implications of systemic conditions • Identifies and assesses patient medications	• Misses one item that would NOT cause harm	• Misses two items that would NOT cause harm	• Misses more than two items that would cause potential harm	Critical errors include: • Misses medical or medication items that would cause potential harm

FACTOR 2: TREATMENT MODIFICATIONS BASED ON MEDICAL CONDITIONS

4	3	2	1	0
• Identifies all treatment modifications	• Misses one item that would NOT cause harm	• Misses two items that would NOT cause harm	• Misses more than two items that would cause potential harm	Critical errors include: • Misses treatment modifications that would cause potential harm

FACTOR 3: PATIENT CONCERNS/CHIEF COMPLAINT

4	3	2	1	0
• Identifies all patient concerns including chief complaint	• Identifies chief complaint but misses one patient concern	• Identifies chief complaint but misses two patient concerns	• Identifies chief complaint but misses more than two patient concerns	Critical errors include: • Chief complaint NOT identified

FACTOR 4: DENTAL HISTORY

4	3	2	1	0
• Identifies all parameters in dental history	• Misses one parameter in dental history	• Misses two parameters in dental history	• Misses more than two parameters in dental history	Critical errors include: • Neglects to address dental history

FACTOR 5: SIGNIFICANT RADIOGRAPHIC FINDINGS

4	3	2	1	0
• Identifies all radiographic findings	• Misses one radiographic finding that does NOT substantially alter treatment plan	• Misses two radiographic findings that do NOT substantially alter treatment plan	• Misses more than two radiographic findings that do NOT substantially alter treatment plan	Critical errors include: • Misses radiographic findings that substantially alters treatment plan

FACTOR 6: CLINICAL FINDINGS

4	3	2	1	0
• Identifies all clinical findings	• Misses one clinical finding that does NOT substantially alter treatment plan	• Misses two clinical findings that do NOT substantially alter treatment plan	• Misses more than two clinical findings that do NOT substantially alter treatment plan	Critical errors include: • Misses clinical findings that substantially alter treatment plan

FACTOR 7: RISK LEVEL ASSESSMENT

4	3	2	1	0
• Risk level (risk factors/indicators and protective factors) identified • Relevance of risk level identified	• Risk level and relevance of risk level identified but misses one item (risk factors/ indicators and protective factors)	• Risk level and relevance of risk level identified but misses two items (risk factors/indicators and protective factors)	• Risk level identified but misses more than two items (risk factors/indicators and protective factors) • Relevance of risk level NOT identified	Critical errors include: • Risk level NOT identified

FACTOR 8: NEED FOR ADDITIONAL DIAGNOSTIC TESTS/REFERRALS

4	3	2	1	0
• Prescribes/acquires all clinically necessary diagnostic test and referrals with comprehensive rationale	• Identifies need for clinically necessary diagnostic tests and referrals with limited rationale	• Identifies need for additional diagnostic tests and referrals without rationale	• Identifies need for additional diagnostic tests and referrals without rationale and prescribes non-contributory test or referrals	Critical errors include: • Does NOT identify clinically necessary diagnostic tests or referrals

FACTOR 9: FINDINGS FROM MOUNTED DIAGNOSTIC CASTS

4	3	2	1	0
• Casts and mounting reflect patient's oral condition • Identifies all diagnostic findings from casts	• Casts and mounting reflect patient's oral condition • Misses one diagnostic finding that does NOT substantially alter treatment plan	• Casts and mounting reflect patient's oral condition but misses two diagnostic findings that do NOT substantially alter treatment plan	• Casts and mounting reflect patient's oral condition but misses more than two diagnostic findings that do NOT substantially alter treatment plan	Critical errors include: • Casts and mounting do NOT reflect patient's oral condition • Misses diagnostic cast findings that substantially alter treatment plan

FACTOR 10: COMPREHENSIVE PROBLEM LIST

4	3	2	1	0
• All problems listed	• One problem NOT identified without potential harm to patient	• Two problems NOT identified without potential harm to patient	• Two or more problems NOT identified without potential harm to patient	Critical errors include: • Problems with potential for harm to patient NOT identified

FACTOR 11: DIAGNOSIS AND INTERACTION OF PROBLEMS

4	3	2	1	0
• All diseases correctly diagnosed • All interactions identified	• One missed diagnosis or interaction without potential harm to patient	• Two missed diagnoses or interactions without potential harm to patient	• More than two missed diagnoses or interactions without potential harm to patient	Critical errors include: • Missed diagnosis or interaction resulting in potential harm to patient

FACTOR 12: OVERALL TREATMENT APPROACH

4	3	2	1	0
• All treatment options identified within standard of care; provides rationale which is optimal	• All treatment options identified within standard of care; provides acceptable rationale	• All treatment options identified within standard of care and lacks sound rationale for treatment	• Incomplete treatment options and lacks sound rationale for treatment	Critical errors include: • Treatment options presented are NOT within standard of care

FACTOR 13: PHASING AND SEQUENCING OF TREATMENT

4	3	2	1	0
• Treatment optimally phased and sequenced	• Treatment phased correctly but one procedure out of sequence with no harm to patient	• Treatment phased correctly but two procedures out of sequence with no harm to patient	• Treatment NOT phased correctly but no potential harm to patient	Critical errors include: • Treatment NOT phased nor sequenced with potential harm to patient

FACTOR 14: COMPREHENSIVENESS OF TREATMENT PLAN

4	3	2	1	0
• Treatment plan addresses all problems • All treatment procedures are indicated	• One treatment procedure that is NOT indicated but will NOT result in harm to patient but treatment plan addresses all problems	• Two or more treatment procedures that are NOT indicated but reflect problem list but treatment plan addresses all problems	• Two or more treatment procedures that are NOT indicated and do NOT reflect problem list • Treatment plan is incomplete but does NOT cause harm to patient	Critical errors include: • Treatment plan is incomplete and causes potential harm to patient • Treatment procedures included that are NOT indicated resulting in harm to patient • Treatment procedures are missing from treatment plan resulting in harm to patient

FACTOR 15: TREATMENT RECORD

4	3	2	1	0
• Summarizes all data collected, diagnoses, and comprehensive rationale for treatment options • Documents presentation of risks and benefits of all treatment options	• Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options and provides limited rationale	• Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options but provides no rationale	• Summarizes all data collected, diagnoses, and treatment options, and documents presentation of risks and benefits only for preferred option	Critical errors include: • Does NOT summarize all data collected, diagnoses and/or treatment options • Does NOT document presentation of risks and benefits of all treatment options

SECTION 9 – DIRECT RESTORATION

PURPOSE

The competency examinations for direct restoration are designed to assess the candidate's independent ability to restore teeth with interproximal primary carious lesions to optimal form, function and esthetics.

MINIMUM CLINICAL EXPERIENCES

The documentation of direct restorative clinical experiences includes 60 restorations.

The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including:

- Amalgams,
- Composites,
- Crown buildups,
- Direct pulp caps, and,
- Temporizations.

OVERVIEW

- Seven (7) scoring factors.
- Two (2) restorations:
  - > Class II amalgam or composite; maximum one slot preparation, and,
  - > Class III or IV composite
- Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.

PATIENT PARAMETERS

Class II – Any permanent posterior tooth

- Treatment needs to be performed in the sequence described in the treatment plan.
- More than one test procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments.
- Caries as shown on either of the two required radiographic images of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Tooth to be treated must be in occlusion.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Tooth with bonded veneer is not acceptable.

Class III/IV – Any permanent anterior tooth

- Treatment needs to be performed in the sequence described in the treatment plan.
- Caries as shown on the required radiographic image of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Carious lesions must involve the interproximal contact area.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Approach must be appropriate for the tooth.
- Tooth with bonded veneer is not acceptable.

SCORING

Scoring points for direct restorations are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- A score of 3 is acceptable; minimum competence
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

ELEMENTS OF THE DIRECT RESTORATION PORTFOLIO

The Direct Restoration portfolio may include, but is not limited to the following:

a) Documentation of the candidate's competency to perform a class II direct restoration on a tooth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials.

   The case selection must be based on minimum direct restoration criteria for any permanent posterior tooth. The treatment performed should follow the sequence of the treatment plan(s). More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs.

   The tooth involved in the restoration must have caries which penetrate the dento-enamel junction and must be in occlusion. Proximal caries must be in contact with at least one adjacent tooth, a natural tooth surface or a permanent restoration; provisional restorations or removal partial dentures are not acceptable adjacent surfaces. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment.

b) Documentation of the candidate's competency to perform a class III/IV direct restoration on a tooth containing primary carious lesions to optimal forms, function and esthetics using composite restorative material. The case selected must be on any permanent anterior tooth and treatment needs to be performed in the sequence described in the treatment plan.

   More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs. The tooth involved in the restoration must have caries which penetrate the dento-enamel junction.

   The tooth to be restored must have an adjacent tooth to be able to restore a proximal contact. Proximal surface of the dentition adjacent to the proposed restoration must be natural tooth structure or a permanent restoration, provisional restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth involved in the restoration must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment. The lesion is not acceptable if it is in contact with circumferential decalcification. The approach must be appropriate for the tooth. Teeth with bonded veneers are not acceptable.

DIRECT RESTORATION SCORING CRITERIA

FACTOR 1: CASE PRESENTATION

5	4	3	2	1	0
• Obtains informed consent • Presents a comprehensive review of medical and dental history • Provides rationale for restorative procedure • Proposes initial design of preparation and restoration • Demonstrates full understanding of the procedure	• Slight deviation from optimal case presentation	• Moderate deviation from optimal case presentation	• Major deviation from optimal case presentation	• Multiple major deviations from optimal case presentation	• Critical errors in assessing patient's medical and/or dental history • Unable to justify treatment • Proposed treatment would cause harm to patient • Proposed treatment not indicated • Misses critical factors in medical and/or dental review that affect treatment or patient well being

FACTOR 2: OUTLINE AND EXTENSIONS

5	4	3	2	1	0
• Optimal outline and extensions such as: > Smooth, flowing > Does not weaken tooth > Includes the lesion > Breaks proximal contacts as appropriate > Appropriate cavosurface angles > Optimal treatment of fissures > No damage to adjacent teeth > Optimal extension for caries/ > decalcification > Appropriate extension requests	• Slight deviation(s) from optimal; minimal impact on treatment	• Moderate, clinically acceptable deviation(s) from optimal; minimal impact on treatment	• Major deviation from optimal such as: > Irregular outline > Outline weakens the tooth > Does not include the lesion > Contacts not broken where appropriate > Proximal extensions excessive > Inappropriate cavosurface angle(s) > Inappropriate treatment of fissures > Adjacent tooth requires major recontouring > Inappropriate extension requests	• Multiple major deviations from optimal including: > Irregular outline > Outline weakens the tooth > Does not include the lesion > Contacts not broken where appropriate > Proximal extensions excessive > Inappropriate cavosurface angle(s) > Inappropriate treatment of fissures > Adjacent tooth requires major recontouring > Inappropriate extension requests	• Critical errors in outline and extensions • Deviations from optimal that are irreversible and have a significant impact on treatment • Damage to adjacent tooth that requires restoration

FACTOR 3: INTERNAL FORM

5	4	3	2	1	0
• Optimal internal form such as: > Optimal pulpal and axial depth > Optimal wall relationships > Optimal axio-pulpal line angles > Optimal internal refinement > All previous restorative material removed > Optimal caries removal > Preparation is clean and free of fluids and/or debris > Appropriate liners and bases > Appropriate extension requests	• Slight deviation(s) from optimal	• Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Excessive or inadequate pulpal or axial depth > Inappropriate wall relationships > Inappropriate internal line angles > Rough or uneven internal features > Previous restorative material present > Inappropriate caries removal > Fluids and/or debris present > Inappropriate handling of liners and bases > Inappropriate extension requests	• Multiple, major deviations from optimal including: > Excessive or inadequate pulpal or axial depth > Inappropriate wall relationships > Inappropriate internal line angles > Rough or uneven internal features > Previous restorative material present > Inappropriate caries removal > Fluids and/or debris present > Inappropriate handling of liners and bases > Inappropriate extension requests	• Critical errors from optimal internal form • Noncarious pulp exposure

FACTOR 4: OPERATIVE ENVIRONMENT

5	4	3	2	1	0
• Soft tissue free of unnecessary damage • Proper patient comfort/pain management • Optimal isolation • Correct teeth isolated • Dam fully inverted • Clamp stable with no tissue damage • No leakage • Preparation can be accessed and visualized	• Slight deviation(s) from optimal	• Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal <u>such as</u>: > Incorrect teeth isolated > Dam not inverted, causing leakage that may compromise the final restoration > Clamp is not stable or impinges on tissue > Preparation cannot be accessed or visualized to allow proper placement of restoration > Major tissue damage	• <u>Multiple</u> major deviations from optimal <u>including</u>: > Incorrect teeth isolated > Dam not inverted, causing leakage that may compromise the final restoration > Clamp is not stable or impinges on tissue > Preparation cannot be accessed or visualized to allow proper placement of restoration > Major tissue damage	• Critical errors from optimal in operative environment • Gross soft tissue damage • Gross lack of concern for patient comfort

FACTOR 5: ANATOMICAL FORM

5	4	3	2	1	0
• Optimal anatomic form such as: > Harmonious and consistent with adjacent tooth structure > Interproximal contour and shape are proper > Interproximal contact area and position are properly restored > Contact is closed > Height and shape of marginal ridge is appropriate	• Slight deviation(s) from optimal	Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Inconsistent with adjacent tooth structure > Interproximal contour and shape are inappropriate > Height and shape of marginal ridge is inappropriate	• Multiple major deviations from optimal including: > Inconsistent with adjacent tooth structure > Interproximal contour and shape are inappropriate > Height and shape of marginal ridge is inappropriate	• Critical errors that require restoration to be redone

FACTOR 6: MARGINS

5	4	3	2	1	0
• Optimal margins • No deficiencies or excesses	• Slight deviation(s) from optimal	• Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Open margin, submarginal, and/or excess restorative material	• Multiple major deviations from optimal	• Critical errors that require restoration to be redone

FACTOR 7: FINISH AND FUNCTION

5	4	3	2	1	0
• Optimal finish and function such as: > Smooth with no pits, voids or irregularities in restoration > Occlusion is properly restored with no interferences > No damage to hard or soft tissue	• Slight deviation(s) from optimal	Moderate, clinically acceptable deviation(s) from optimal	• Major deviation from optimal such as: > Significant pits, voids or irregularities in the surfaces > Severe hyper-occlusion or hypo-occlusion > Moderate damage to hard or soft tissue	• Multiple major deviations from optimal	• Critical errors that require restoration to be redone • Procedure is not completed within allotted time • Unnecessary, gross damage to hard and soft tissue as related to finishing procedure

SECTION 10 – INDIRECT RESTORATION

PURPOSE

The competency examination for indirect restoration is designed to assess the candidate's independent ability to restore teeth requiring an indirect restoration to optimal form, function and esthetics with a full or partial coverage ceramic, metal or metal-ceramic indirect restoration.

MINIMUM CLINICAL EXPERIENCES

The documentation of indirect restorative clinical experiences will include a minimum of 14 restorations.

The restorations completed in the clinical experiences may be a combination of the following procedures:

- Inlays,
- Onlays,
- Crowns,
- Abutments,
- Pontics,
- Veneers,
- Cast posts,
- Overdenture copings, or,
- Dental implant restorations.

OVERVIEW

- Seven (7) scoring factors.
- One (1) indirect restoration which may be a combination of the following procedures:

    > Ceramic restoration must be onlay or more extensive
    > Partial gold restoration must be onlay or more extensive
    > Metal ceramic restoration (PFM)
    > Full gold restoration

- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.

- Requires patient management; candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

PATIENT PARAMETERS

- Treatment needs to be performed in the sequence described in the treatment plan.
- Tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment.
- Tooth must be in occlusal contact with a natural tooth or a permanent restoration. Occlusion with a full or partial denture is not acceptable.
- The restoration must include at least one cusp.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration; temporary restorations or removable partial dentures are not acceptable adjacent surfaces.
- The candidate may not have performed any portion of the crown preparation in advance.
- Direct restorative materials which are placed to contribute to the retention and resistance form of the final restoration (buildups) may be completed ahead of time, if needed.
- Restoration must be completed on the same tooth and same patient by the same candidate.
- Validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of the existing crown.

SCORING

Scoring points for indirect restoration is defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- A score of 3 is acceptable; minimum competence
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

ELEMENTS OF THE INDIRECT RESTORATION PORTFOLIO

The indirect restoration portfolio may include, but is not limited to the following:

a) Documentation of the candidate's competency to complete a ceramic onlay or more extensive indirect restorations. The treatment needs to be performed in the sequence in the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be in need of endodontic treatment. The tooth selected for restoration, must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of the onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

b) Documentation of the candidate's competency to complete a partial gold restoration must be an onlay or more extensive indirect restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

c) Documentation of the candidate's competency to perform a full gold restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead

of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

d) Documentation of the candidate's competency to perform a metal-ceramic restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis: cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restorations must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient.

e) A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.

INDIRECT RESTORATION SCORING CRITERIA

FACTOR 1: CASE PRESENTATION

5	4	3	2	1	0
• Obtains informed consent • Presents a comprehensive medical and dental review • Provides rationale for restorative procedure • Proposes initial design of restoration • Provides method for provisionalization • Demonstrates full understanding of the procedure • Sequencing of treatment follows standards of care	• Slight deviations from optimal case presentation	• Moderate deviations from optimal case presentation	• Major deviation from optimal case presentation • Provides inappropriate justification for treatment • Sequencing of treatment does not follow standards of care	• Multiple major deviations from optimal case presentation	• Critical errors in assessing patient's medical and/or dental history • Unable to justify treatment • Proposed treatment would cause harm to patient • Proposed treatment not indicated • Misses critical factors in medical and dental review that affect treatment or patient well being

FACTOR 2: PREPARATION

5	4	3	2	1	0
• Meets all accepted criteria for optimal preparation: a) Occlusal /incisal reduction b) Axial reduction c) Finish lines d) Caries removal e) Pulpal protection f) Soft tissue management g) No damage to soft and hard tissues h) Resistance and retention i) Debridement	• Slight deviations from optimal; minimal impact on treatment	• Moderate, clinically acceptable deviations from optimal; minimal impact on treatment	• Major deviation from optimal but correctable without significantly changing the procedure	• Multiple major deviations from optimal preparation	• Critical errors that are irreversible and have a significant impact on treatment • Critical errors that require major modifications of the proposed treatment such as: a) Onlay that must change to full crown b) Overextension requiring crown lengthening

FACTOR 3: IMPRESSION

5	4	3	2	1	0
• Achieves optimal, clinically acceptable impression achieved in one attempt a) Impression extends beyond finish lines b) Detail of preparation and adjacent teeth captured accurately c) Free of voids in critical areas d) No aspect of impression technique that would result in inaccuracy e) Interocclusal record is accurate, if needed	• Achieves clinically acceptable impression in second attempt	• Achieves clinically acceptable impression more than two attempts	• Major deviation that require retaking impression <u>such as</u>: > Lack of recognition of unacceptable impression or interocclusal relationship	• <u>Multiple</u> major deviations from optimal in impression <u>including</u>: > Lack of recognition of unacceptable impression or interocclusal relationship	• failure to achieve a clinically acceptable impression after five (5) attempts • Critical errors in impression procedure cause unnecessary tissue damage that require corrective treatment procedures

FACTOR 4: PROVISIONAL

5	4	3	2	1	0
• Meets all accepted criteria for optimal provisional: a) Occlusal form and function b) Proximal contact c) Axial contours d) Marginal fit e) External surfaces smooth and polished without pits, voids, or debris f) Optimal internal adaptation g) Retention h) Esthetics	• Slight deviations from optimal have minimal impact on treatment	• Moderate deviations from accepted criteria have minimal impact on treatment	• Major deviation from optimal that can be corrected such as: > Lack of recognition of major deviation that can be corrected	• Multiple major deviations that have significant impact on treatment including: > Lack of recognition of major deviation that can be corrected	• Critical errors that are clinically unacceptable

FACTOR 5: CANDIDATE EVALUATION OF LABORATORY WORK

5	4	3	2	1	0
• Verifies that restoration meets all accepted criteria • Verifies errors in restoration and proposes changes, if needed	• Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment	• Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment	• Lack of recognition of major deviation from optimal that can be corrected	• Lack of recognition of multiple major deviations from optimal	• Critical errors that require restoration to be redone

FACTOR 6: PRE-CEMENTATION

5	4	3	2	1	0
• Meets all accepted criteria for pre-cementation: a) Occlusal form and function b) Proximal contact c) Axial contours d) Marginal fit e) External surfaces smooth and polished without pits, voids, or debris f) Optimal internal adaptation g) Retention h) Esthetics i) Patient acceptance	• Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment	• Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment	• Lack of recognition of major deviation that can be corrected	• Lack of recognition of multiple major deviations from optimal	• Lack of recognition of critical errors which cannot be corrected

FACTOR 7: CEMENTATION AND FINISH

5	4	3	2	1	0
• Meets all accepted criteria for optimal cementation a) Occlusal form and function b) Proximal contact c) Axial contours d) Marginal fit e) External surfaces smooth and polished without pits, voids, or debris f) Optimal internal adaptation g) Retention h) Esthetics i) All excess cement removed j) No unnecessary tissue trauma k) Appropriate postoperative instructions	• Slight deviations from optimal; minimal impact on treatment	• Moderate deviations from accepted criteria; minimal impact on treatment	• Major deviation from accepted that can be corrected	• Multiple major deviations from optimal	• Critical errors which require restoration to be redone • Procedure is not completed within allotted time • Unnecessary, gross damage to hard and soft tissue as related to finishing

SECTION 11 – REMOVABLE PROSTHODOTICS

PURPOSE

The competency examination for removable prosthodontics is designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a prosthesis from diagnosis and treatment planning to delivery of the prosthetic device and post-insertion follow-up.

MINIMUM CLINICAL EXPERIENCES

The documentation of oral of removable prosthodontic clinical experiences shall include five (5) prostheses.

One of the five prostheses may be used as a Portfolio competency examination provided that it is completed in an independent manner with no faculty intervention.

A prosthesis is defined to include any of the following:

- Full denture,
- Partial denture (cast framework),
- Partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth),
- Immediate treatment denture, or,
- Overdenture retained by natural or dental implants.

OVERVIEW

- Twelve (12) scoring factors.
- One (1) of the following prosthetic treatments from start to finish on the same patient:
    - > Denture or overdenture for a single edentulous arch, or,
    - > Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch
- An immediate or interim denture.
- No patient sharing; cannot split patients between candidates
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.
- Case complexity is not a criteria.

PATIENT PARAMETERS

Procedures may be performed on patients with supported soft tissue, implants or natural tooth retained overdentures.

SCORING

Scoring points for removable prosthodontics are defined as follows:

- A score of 1 is unacceptable with gross errors
- A score of 2 is unacceptable with major errors
- A score of 3 is minimum competence with moderate errors that do not compromise outcome
- A score of 4 is acceptable with minor errors that do not compromise outcome
- A score of 5 is optimal with no errors evident

ELEMENTS OF THE REMOVABLE PROSTHODONTICS PORTFOLIO

a) Documentation the candidate developed a diagnosis, determined treatment options and prognosis for the patient to receive a removable prosthesis. The documentation may include, but is not limited to the following:

- Evidence the candidate obtained a patient history, (e.g. medical, dental and psychosocial).
- Evaluation of the patient's chief complaint.
- Radiographs and photographs of the patient.
- Evidence the candidate performed a clinical examination, (e.g. hard/soft tissue charting, endodontic evaluation, occlusal examination, skeletal/jaw relationship, VDO, DR, MIP).
- Evaluation of existing prosthesis and the patient's concerns.
- Evidence the candidate obtained and mounted a diagnostic cast.
- Evidence the candidate determined the complexity of the case based on ACP classifications.
- Evidence the patient was presented with treatment plan options and assessment of the prognosis, (e.g. complete dentures, partial denture, overdenture, implant options, FPD).
- Evidence the candidate analyzed the patient risks/benefits for the various treatment options.
- Evidence the candidate exercised critical thinking and made evidence –based treatment decisions.

b) Documentation of the candidate's competency to successfully restore edentulous spaces with removable prosthesis. The documentations may include but is not limited to the following:

- Evidence the candidate developed a diagnosis and treatment plan for the removable prosthesis.
- Evidence the candidate obtained diagnostic casts.
- Evidence the candidate performed diagnostic wax-up/survey framework designs.
- Evidence the candidate performed an assessment to determine the need for pre-prosthetic surgery and made the necessary referral.
- Evidence the candidate performed tooth modifications and/or survey crowns, when indicated.
- Evidence the candidate obtained master impressions and casts.
- Evidence the candidate obtained occlusal records.
- Evidence the candidate performed a try-in and evaluated the trial dentures.
- Evidence the candidate inserted the prosthesis and provided the patient with post-insertion care.
- Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

c) Documentation of the candidate's competency to manage tooth loss transitions with immediate or transitional prostheses. The documentation may include, but is limited to the following:

- Evidence the candidate developed a diagnosis and treatment plan that identified teeth that could be salvaged and or teeth that needed extraction.
- Evidence the candidate educated the patient regarding the healing process, denture experience, and future treatment need.
- Evidence the candidate developed prosthetic phases which included surgical plans.
- Evidence the candidate obtained casts (preliminary and final impressions).
- Evidence the candidate obtained the occlusal records.
- Evidence the candidate did try-ins and evaluated trial dentures.
- Evidence the candidate competently managed and coordinated the surgical phase.
- Evidence the candidate provided the patient post insertion care including adjustment, relines and patient counseling.
- Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

d) Documentation of the candidate's competency to manage prosthetic problems. The documentation may include, but is not limited to the following:

- Evidence the candidate competently managed real or perceived patient problems.

- Evidence the candidate evaluated existing prosthesis.
- Evidence the candidate performed uncomplicated repairs, relines, re-base, re-set or re-do, if needed.
- Evidence the candidate made a determination if specialty referral was necessary.
- Evidence the candidate obtained impressions/records/information for laboratory use.
- Evidence the candidate competently communicated needed prosthetic procedure to laboratory technician.
- Evidence the candidate inserted the prosthesis and provided the patient follow-up care.
- Evidence the candidate performed in-office maintenance, (e.g. prosthesis cleaning, clasp tightening and occlusal adjustments).

e) Documentation the candidate directed and evaluated the laboratory services for the prosthesis. The documentation may include, but is not limited to the following:

- Complete laboratory prescriptions sent to the dental technician.
- Copies of all communications with the laboratory technicians.
- Evaluations of the laboratory work product, (e.g. frameworks, processed dentures).

REMOVABLE PROSTHODONTICS SCORING CRITERIA

FACTOR 1: PATIENT EVALUATION AND DIAGNOSIS

5	4	3	2	1
• Evaluation and diagnosis is comprehensive and discriminating • Recognizes significant diagnostic implications of all findings	• Recognizes significant diagnostic implications but misses some findings that do NOT affect diagnosis	• Recognizes significant findings but there are errors in findings or judgment that do NOT compromise diagnosis	• Does NOT recognize significant findings or diagnostic implications • Diagnosis is jeopardized	• Gross errors in evaluation or judgment • Gross errors in diagnosis

FACTOR 2: TREATMENT PLAN AND SEQUENCING

5	4	3	2	1
• Presents/ formulates all treatment options and understands clinical nuances of each option • Presents comprehensive treatment plan based on clinical evidence, patient history and direct examination • Performs risk-based analysis to present appropriate treatment options and prognosis • Demonstrates critical thinking as evidenced in steps in treatment plan • No errors in planning and sequencing	• Presents/formulates most treatment options and understands rationale of each option • Treatment plan is appropriate some contributing factors NOT considered • Minor errors that do NOT affect planning and sequencing	• Presents/formulates appropriate treatment options with less than ideal understanding of chief complaint, diagnosis, and prognosis • Moderate errors that do NOT compromise planning and sequencing	• Does NOT address patient's chief complaint • Treatment plan NOT based on diagnosis • Major errors in evidenced based, critical thinking, risk-based, and prognostic assessment • Treatment sequence inappropriate	• Treatment plan NOT based on diagnostic findings or prognostic information • Treatment plan grossly inadequate • Treatment sequence grossly inappropriate

FACTOR 3: PRELIMINARY IMPRESSIONS

5	4	3	2	1
• Perform and recognize adequate capture of anatomy; free of distortions and voids	• Performs impression with minor errors that do NOT affect final outcome	• Performs impression with moderate errors that do NOT compromise final outcome	• Performs impression with major errors, or fails to recognize that final outcome is compromised	• Inadequate capture of anatomy or gross distortion/voids • Fails to recognize that subsequent steps are impossible

FACTOR 4: RPD DESIGN (IF APPLICABLE)

5	4	3	2	1
• Design demonstrates understanding of biomechanical and esthetic principles • Casts are surveyed accurately • Design is drawn with detail	• Design demonstrates understanding of biomechanical and esthetic principles with minor errors • Minor errors in cast survey and design	• Design is functional but includes rests, clasp assembly or major connector that are NOT first choices • Moderate errors in survey and design • Moderate errors in understanding of RPD design principles	• Demonstrates lack of understanding of biomechanical or esthetic principles • Major errors in cast survey and design	• Design is grossly inappropriate • Inaccurate survey • Illegible drawing

FACTOR 5: TOOTH MODIFICATION (IF APPLICABLE)

5	4	3	2	1
• Parallel guiding planes • Optimal size and location of rest preparations • Conservative recontouring of abutment teeth for optimal location of clasp and to optimize occlusal plane • Survey crowns as needed	• Minor deficiencies in tooth modification; RPD fit and service unaffected	• Moderate deficiencies in tooth modifications but no compromise in RPD fit and service	• Major errors in tooth modifications leading to compromised RPD fit and service • Tooth modifications may require restorations	• RPD abutment teeth are grossly over-prepared

FACTOR 6: BORDER MOLDING AND FINAL IMPRESSIONS

5	4	3	2	1
• Obtain optimal vestibular extension and peripheral seal • Perform and recognize adequate capture of anatomy • Impression free of distortions/voids	• Border molding and/or impression have minor errors that do NOT affect final outcome	• Border molding and/or impression have moderate deviations that do NOT compromise final outcome	• Border molding and/or impression have major errors that affect final outcome	• Border molding and/or impression do NOT adequately capture of anatomy or gross distortion/voids so that final outcome impossible

FACTOR 7: FRAMEWORK TRY-IN (IF APPLICABLE)

5	4	3	2	1
• Perform and recognize functional and occlusal adjustment • Complete seating of framework is achieved • Determine sequence for establishing denture-base support	• Minor deficiencies in ability to recognize and correct minor discrepancies in framework fit but do NOT affect RPD service	• Moderate deficiencies in ability to recognize or correct discrepancies in framework fit but no significant compromise to RPD service	• Major errors in framework fit NOT recognized • Errors in judgment regarding sequence of correction	• Gross errors in framework fit NOT recognized • Unable to determine sequence of correction

FACTOR 8: JAW RELATION RECORDS

5	4	3	2	1
• Smooth record bases with appropriate peripheral extensions/ thickness • Smoothly contoured wax rim establishes esthetic parameters • Vertical dimension is physiologically appropriate • Accurately captures centric relation • Relates opposing casts without interference	• Minor discrepancies in jaw relation records that do NOT adversely affect prosthetic service	• Moderate discrepancies in jaw relation records that do NOT compromise prosthetic service; records do NOT require repeating	• Major errors in jaw relation records that adversely affect prosthetic service; records should be redone	• Gross errors in jaw relation records with poor understanding and judgment; records should be redone

FACTOR 9: TRIAL DENTURES

5	4	3	2	1
• Recognizes optimal esthetic (midline, incisal length, tooth mold and shade, arrangement), occlusal (MIP=CR, VDO < VDR, bilateral posterior contact), speech and contour aspects of trial dentures • Deviations from the optimal are corrected or managed appropriately	• Minor deficiencies in ability to recognize and correct discrepancies in esthetics, vertical dimension, occlusion, phonetics and contour	• Moderate deficiencies in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which do NOT compromise final outcome	• Major errors in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which adversely affect final outcome	• Demonstrates inability to recognize or correct gross errors which will result in failure of final outcome

FACTOR 10: INSERTION OF REMOVABLE PROSTHESIS

5	4	3	2	1
• Optimize definitive prosthesis, recognizing errors and correcting if necessary, including the following: > Tissue fit > Prosthetic support, stability and retention > RPD extension base tissue support > Vestibular extension and bulk > Occlusion; clinical remount required > Phonetics > Contours and polish > Patient home care instructions	• Minor discrepancies in judgment and/or performance of optimizing prosthesis fit and function; no adverse affect on prosthesis service	• Moderate discrepancies in judgment and performance of optimizing prosthesis fit/function; no compromise on prosthesis service	• Major errors in judgment and performance of optimizing prosthesis fit/function • Prosthesis service adversely affected; may require significant correction of prosthesis	• Gross errors in judgment and performance results in failure of prosthesis with no possibility to correct; prosthesis must be redone

FACTOR 11: POST-INSERTION (1 WEEK)

5	4	3	2	1
• Perform an appropriate recall sequence to evaluate and diagnose prosthesis problem and make adjustments until patient is satisfied with fit, form and function of new prosthesis • Enroll patient in maintenance program • Demonstrate familiarity with common prosthesis complications and solutions	• Minor discrepancies in ability to evaluate and solve prosthesis problems; no affect on patient comfort and function	• Moderate discrepancies in ability to evaluate and solve prosthesis problems that do NOT compromise patient comfort and function	• Major errors in ability to evaluate and solve prosthesis problems that adversely affect patient comfort and function	• Gross errors in ability to evaluate and solve prosthesis problems • Patient confidence is compromised

FACTOR 12: LABORATORY SERVICES FOR PROSTHESIS

5	4	3	2	1
• Prescription clearly communicates desired laboratory work and materials • Complies with infection control protocols between clinic and laboratory environments • Accurately evaluates laboratory work products	• Prescription, or management of laboratory services has minor errors that do NOT adversely affect prosthesis	• Prescription, or management of laboratory services has moderate discrepancies that do NOT compromise prosthesis	• Prescription, or management of laboratory services, has major errors that adversely affect prosthesis	• Prescription, or management of laboratory services has gross errors that result in prosthesis failure

SECTION 12 – ENDODONTICS

PURPOSE

The competency examination for endodontics is designed to assess the candidate's independent ability to demonstrate clinical skills in all aspects of a case from diagnosis to completion of conventional nonsurgical endodontic interventions.

MINIMUM CLINICAL EXPERIENCES

- Ten (10) scoring factors.
- One (1) clinical case.
- Requires patient management; therefore, candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

OVERVIEW

The documentation of endodontic clinical experiences on patients must include five (5) canals or any combination of canals in three separate teeth.

PATIENT PARAMETERS

- Any tooth to completion by the same candidate clinician on the same patient.
- Completed case is defined as a tooth with an acceptable and durable coronal seal.

SCORING

Scoring points for endodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

ELEMENTS OF THE ENDODONTICS PORTFOLIO

The Endodontics portfolio may include, but is not limited to the following:

a) Documentation the candidate applied case selection criteria for endodontic cases. The Portfolio must contain evidence the cases selected met American Association of Endodontics case criteria for minimum difficulty such that treated teeth have uncomplicated morphologies, have signs and symptoms of swelling and acute inflammation and have not had previous complete or partial endodontic therapy.

- Candidates determine a diagnostic need for endodontic therapy.
- Candidates performed charting and diagnostic testing.
- Candidates took and interpreted radiographs of the patient oral condition.
- Candidates made a pulpal diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the pulpal diagnosis was within approved parameters (within normal limits, reversible pulpitis, irreversible pulpitis, necrotic pulp).
- Candidates make a periapical diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the periapical diagnosis was within approved parameters (within normal limits, asymptomatic apical periodontitis, symptomatic apical periodontitis, acute apical abscess, chronic apical abscess).
- Evidence the candidate developed an endodontic treatment plan that included trauma treatment, management of emergencies and referrals when indicated.

b) Documentation the candidate performed pretreatment preparation for endodontic treatment. Documentation may include, but is not limited to the following:

- Evidence the candidate competently managed the patient's pain.
- Evidence the candidate removed caries and failed restorations.
- Evidence the candidate determined the tooth restorability.
- Evidence the candidate achieved isolation.

c) The candidate competently performed access opening. Documentation may include, but is not limited to the following:

- Evidence the candidate created the indicated outline form.
- Evidence the candidate created straight line access.
- Evidence the candidate maintained structural integrity.
- Evidence the candidate completed un-roofing of pulp chamber.
- Evidence the candidate identified all canal systems.

d) Documentation the candidate performed proper cleaning and shaping techniques. Documentation may include, but is not limited to the following:

- Evidence the candidate maintained canal integrity.
- Evidence the candidate preserved canal shape and flow.
- Evidence the candidate applied protocols for establishing working length.
- Evidence the candidate managed apical control.
- Evidence the candidate applied disinfection protocols.

e) Documentation the candidate performed proper obturation protocols. Documentation may include, but is not limited to evidence the candidate applied obturation protocols, including selection and fitting of master cone, determination of canal condition before obturation, and verification of sealer consistency and adequacy of coating.

f) Documentation the candidate demonstrated proper length control of obturation, including achievement of dense obturation of filling material, obturation achieved to a clinically appropriate coronal height.

g) Documentation the candidate competently completed the endodontic case including evidence that the candidate achieved coronal seal to prevent re-contamination and the candidate created diagnostic, radiographic and narrative documentation.

h) Documentation the candidate provided recommendations for post-endodontic treatment, including evidence that the candidate recommended final restoration alternatives and provided the patient with recommendations for outcome assessment and follow-up.

ENDODONTICS SCORING CRITERIA

FACTOR 1: PRETREATMENT CLINICAL TESTING AND RADIOGRAPHIC IMAGING

4	3	2	1	0
• Clinical tests and radiographic imaging completed and recorded accurately • Radiographic images are of diagnostic quality	• Clinical tests and radiographic imaging completed and recorded accurately with minor discrepancies	• Some clinical tests and radiographic images are lacking but diagnosis can be determined	• Some clinical tests and radiographic images are lacking and diagnosis is questionable	Critical errors include: • Clinical tests and radiographic images are lacking and diagnosis CANNOT be determined • Radiographic images are missing or are NOT of diagnostic quality

FACTOR 2: ENDODONTIC DIAGNOSIS

4	3	2	1	0
• Establishes correct pulpal and periapical diagnosis with accurate interpretation of clinical tests and radiographic images	• Establishes correct pulpal and periapical diagnosis with accurate interpretation, but missing one clinical test and/or radiographic image	• Establishes correct pulpal and periapical diagnosis with adequate interpretation, but missing multiple clinical tests and radiographic images that do NOT impact diagnosis	• Establishes inaccurate pulpal or periapical diagnosis, and missing multiple clinical tests and radiographic images that impact diagnosis	Critical errors include: • Demonstrates lack of understanding of endodontic diagnosis • No clinical tests were done

FACTOR 3: ENDODONTIC TREATMENT PLAN

4	3	2	1	0
• Prognosis of treatment outcomes determined • Comprehensive evaluation of medical and dental history • Selects appropriate treatments based on clinical evidence • Understands complexities of the case such that all treatment risks identified • Informed consent obtained including alternative treatments	• Prognosis of treatment outcomes determined and adequate evaluation of medical and dental history • Selects appropriate treatment(s) • Significant treatment risks identified • Informed consent obtained	• Prognosis of treatment outcomes determined and minimal evaluation of one of the following: > Medical or dental history > Appropriate treatment(s) selected, > Most treatment risks identified, >Informed consent obtained	• Prognosis of treatment outcomes unclear • Inadequate evaluation of medical and dental history despite appropriate treatments selected • Key treatment risks NOT identified	Critical errors include: • Demonstrates lack of evaluation of relevant medical and dental history • Inappropriate treatment planning • No treatment risks identified • No informed consent obtained • Demonstrates inappropriate case selection • Prognosis of treatment outcomes NOT determined

FACTOR 4: ANESTHESIA AND PAIN CONTROL

4	3	2	1	0
• Thorough knowledge of technique and materials used • Monitors vital signs and patient response throughout anesthesia • Anesthesia administration effective	• Thorough knowledge of technique • Profound anesthesia achieved • Monitors patient response throughout anesthesia	• Can proceed with treatment without faculty assistance • Adequate anesthesia achieved	• Elements of anesthesia or pain control absent but patient care NOT compromised	Critical errors include: • Incorrect anesthetic technique • Inadequate pain control and patient care is compromised • Requires faculty assistance

FACTOR 5: CARIES REMOVAL, REMOVAL OF FAILING RESTORATIONS, EVALUATION OF RESTORABILITY, SITE ISOLATION

4	3	2	1	0
• Complete removal of visible caries • Removal of failing restoration • Establishes complete structural restorability • Achieves complete isolation with rubber dam	• No visible caries and failing restorations removed • Establishes significant aspects of structural restorability and achieves effective isolation with rubber dam	• No visible caries present • Establishes likely restorability and achieves adequate isolation with rubber dam	• Caries removal compromised that potentially impacts procedure • Compromised coronal seal	Critical errors include: • Gross visible caries • Failing restoration present • Nonrestorable excluding medical indications • Ineffective isolation

FACTOR 6: ACCESS OPENING

4	3	2	1	0
• Optimum outline and access form with no obstructions • All canals identified • Roof and pulp horns removed	• Slight underextension of outline form but walls smooth but all canals identified and roof and pulp horns removed	• Moderate under- or overextension of outline form, minor irregularities for wall smoothness but all canals identified and roof and pulp horns removed	• Crown integrity compromised by overextension but tooth remains restorable • All canals identified but minor roof and pulp horns remain	Critical errors include: • Tooth is NOT restorable after access procedure or perforation • Structural compromise • Canal(s) missed or unidentified

FACTOR 7: CANAL PREPARATION TECHNIQUE

4	3	2	1	0
• Optimum canal length determination and preparation within 0.5-1.0 mm of radiographic apex • Maintenance of original canal position and integrity	• Adequate canal length determination and preparation within 1.5 mm short of radiographic apex • Mild deviations of original canal shape	• Acceptable canal length determination and preparation within 2 mm short of working length • Moderate deviations of original canal shape	• Canal length and preparation shorter than original working length • Canal length > 2 mm short or 1 mm long of radiographic apex • Severe deviations of original canal shape but treatable • Separated instrument that does NOT prevent canal preparation	Critical errors include: • Working length determination > 2 mm short or long of radiographic apex • Sodium hypochlorite accident • Canal perforated or NOT treatable • Separated instrument preventing canal preparation

FACTOR 8: MASTER CONE FIT

4	3	2	1	0
• Optimum cone fit and length verified within 0.5-1.0 mm of radiographic apex • Maintenance of canal position and integrity as demonstrated in cone fit	• Adequate cone fit and length verified within 1.5 mm short of radiographic apex • Mild deviations of original canal shape	• Acceptable cone fit and length verified within 2 mm short radiographic apex • Moderate deviations of original canal shape • Achieves tugback before lateral obturation	• Cone length determination > 2 mm short or long from radiographic apex • Cone fit > 2 mm short or > 1 mm long of radiographic apex	Critical errors include: • Master cone too small or too large and/or cone fit >2 mm short or long of radiographic apex

FACTOR 9: OBTURATION TECHNIQUE

4	3	2	1	0
• Achieves dense fill within 0.5-1.0 mm short of radiographic apex • None or minor overextension of sealer • No solid core material overextended	• Achieves dense fill within the apical two-thirds and less than 1.5 mm short of radiographic apex • Less than 1 mm of sealer extruded	• Achieves dense fill in apical third without voids • Solid core material 1.5- 2.0 mm short or 1 mm long of radiographic apex • 1-2 mm of sealer extruded	• Apical third has slight to moderate voids • Solid core material 2-3 mm short or 1-2 mm long • More than 2 mm of sealer extruded	Critical errors include: • Solid core material greater than 3 mm short or greater than 2 mm long of radiographic apex and/or significant voids throughout fill

FACTOR 10: COMPLETION OF CASE

4	3	2	1	0
• Optimum coronal seal placed prior to permanent restoration • Optimum evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes • Evidence of comprehensive and inclusive post-operative instructions	• Effective coronal seal placed prior to permanent restoration • Thorough evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes and evidence of post-operative instructions	• Acceptable durable coronal seal placed • Acceptable documentation; e.g., radiographs, clinical notes, assessment of outcomes and evidence of post-operative instructions	• Acceptable coronal seal placed with limited longevity • Evidence of incomplete documentation • Evidence of incomplete post-operative instructions	Critical errors include: • Poor coronal seal • Prognosis likely impacted by iatrogenic treatment factors • Improper or no documentation • No evidence of post-operative instruction

SECTION 13 – PERIODONTICS

PURPOSE

The competency examination for periodontics is designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a case from treatment planning to patient management.

MINIMUM CLINICAL EXPERIENCES

The documentation of periodontal clinical experiences shall include 25 cases.
A periodontal experience may include, but is not limited to:

- An adult prophylaxis,
- Treatment of periodontal disease such as scaling and root planning,
- Any periodontal surgical procedure, and,
- Assisting on a periodontal surgical procedure when performed by a faculty or an advanced dental education candidate in periodontics

The combined clinical periodontal experience must include a minimum of five (5) quadrants of scaling and root planing procedures.

OVERVIEW

- Nine (9) scoring factors.
- One (1) case to be scored in three parts:
  - Part A. Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan
  - Part B. Calculus detection, effectiveness of calculus removal
  - Part C. Periodontal re-evaluation
- Ideally, all three parts are to be performed on the same patient.
- In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.

PATIENT PARAMETERS

a) Examination, diagnosis and treatment planning
   - Minimum twenty (20) natural teeth with at least 4 molars.

- At least one probing depth of 5 mm or greater must be present on at least four (4) of the teeth, excluding third molars, with at least two of these teeth with clinical attachment loss of 2 mm or greater.
- Full mouth assessment or examination.
- No previous periodontal treatment at this institution, and no nonsurgical or surgical treatment within past 6 months.

b) Calculus detection and periodontal instrumentation (scaling and root planing)

- Minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which must be a molar.
- Third molars can be used but they must be fully erupted.
- At least one probing depth of 5 mm or greater must be present on at least two (2) of the teeth that require scaling and root planing.
- Minimum of six (6) surfaces of clinically demonstrable subgingival calculus must be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus must be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual.
  If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.

c) Re-evaluation

- Candidate must be able to demonstrate a thorough knowledge of the case.
- Candidate must perform at least two (2) quadrants of scaling and root planing on the patient being reevaluated.
- Candidate must perform at least two documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing should have been completed within an interval of 6 weeks or less.
- Minimum twenty (20) natural teeth with at least four (4) molars
- Baseline probing depth of at least 5 mm on at least four (4) of the teeth, excluding third molars.

SCORING

Scoring points for periodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

ELEMENTS OF THE PERIODONTICS PORTFOLIO

a) Documentation the candidate performed a comprehensive periodontal examination. The comprehensive periodontal examination may include, but is not limited to the following:

(1) Evidence the candidate reviewed the patient's medical and dental history.
(2) Evidence the candidate evaluated the patient's radiographs.
(3) Evidence the candidate performed extra- and intra-oral examinations of the patient.
(4) Evidence the candidate performed comprehensive periodontal data collection.
- Evidence the candidate evaluated the patient's plaque index, probing depths, bleeding on probing, suppurations, cementoenamel junction to the gingival margin (CEJ-GM), clinical attachment level tooth mobility and furcations
- Evidence the candidate performed an occlusal assessment

b) Documentation the candidate diagnosed and developed a periodontal treatment plan that documents the following:

(1) The candidate determined the periodontal diagnosis.
(2) The candidate formulated an initial periodontal treatment plan that demonstrated the candidate:

- Determined to treat or refer the patient.
- Discussed with patient the etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient-specific oral hygiene instructions.
- Determined non-surgical periodontal therapy.
- Determined need for re-evaluation.
- Determined recall interval.

c) Documentation the candidate performed nonsurgical periodontal therapy that he/she:

(1) Detected supra- and subgingival calculus
(2) Performed periodontal instrumentation:
- Removed calculus
- Removed plaque
- Removed stains

(3) Demonstrated that the candidate did not inflict excessive soft tissue trauma
(4) Demonstrated that the candidate provided the patient with anesthesia

d) Documentation the candidate performed periodontal re-evaluation

(1) Evidence the candidate evaluated effectiveness of oral hygiene
(2) Evidence the candidate assessed periodontal outcomes:
- Reviewed the medical and dental history
- Reviewed the patient's radiographs
- Performed comprehensive periodontal data collections (e. g. , evaluation of plaque index, probing depths, bleeding on probing, suppurations, cementoenamel junction to the gingival margin (CEJ-GM), clinical attachment level, furcations, and tooth mobility

(3) Evidence the candidate discussed with the patient his/her periodontal status as compared to the baseline, patient-specific oral hygiene instructions and modifications of specific risk factors
(4) Evidence the candidate determined further periodontal needs including need for referral to a periodontist and periodontal surgery.
(5) Evidence the candidate established a recall interval for periodontal treatment.

PERIODONTICS SCORING CRITERIA

FACTOR 1: REVIEW MEDICAL AND DENTAL HISTORY (Part A)

4	3	2	1	0
• Demonstrates complete knowledge and understanding of implications to dental care • Provides clear presentation of case	• Demonstrates complete understanding of implications to dental care but presentation could be improved	• Recognizes significant findings • Misses some information but minimal impact on patient care	• Recognizes medical conditions but fails to place in context of dental care • Unaware of medications or required precautions for dental appointment • Lack of information compromises patient care	Critical errors include: • Lacks current information • Endangers patient • Does NOT include vital signs • Leaves questions regarding medical or dental history unanswered • Does NOT identify need for medical consult

FACTOR 2: RADIOGRAPHIC FINDINGS (Part A)

4	3	2	1	0
• Identifies and interprets all radiographic findings	• Identifies and interprets significant radiographic findings	• Interprets radiographic findings with minor deviations that do NOT substantially alter treatment	• Misses significant radiographic findings	Critical errors include: • Grossly misinterprets radiographic findings • Fails to identify non-diagnostic radiographs • Presents with outdated radiographs

FACTOR 3: COMPREHENSIVE PERIODONTAL DATA COLLECTION (Part A - applies to one quadrant selected by examiner)

4	3	2	1	0
• Provides accurate assessment of all parameters in quadrant	• Deviations of pocket depth up to 1 mm • Correctly identifies all furcations • Correctly identifies all tooth mobility • Correctly identifies gingival recession • Correctly identifies areas with no attached gingiva	• Not more than one deviation of 2 mm or more in pocket depth • Correctly identifies Class II or III furcations involvement • Incorrectly identifies tooth mobility by one step in no more than one tooth • Over/underestimates gingival recession by ≤ 1 mm on any surface • Recognizes concept of clinical attachment level and differentiate from probing pocket depth	• More than one deviation of 2 mm or more in pocket depth • Fails to correctly identify Class II or III furcations involvement • Fails to identify areas with no attached gingiva • Overestimates Class 0 and 1 furcations • Over/underestimates tooth mobility by two steps on any tooth • Fails to correctly identify Grade 2 or 3 mobility • Over/underestimates gingival recession by more than 2 mm on any surface • Performs incomplete periodontal examination • Fails to recognize concept of clinical attachment level and differentiate from probing pocket depth	Critical errors include: • Performs periodontal examination which has no diagnostic value • Provides inaccurate assessment of key parameters

FACTOR 4: EVALUATE PERIODONTAL ETIOLOGY/RISK FACTORS (Part A)

4	3	2	1	0
• Identifies all systemic, local etiologic and risk factors	• Misses one risk factor	• Misses two risk factors but treatment is NOT substantially impacted	• Misses risk factors which compromise treatment planning and patient care	Critical errors include: • Fails to identify all risk factors

FACTOR 5: COMPREHENSIVE PERIODONTAL DIAGNOSIS (Part A)

4	3	2	1	0
• Provides accurate and complete diagnosis based on comprehensive clinical examination and findings • Demonstrates comprehensive understanding of periodontal diagnosis	• Provides accurate and complete diagnosis based on clinical examination and findings pertinent to the case	• Differentiates between periodontal health, gingivitis and periodontitis • Makes acceptable diagnosis with minimal deviations from ideal but treatment NOT impacted	• Fails to diagnose periodontitis • Makes diagnosis with critical deviations from optimal • Provides a diagnosis which lacks rationale	Critical errors include: • Fails to make a diagnosis • Provides diagnosis which is grossly incorrect

FACTOR 6: TREATMENT PLAN (Part A)

4	3	2	1	0
• Provides comprehensive and clinically appropriate treatment plan including clear description of etiology, benefits of treatment, alternatives, and risk factors	• Provides comprehensive and clinically appropriate treatment plan including clinically appropriate alternative treatment plan (if any) • Provides adequate description of risks and benefits of treatment and alternatives	• Provides clinically appropriate treatment plan but fails to address some factors that are unlikely to affect outcome • Does NOT provide clear description of risks and benefits of treatment and alternatives	• Provides treatment plan which fails to address relevant factors which are likely to affect outcome • Provides incomplete periodontal treatment plan that is below the standard of care and adversely affects outcome	Critical errors include: • Provides clinically inappropriate treatment plan which could harm the patient

FACTOR 7: CALCULUS DETECTION (Part B)

4	3	2	1	0
• Demonstrates complete detection of all subgingival calculus present in quadrant(s)	• Incorrectly identifies absence or presence of one area of clinically demonstrable subgingival calculus	• Incorrectly identifies absence or presence two areas of clinically demonstrable subgingival calculus	• Misses three areas of clinically demonstrable subgingival calculus	Critical errors include: • Misses or incorrectly identifies four or more areas of clinically demonstrable subgingival calculus

FACTOR 8: EFFECTIVENESS OF CALCULUS REMOVAL (Part B)

4	3	2	1	0
• Demonstrates complete removal of all calculus plaque and stains from tooth surfaces • Does NOT cause any tissue trauma • Does NOT cause any patient discomfort	• Demonstrates complete removal of all other deposits except for stains in pits and fissures • Minimizes patient discomfort	• Misses one area of clinically demonstrable subgingival calculus • Demonstrates removal of all other deposits but some remaining minor stains on accessible surfaces • Provides sufficient pain management for treatment	• Misses two areas of clinically demonstrable subgingival calculus • Causes major tissue trauma • Leaves moderate plaque and supragingival calculus • Inadequate pain management	Critical errors include: • Misses three areas of clinically demonstrable subgingival calculus • Leaves heavy stain, plaque, supragingival calculus • No pain management

FACTOR 9: PERIODONTAL RE-EVALUATION (Part C)

4	3	2	1	0
• Identifies all clinical changes of periodontal condition and describes the biological basis of changes • Evaluates patient's oral hygiene, provides patient-specific oral hygiene instruction, and educates patient on the significance of plaque removal and periodontal disease treatment • Evaluates and determines all of the patient's specific periodontal needs with detailed rationale for further periodontal procedures	• Identifies all clinical changes of periodontal condition • Evaluates and determines specific needs for periodontal care with rationale for further periodontal procedures • Accurately assesses all of patient's oral hygiene problems • Provides oral hygiene instructions that addresses all of patient's needs • Evaluates and determines all of the patient's specific periodontal needs without detailed rationale	• Identifies most clinical changes of periodontal condition but fails to identify minor changes • Accurately assesses most of patient's oral hygiene problems • Provides oral hygiene instructions that only address most of the patient's needs • Evaluates and determines general needs for periodontal care including recall intervals and referral, if indicated	• Fails to identify persistent signs and symptoms of periodontal disease • Fails to present an oral hygiene plan • Makes recommendation for further periodontal treatment that is inappropriate and demonstrates lack of understanding of patient's periodontal needs	Critical errors include: • Fails to recognize any clinical change in periodontal condition • Did NOT assess patient's oral hygiene care or needs • Has NOT evaluated and/or determined patient's periodontal needs • Fails to recognize need for referral

SECTION 14 – EXAMINER TRAINING AND CALIBRATION

In order to meet the standard required for psychometrically sound examinations, training and calibration procedures must be linked back to the competencies defined by a job analysis and to the evaluation system. All the schools must calibrate their faculty to the same rating criteria. Again, faculty from six Board approved dental schools must be involved in the process to ensure those faculty apply the same standards to candidates' performance. It is very important for the Board to be aware of threats to the validity of the examination that arise from improper training and calibration. If the examiners are improperly trained and calibrated, the examiners would compromise the Portfolio Examination's ability to produce results that warrant valid conclusions about candidates' clinical competence.

APPLICABLE STANDARDS

Standard 5.1 "Test administrators should follow carefully the standardized procedures for administration and scoring as specified by the test developer, unless the situation or a test taker's disability dictates an exception should be made." (p. 63)

Standard 5.8 "Test scoring services should document the procedures that were followed to assure accuracy of scoring. The frequency of scoring errors should be monitored and reported to users of the service on reasonable request. Any systematic source of scoring errors should be corrected." (p. 64)

Standard 5.9 "When test scoring involves human judgment, scoring rubrics should specify criteria for scoring. Adherence to established scoring criteria should be monitored and checked regularly. Monitoring procedures should be documented." (p. 65)

EXAMINER SELECTION CRITERIA

The Board has outlined a process for selection of dental school faculty who wish to serve as a portfolio examiner. Each portfolio examiner is required to undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods:

a) At the beginning of each school year, each school submits the names, credentials and qualifications of the dental school faculty to be appointed by the Board as Portfolio examiners. Documentation of qualifications must include but

is not limited to, evidence the dental school faculty examiner satisfies the dental school criteria and standards established by his/her school to conduct Portfolio competency examinations. The school faculty examiner must have documented experience in conducting examinations in an objective manner.

b) In addition to the names, credentials and qualifications, the Board approved school must submit documentation the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements. Changes to the list of school faculty examiners must be reported to the Board. The school must provide the Board an annual updated list of their faculty examiners.

c) The Board reserves the right to approve or disapprove dental school faculty who wish to serve as Portfolio examiners.

STANDARDIZED TRAINING PROCESS

Examiners are required to attend standardized, Board approved training "calibration" sessions offered at their schools. Each training course will be presented by designated Portfolio examiners at their respective schools and require the prospective examiners to participate in both didactic and hands-on activities.

Didactic training component. During didactic training, designated Portfolio examiners will present an overview of the examination and its evaluation (grading) system through lecture, review of examiner training manual, slide presentations (Powerpoint), sample documentation, sample cases, etc., prior to participating in the actual rating of candidates.

Hands-on component. Training activities have multiple examples of performance that clearly relate to the specific judgments that examiners are expected to provide during the competency examinations. Hands-on training sessions includes an overview of the rating process, clear examples of rating errors, examples of how to mark the grading forms, a series of several sample cases for examiners to hone their skills, and numerous opportunities for training staff to provide feedback to individual examiners.

Monitoring calibration of examiners. Calibration of examiners will be conducted regularly to maintain common standards as an ongoing process. Examiners are provided feedback about their performance and how their scoring varies from their fellow examiners. Examiners whose error rate exceeds a prespecified percentage error will be re-calibrated. If any examiner is unable to be re-calibrated, the Board would dismiss the examiner from the Portfolio Examination process.

TYPES OF RATING ERRORS

Rating errors are systematic biases which may affect the examiner's ability to provide a fair and objective evaluation of candidates. Several common rating errors can interfere with the rating process by diminishing the accuracy, effectiveness and fairness of the ratings (Cascio, 1992).

Rating errors can be avoided by systematically applying the established grading criteria that clearly define acceptable and unacceptable performance. Basically, examiners should use their professional judgment in applying the grading criteria for each grading factor and rate the candidates' performance accordingly.

1. FIRST IMPRESSIONS. First impressions can have a lasting and troublesome effect on the evaluation process. During the first few minutes of the examination, the examiner may form a favorable or unfavorable impression of the candidate. The end result is that the examiner may distort or ignore various aspects of candidates' performance.

2. HALO/HORN EFFECT. Halo or horn effect is a broader example of the type of influence which occurs during first impressions. Halo refers to positive overgeneralization based on a positive aspect of performance. Horn refers negative overgeneralization based on a negative aspect of performance. Thus, if the candidate exhibits good or poor performance for one grading factor, the ratings for all factors are distorted.

3. STEREOTYPING. Stereotyping refers to unfair bias towards a candidate without being aware of the bias. There is a tendency to generalize, favorably or unfavorably, across groups and ignore individual differences. Examiners should be aware of individual differences of candidates rather than generalizations about a group of people.

4. SIMILARITY EFFECTS. Similarity effects are the tendency of examiners to rate candidates more favorably if because the candidates perform tasks in the same style or use the same process as they do.

5. CONTRAST EFFECTS. Contrast effects are the result of evaluating the candidate relative to other candidates rather than applying the established grading criteria.

6. CENTRAL TENDENCY. Central tendency is the inclination to "play it safe" and rate candidates in the middle even when candidate performance merits higher or lower ratings.

7. NEGATIVE AND POSITIVE LENIENCY. Leniency (level) error is the tendency of an examiner to rate candidates lower or higher on a consistent basis rather than base ratings on the candidate's performance.

8. FRAME OF REFERENCE. Frame of reference error occurs when examiners compare candidate performance to their personal standards of care.

9. RECENCY EFFECT. Recent information is better remembered and receives greater weight in forming a judgment that earlier presented information.

CROSS TRAINING OF EXAMINERS

Training sessions will be conducted on an ongoing basis in both northern and southern California, with the expectation that examiners participating in the Portfolio Examination process will have ample opportunities to participate in competency examinations conducted at a school other than their own. It may not be necessary to have examiners from other schools rate each and every candidate; however, periodic participation of examiners from outside schools can strengthen the credibility of the process and ensure objectivity of ratings.

SECTION 15 – AUDIT PROCESS

This Audit Process is designed to serve multiple purposes. First it will provide information for auditors who will conduct site visits on behalf of the Dental Board of California (Board). The purpose of the site visits is to determine if the participating dental schools are following the procedures established for the evaluation and calibration system set forth by the Board for the Portfolio Examination. Second, it will provide information on which participating dental schools can conduct a self-assessment of its adherence to the Board's examination procedures. Third, it will provide a protocol for collecting documentation that will serve as validity evidence for the examination.

During an audit, in-depth information is obtained about the administrative and psychometric aspects of the Portfolio Examination, much like the accreditation process. An audit team comprised of faculty from the dental schools and persons designated by the Board would verify compliance with accepted professional testing standards, e.g., Standards for Educational and Psychological Testing, as well as verifying that the portfolios have been implemented according to the goals of the portfolio process.

APPLICABLE STANDARDS

Standard 3.15 "When using a standardized testing format to collect structured behavior samples, the domain, test design, test specifications and materials should be documented as for any other test. Such documentation should include a clear definition of the behavior expected of the test takers, the nature of expected responses, and any materials or directions that are necessary to carry out the testing." (p. 46)

ROLE OF THE BOARD

The Board has several responsibilities with regard to the audit of the examination:

- Oversight of audit process.
- Establishment of grading standards necessary for public protection.
- Developing audit protocols and criteria for assessing schools' compliance with the evaluation system and calibration process.
- Hands-on training for auditors in the evaluation system.

- Selecting auditors who can maintain the independence between themselves and the Portfolio Examination process.

ROLE OF AUDIT TEAM

The audit team is responsible for verification of the examination process and examination results, and, collection and evaluation of specific written documentation which respond to a set of standardized audit questions and summarizing the findings in a written report. A site visit can be conducted to verify portfolio documentation and clear up unresolved questions.

The audit team would be comprised of persons who can remain objective and neutral to the interests of the school being audited. The audit team should be knowledgeable of subject matter, psychometric standards, psychometrics and credentialing testing.

The audit team should be prepared to evaluate the information provided in a written report to the Board that documents the strengths and weaknesses of each school's administrative process.

DOCUMENTATION FOR VALIDITY EVIDENCE

Each candidate will have a portfolio of completed, signed rating (grade) sheets which provide evidence that clinical competency examinations in the six areas of practice have been successfully completed.

In addition to the signed rating (grade) sheets, there is content-specific documentation that must be provided. A list of acceptable documentation is presented on the following page.

It is anticipated that audit team will be presented with a representative sample of documentation from the candidate competency examinations.

Table 9 – Content-specific documentation

ORAL DIAGNOSIS AND TREATMENT PLANNING	• Full workup of case
DIRECT RESTORATION	• Restorative diagnosis and treatment plan • Preoperative radiographs, e.g., original lesion in Class II, III, IV • Postoperative radiographs including final fill
INDIRECT RESTORATION	• Restorative diagnosis and treatment plan • Preoperative radiographs • Postoperative radiographs including successfully cemented crown or onlay
REMOVABLE PROSTHODONTICS	• Removable prosthodontic diagnosis and treatment plan • Preoperative radiographs illustrating treatment condition • Preoperative and postoperative intraoral photographs of finished appliance
PERIODONTICS	• Periodontal diagnosis and treatment plan • Charted pocket readings • Preoperative radiographs including subgingival calculus • Postoperative radiographs • Follow-up report
ENDODONTICS	• Endodontic diagnosis and treatment plan • Preoperative radiographs of treatment site • Postoperative radiographs of treatment site

SCHEDULE FOR AUDITS

For the first two years, the Board will send audit teams to each of the participating dental schools and conduct an audit of Portfolio competency examinations or until the Board is satisfied that the schools are in compliance with the standardized processes of the Portfolio Examination.

In subsequent years, the Board will conduct audits of the Portfolio competency examinations every two years (biennially).

AUDIT CHECKLIST

RESOURCES	• Who is responsible for training Board approved Portfolio examiners? • Who is responsible for training dental school staff to assign final scaled scores and prepare final score reports and other required documentation to the Board? • What quality control procedures are in place to ensure that the final scaled scores and score reports are accurate?
NAMES AND QUALIFICATIONS OF EXAMINERS	• What is the process for identifying faculty to serve as Portfolio examiners? • What are the qualifications of Board approved Portfolio examiners?
TRAINING AND CALIBRATION OF EXAMINERS	• What procedures are used to train Portfolio examiners? • Are scoring benchmarks clearly established during training? • What procedures are used to maintain calibration of Portfolio examiners? • How are disagreements between examiners handled?
TEST SECURITY	• What procedures are in place to permit auditors to view patient information for the purposes of the audit? • What procedures are in place to maintain the security of the Portfolio examination materials before, during and after each competency examination? • What procedures are in place to maintain security of final scoring procedures and final scores?
QUALITY OF DOCUMENTATION	• Is the quality of the documentation consistent with accepted standards of care for each type of competency examination? • Are comments routinely available on the grading worksheets to justify an examiner's ratings?
PERFORMANCE STATISTICS	• What procedures are in place to produce reliability statistics for Portfolio examiners? • What procedures are in place to maintain pass/fail statistics?
INCIDENT REPORTS	• What procedures are in place to handle incidents that may arise during the implementation of competency examinations of the Portfolio Examination?
UNSUCCESSFUL CANDIDATES	• What procedures are in place for candidates who fail a competency examination and who wish to pursue the Portfolio Examination pathway to initial licensure?

AUDIT SITE VISIT REPORT

Following each audit site visit, the Board's audit team will prepare a formal report of its findings. The report is confidential and will be shared only with the

participating school whose Portfolio competency examinations were the focus of the report.

The intent of the audit site visit report is to determine if the participating schools are following the standardized procedures of the Portfolio Examination and provide feedback with regard to implementation of the competency examinations.

The audit site visit report may be structured to include:

- Audit objectives and scope
- Period of time included in the audit
- Audit methods
- Auditors' findings
- Auditor recommendations

SECTION 16 - REFERENCES

Albino, J. E. N., Neumann, G. A., Kramer, S. C., Andrieu, S. C., Henson, L., Horn, B., & Hendricson, W. D. (2008) Assessing dental students' competence: Best practice recommendations in the performance assessment literatures and investigation of current practices in predoctoral education. Journal of Dental Education, 72, 1405-1435.

American Association of Dental Examiners Composite (20th ed.). (2009). Chicago, IL: Author.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education (1999). Standards for educational and psychological testing. Washington, DC: Author.

Cascio, W.F. (1992). Managing human resources (3rd ed.) New York: McGraw-Hill.

Chambers, D. W. (2004). Portfolios for determining initial licensure competency. Journal of the American Dental Association, 135, 173-184.

Chambers, D. W., & Gerrow, J. D. (1994). Manual for developing and formatting competency statements. Journal of Dental Education, 58(5), 361-366.

Chinn, R. N., & Hertz, N. R. (2007). Comparative analysis of competencies in the California dental examination and advanced clinical residency programs. Folsom, CA: Comira.

Commission on Dental Accreditation (2008). Accreditation Standards for Dental Education Programs. Chicago, IL: American Dental Association.

Davis, M. H., & Ponnamperuma, G. G. (2005). Portfolio assessment. Journal of Veterinary Medical Education, 332(3), 279-284.

Davis, M. H., Friedman Ben-David, M., Harden, R. M., Howie, P., Ker, J., McGhee, C., Pippard, M. J., & Snadden, D. (2001). Portfolio assessment in medical students' final examinations. Medical Teacher, 23(4), p. 357-366.

Dental education and licensure in the United States and Canada: A comparison. (2001). Chicago, IL. American Dental Association, Council on Dental Education and Licensure.

DOE Handbook: Table-top job analysis. (DOE-HDBK1076-94). (1994). Washington, DC: Department of Energy.

Driessen, E., van der Vleuten, C., Schuwirth, L., van Tartwijk, J., & & Vermunt, J. (2005). The use of qualitative research criteria for portfolio assessment as an alternative to reliability evaluation: A case study. Medical Education, 39(2), 214-220.

Flanagan, J. C. (1954). The critical incident technique. Psychological Bulletin, 51(4), 327-358.

Friedman Ben-David, M., Davis, M., Harden, R., Howie, P., Ker, J., & Pippard, M. (2001). AMEE Guide No. 24. Portfolios as a method of student assessment. Medical Teacher, 23(6), 535-551.

Hammond, D. & Buckendahl, C. W., (2006). Point/Counterpoint: Do portfolio assessments have a place in dental licensure?: No portfolio assessment should not be used in dental licensure. Journal of the American Dental Association, 137, 30-41.

Loma Linda University School of Dentistry: Clinical competency examinations. (2009). Loma Linda, CA: Author.

McMullan, M. (2003). Portfolios and assessment of competence: A review of the literature. Journal of Advanced Nursing, 41(3), 283-294.

Patterson, F., Ferguson, E. & Thomas, S. (2008). Using job analysis to identify core and specific competencies: Implications for selection and recruitment. Medical Education, 42, 1195-1204.

Ranney, R. R. & Hambleton, R. (2006). Point/Counterpoint: Do portfolio assessments have a place in dental licensure?: Yes, portfolio assessments can be used successfully in dental licensure. Journal of the American Dental Association, 137, 30-41.

Webb, C., Endacott, R., Gray, M. A., Jasper, M. A., McMullan, M. & Scholes, J. (2003) Evaluating portfolio assessment systems: What are the appropriate criteria? Nurse Education Today, 23, 600-609.

University of California Los Angeles School of Dentistry: Clinical competency examinations. (2009). Los Angeles, CA: Author.

University of California San Francisco School of Dentistry: Clinical competency examinations. (2009).San Francisco, CA: Author.

University of the Pacific School of Dentistry: Clinical competency examinations. (2009). San Francisco, CA: Author.

University of Southern California School of Dentistry: Clinical competency examinations. (2009). Los Angeles, CA: Author.

APPENDIX A - CONSULTANT BACKGROUND

ROBERTA N. CHINN, PH.D
PSYCHOMETRICIAN

Dr. Roberta Chinn is a psychometrician at PSI. She has more than 23 years of experience in the measurement field. She received her Bachelor of Science degree from the University of California at Davis in psychology, her Master of Arts degree from the University of the Pacific in experimental psychology, and her Ph.D. in experimental and cognitive psychology from Louisiana State University.

Prior to joining PSI in 2011, Dr. Chinn was the Assistant Director of Psychometric Services at Comira, a general partner at HZ Assessments, a private psychometric consulting firm that she co-founded in 2001, and a senior measurement consultant at the Office of Examination Resources at the California Department of Consumer Affairs for nearly 12 years. During her tenure at Consumer Affairs, she handled sensitive aspects of examination programs for more than 30 boards and was instrumental in the development of standardized practical examinations, applied law and ethics examinations, and standardized oral examinations.

She has developed licensing and certification examinations in Arizona, California, Colorado, District of Columbia, Oregon, and Washington as well as for national credentialing organizations (e.g., Commission on Dietetic Registration of the Academy of Nutrition and Dietetics, Appraisal Qualifications Board, National Council of Architect Registration Boards). She has extensive experience in government settings and has conducted validation studies, developed licensing and certification examinations, and/or established cut scores for over 60 professions including commercial and residential appraisers, court reporters, predoctoral and postdoctoral dentists, dental auxiliaries, specialist dietitians, structural engineers, engineering geologists, environmental site assessors, fiduciaries, hydrogeologists, pest control personnel, clinical psychologists, ship pilots, pharmacists, clinical psychologists, speech-language pathologists and veterinarians. She specializes in the development of multiple-choice, performance and oral examinations and has developed innovative methods to streamline procedures for job (practice) analyses and examination development. Her research on alternative item types for competency assessment was recently published in Evaluation in the Health Professions and research on practice analysis was recently published in the Journal of Enteral and Parental Nutrition.

She has chaired and presented at the annual meetings of the Council on Licensure, Enforcement and Regulation and the National Council on Measurement in Education and has also co-authored several technical papers and journal articles. She is a member of the American Psychological Association, the American Educational Research Association, the National Council on Measurement in Education, and the Council on Licensure, Enforcement and Regulation.

NORMAN R. HERTZ, PH.D.
APPLIED PSYCHOLOGIST

Dr. Hertz is an Applied Psychologist at Progeny Systems Corporation. He is a licensed psychologist with over 30 years of experience in the measurement field. He received his Bachelor of Arts degree from Baylor University in psychology, his Master of Science degree in psychology and his Ph.D. in industrial-organizational psychology from the University of Memphis.

Prior joining Progeny in 2011, he was the Director of Psychometric Services at Comira, the managing partner of HZ Assessments, a private psychometric consulting firm that he co-founded after his retirement from the California Department of Consumer Affairs in 2001, and the Chief of the Office of Examination Resources at the California Department of Consumer Affairs. He has provided psychometric expertise to national and international organizations and has developed licensing and certification examinations for several western states including Arizona, California, Colorado, District of Columbia, Oregon and Washington. He has extensive experience in private industry and government settings and has conducted validation studies, developed licensing and certification examinations, and established cut scores for more than 60 professions, ranging from the construction trades to medical specialties. He has provided litigation support for numerous examinations including legal document preparers, court reporters, and ship pilots. His service on the psychometric oversight committee for the American Institute of Certified Public Accountants was incorporated into the examination development and scoring processes used in the present day.

During his 15-year tenure at the California Department of Consumer Affairs, he handled the most sensitive aspects of examination programs for more than 30 boards including expert witness testimony for state legislative committees, state regulatory boards, and consultant-auditor for national organizations such as the National Council of State Boards of Nursing, National Council of Architect Registration American Institute of Certified Public Accountants, Boards, National Association of Boards of Pharmacy, National Board of Examiners in Optometry.

He has chaired and presented at the annual meetings of the Council on Licensure, Enforcement and Regulation and the National Council on Measurement in Education and has also co-authored several technical papers and journal articles. He is a member of the American Psychological Association, the Society for Industrial Organizational Psychology, the American Educational Research Association, the National Council on Measurement in Education, and the Council on Licensure, Enforcement and Regulation.

June 30, 2011

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL BOARD OF CALIFORNIA

Org Chart
FY 2010-2011
Authorized Positions 72.8

Filled: 61.8
Vacant: 11.0

Blanket: 9.0

OPERATIONS DIVISION

Executive Assistant
Linda Byers
624-110-1728-001

(4.0)
Executive Officer
Richard DeCuir
624-110-8840-001

Special Consultant
(Retired Annuitant)
Georgetta Coleman-Griffith
624-110-4660-907

Office Technician (Typing)
Suzanne Torres
624-110-1139-007

Staff Services Manager III
Denise Johnson
624-110-4802-001

ENFORCEMENT DIVISION

(4.0)
Supervising Investigator II
Kimberly Trefry
624-110-8597-003

Dental Consultant
Richard Liebig
624-110-7843-002
Dental Consultant
VACANT
(CPEI/BCP)
7843-003

Office Technician (Typing)
Dee Jorz
624-110-1139-805

ADMINISTRATION

(3.8)
Staff Information Systems Analyst
Joe Muncie
1312-001
Associate Governmental Program Analyst
Paula Fernandez
5393-008
Associate Governmental Program Analyst
Sarah Wallace
(incumbent is FT)
5393-801 (.8)
Staff Services Analyst
Sharon Langness
5157-802

LICENSING & EXAMINATION

(12.0)
Staff Services Manager I
Donna Kantner
624-110-4800-002

(9.0)
Staff Services Manager I
Dawn Dill
624-210-4800-001

Customer Service and Support Unit
Office Assistant (Typing)
Paul Loder
1379-001
Office Assistant (Typing)
Nicole Novak
(LT – exp 05/31/12)
1379-003 (.5)
Office Assistant (General)
VACANT
(A. Boxwell 05/10/11)
1441-005

Licensing and Examination Unit
Associate Governmental Program Analyst
Jessica Olney
5393-803
Staff Services Analyst
Jeane Ward
5157-003
Staff Services Analyst
Jennifer Jackson
5157-004
Staff Services Analyst
Neloofar Forget
(Incumbent is .5 and serving a LT- exp 09/30/12)
5157-008 (.5)
Staff Services Analyst
Rosa Mata
(Incumbent in Orange FO)
5157-013
Staff Services Analyst
David Wolf
5157-016
Staff Services Analyst
Eric Rivera
5157-017
Office Technician (Typing)
VACANT
(A. Wautier 03/16/11)
1139-803
Office Assistant (General)
Patrice Powe
1441-001

Dental Assisting Program
Associate Governmental Program Analyst
Tanya Webber
210-5393-800
Management Services Technician
Gordon Redoble
210-5278-003
Management Services Technician
VACANT
(L. Fisher 06/19/11)
(LT exp 12/06/11)
210-5278-004
Management Services Technician
VACANT
(T. Vallery 06/19/11)
(LT exp 09/30/12)
210-5278-005
Office Technician (Typing)
Jessica Cate
210-1139-004
Office Technician (General)
VACANT
(C. Row 06/17/11)
210-1138-001
Office Assistant (Typing)
Dorothy Perez
210-1379-003
Office Assistant (General)
Kelly Nimrick
210-1441-001

ENFORCEMENT

(7.0)
Staff Services Manager I
April Alameda
624-110-4800-003

(8.5)
Staff Services Manager I
Lori Reis
624-110-4800-001

(8.0)
Supervising Investigator I
Nancy Butler
624-110-8596-004

(14.0)
Supervising Investigator I
Theresa Lane
624-110-8596-003

Investigative Analysis Unit
Sacramento FO
Associate Governmental Program Analyst
Shannan Borton
(T&D – 8612 Special Investigator 04/12/11 – 04/11/12)
5393-811
Associate Governmental Program Analyst
Dawn Kammerer
(T&D – 8612 Special Investigator 04/12/11 – 04/11/12)
5393-xxx
Associate Governmental Program Analyst
Erica Cano
5393-808
Associate Governmental Program Analyst
Sean Cogan
5393-809
Associate Governmental Program Analyst
Sheila Keechel
5393-810
Staff Services Analyst
Cristina Hall
5157-015
Associate Governmental Program Analyst
(Retired Annuitant)
Dominique Bach
5393-907
Associate Governmental Program Analyst
(Retired Annuitant)
Kathleen Bazil
5393-907

Complaint and Compliance Unit
Associate Governmental Program Analyst
Oralia Moya
5393-007 **(span)**
Associate Governmental Program Analyst
Linda Garcia
5393-805
Associate Governmental Program Analyst
Marcos Armas
5393-806
Associate Governmental Program Analyst
Wendy Schmidt
5393-907
Staff Services Analyst
Jacqueline Byrnes
(Incumbent is .5)
5157-001 (.5)
Staff Services Analyst
Tina Vallery
(LT exp 09/30/12)
5157-009 (span)
Staff Services Analyst
Laura Fisher
(LT exp 12/06/11)
5157-012
Office Technician (Typing)
Tina Wilson
1139-010
Office Technician (Typing)
VACANT
(D. Owen 03/01/11)
1139-012
Staff Services Analyst (Retired Annuitant)
Joan Hawkins
5157-907
Staff Services Analyst (Retired Annuitant)
Linda Pyle
5157-907
Staff Services Analyst (Retired Annuitant)
Mary Countryman
5157-907

Sacramento FO
Senior Investigator
Geno Davis
8595-001
Senior Investigator
Karyn Dunn
8595-013
Senior Investigator
VACANT
(K. Dunn 10/31/09
8595-020
Investigator
Kyle Clanton
8594-001
Investigator
Adam Iremonger
8594-015
Investigator
VACANT
(CPEI/BCP)
8594-021
Inspector II
Shirley Boldrini
8833-007

(2.5)
Discipline Coordination Unit
Associate Governmental Program Analyst
Jocelyn Campos
5393-804
Associate Governmental Program Analyst
Adrienne Mueller
2 yr LT – exp 09/30/12
5393-600
Associate Governmental Program Analyst
Karen Fischer
(Incumbent is .5 serving 2 yr LT – exp 09/30/12)
5393-601 (.5)
Staff Services Analyst (Retired Annuitant)
Anita Dowty
5157-907

Investigative Analysis Unit
Orange FO
Special Investigator
Vicki Furtek
8612-003
Enforcement Representative I
Bernice Gamez
(T&D – 8612 Special Investigator 04/25/11 – 04/24/12)
8791-001

Orange FO
Senior Investigator
Russ Predmore
8595-009
Senior Investigator
Vicki Williams
8595-015
Senior Investigator
Shannon Reza
8595-017
Senior Investigator
Stephen Nicas
8595-018
Senior Investigator
Denise Ciganovich
8595-019
Investigator
VACANT
(D. Calhoun 08/06/09)
8594-016
Investigator
Kaycee Hunter
8594-019
Investigator
Monica Santiago
8594-020 **(span)**
Investigator
VACANT
(CPEI/BCP)
8594-022
Inspector II
Dwaylon Calhoun
8833-002
Office Technician (Typing)
Jimmy Zermeno
1139-001 **(span)**
Associate Governmental Program Analyst
(Retired Annuitant)
Joseph Lopez
5393-907

DENTAL BOARD LEGEND

Executive Officer – 1
SSM III – 1
Supv Investigator II – 1
Dental Consultant – 2
Supv Investigator I –2
Staff Svs Mgr I – 4
Sr Investigator - 8
Special Investigator – 3.5
Investigator – 7.5
Inspector II – 2
SISA – 1
AGPA – 12.3 + 1 blanket
SSA – 10
EA – 1
MST – 3
OT (T) – 7
OT (G) – 1
OA (T) – 2.5
OA (G) – 3
Retired Annuitant – 8

Black = **Filled**
Red = **Vacant**
Green = **CPEI/BCP FY 10/11 (Included in 72.8)**
Lt. Blue = **Blanket/Temporary Position (Not included in 72.8)**

Richard DeCuir, Executive Officer _____ Date _____

Personnel Office _____ Date _____

June 30, 2012

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL BOARD OF CALIFORNIA

Org Chart
FY 2011-2012
Authorized Positions 72.8

Filled: 66.3
Vacant: 6.5

Blanket: 8.0

OPERATIONS DIVISION

Executive Assistant
Linda Byers
624-110-1728-001

(3.0)
Executive Officer
Richard DeCuir
624-110-8840-001

Special Consultant
(Retired Annuitant)
Georgetta Coleman-Griffith
624-110-4660-907

Staff Services Manager III
Denise Johnson
624-110-4802-001

ENFORCEMENT DIVISION

(4.0)
Supervising Investigator II
Kimberly Trefry
624-110-8597-003

Dental Consultant
Richard Liebig
624-110-7843-002
Dental Consultant
VACANT
(R. Liebig 12/29/11)
(CPEI/BCP)
7843-003

Office Technician (Typing)
Barbara de Helena
624-110-1139-805

ADMINISTRATION

(3.8)
Staff Information Systems Analyst
Joe Muncie
1312-001
Associate Governmental Program Analyst
Paula Fernandez
5393-008
Associate Governmental Program Analyst
Sarah Wallace
(incumbent is FT)
5393-801 (.8)
Associate Governmental Program Analyst
F. Genie Albertsen
5393-802

LICENSING & EXAMINATION

(13.0)
Staff Services Manager I
VACANT
(D. Kantner 02/29/12)
624-110-4800-002

Customer Service and Support Unit
Office Assistant (Typing)
Paul Loder
1379-001
Office Assistant (Typing)
VACANT
(N. Novak LT expired 05/31/12)
1379-003 (.5)
Office Assistant (General)
Joshua Bennett
1441-005

Licensing and Examination Unit
Associate Governmental Program Analyst
Jessica Olney
5393-803
Staff Services Analyst
Jeane Ward
5157-003
Staff Services Analyst
Jennifer Jackson
5157-004
Staff Services Analyst
Neloofar Forget
(Incumbent is .5 and serving a LT- exp 09/30/12)
5157-008 (.5)
Staff Services Analyst
Rosa Mata
(Incumbent in Orange FO)
5157-013
Staff Services Analyst
David Wolf
5157-016
Staff Services Analyst
Eric Rivera
5157-017
Office Technician (Typing)
Isis Stanley
1139-007
Office Technician (Typing)
Suzanne Torres
1139-803
Office Assistant (General)
Patrice Powe
1441-001

(9.0)
Staff Services Manager I
Dawn Dill
624-210-4800-001

Dental Assisting Program
Associate Governmental Program Analyst
Sharon Langness
210-5393-800
Management Services Technician
Gordon Redoble
210-5278-003
Management Services Technician
Linda Bronson
210-5278-004
Management Services Technician
Tina Vallery
210-5278-005
Office Technician (Typing)
Jessica Cate
210-1139-004
Office Technician (General)
Joseph Crawford
210-1138-001
Office Assistant (Typing)
Dorothy Perez
210-1379-003
Office Assistant (General)
Kelly Nimrick
210-1441-001

ENFORCEMENT

(7.0)
Staff Services Manager I
April Alameda
624-110-4800-003

Investigative Analysis Unit
Special Investigator
Shannan Borton
8612-006
Special Investigator
Dawn Kammerer
8612-008
Associate Governmental Program Analyst
Erica Cano
5393-808 (span)
Associate Governmental Program Analyst
Sean Cogan
5393-809
Associate Governmental Program Analyst
Sheila Keechel
5393-810
Staff Services Analyst
A. Scott Vice
5157-015
Associate Governmental Program Analyst
(Retired Annuitant)
Dominique Bach
5393-907
Associate Governmental Program Analyst
(Retired Annuitant)
Kathleen Bazil
5393-907

(8.5)
Staff Services Manager I
Lori Reis
624-110-4800-001

Complaint and Compliance Unit
Associate Governmental Program Analyst
Oralia Moya
5393-007 (span)
Associate Governmental Program Analyst
Linda Garcia
5393-805
Associate Governmental Program Analyst
Wendy Schmidt
5393-806
Staff Services Analyst
Jacqueline Byrnes
(Incumbent is .5)
5157-001 (.5)
Staff Services Analyst
VACANT
(D. Brace 03/16/12)
5157-009
Staff Services Analyst
Laura Fisher
5157-012
Office Technician (Typing)
Andraya Barnard
1139-010
Office Technician (Typing)
Tina Wilson
1139-012
Staff Services Analyst
(Retired Annuitant)
Joan Hawkins
5157-907
Staff Services Analyst
(Retired Annuitant)
Linda Pyle
5157-907
Staff Services Analyst
(Retired Annuitant)
Mary Countryman
5157-907

(7.0)
Supervising Investigator I
Nancy Butler
624-110-8596-004

Sacramento FO
Investigator
Karyn Dunn
8610-002
Investigator
Geno Davis
8610-010
Investigator
Adam Iremonger
8610-011
Investigator
VACANT
(CPEI/BCP)
(rcls frm 8594-021)
8610-012
Investigator
VACANT
(K. Dunn 10/31/09 rcls frm 8595-020)
8610-015
Inspector II
Shirley Boldrini
8833-007

(2.5)
Discipline Coordination Unit
Associate Governmental Program Analyst
Jocelyn Campos
5393-804
Associate Governmental Program Analyst
Adrienne Mueller
2 yr LT – exp 09/30/12
5393-600
Associate Governmental Program Analyst
Karen Fischer
(Incumbent is .5 serving 2 yr LT – exp 09/30/12)
5393-601 (.5)
Staff Services Analyst
(Retired Annuitant)
Anita Dowty
5157-907

(8.0)
Supervising Investigator I
Theresa Lane
624-110-8596-003

Orange FO
Investigator
Shannon Reza
(Incumbent is .5)
8610-003
Investigator
Stephen Nicas
8610-004
Investigator
Denise Macy
8610-005
Investigator
Kaycee Hunter
8610-007
Investigator
Carlos Alvarez
8610-013
Special Investigator
Vicki Furtek
8612-003
Office Technician (Typing)
Jimmy Zermeno
1139-001 (span)
Associate Governmental Program Analyst
(Retired Annuitant)
Joseph Lopez
5393-907

(7.0)
Supervising Investigator I
Vicki Williams
624-110-8596-005

Orange FO
Investigator
Russ Predmore
8610-001
Investigator
Monica Ackerson
8610-008 (span)
Investigator
VACANT
(V. Williams 06/10/11)
8610-009
Investigator
Patrick Morrissey
8610-014
Special Investigator
Bernice Santa Ana
8612-007
Inspector II
Dwaylon Calhoun
8833-002

DENTAL BOARD LEGEND

Executive Officer – 1
SSM III – 1
Supv Investigator II – 1
Dental Consultant – 2
Supv Investigator I –3
Staff Svs Mgr I – 4
Investigator - 14
Special Investigator – 4
Inspector II – 2
SISA – 1
AGPA – 13.3
SSA – 9
EA – 1
MST – 3
OT (T) – 7
OT (G) – 1
OA (T) – 2.5
OA (G) – 3
Retired Annuitant – 8

Black = Filled
Red = Vacant
Green = CPEI/BCP FY 10/11 (Included in 72.8)
Lt. Blue = Blanket/Temporary Position (Not included in 72.8)
Purple = Blanket 999/Permanent Position (Not included in 72.8)

_____ _____
Richard DeCuir, Executive Officer Date

_____ _____
Personnel Office Date

June 30, 2013

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL BOARD OF CALIFORNIA

Org Chart
FY 2012-2013
Authorized Positions 69.3

Filled: 63.8
Vacant: 5.5

Blanket: 5.5
Blanket 999: 2.0

OPERATIONS DIVISION

Executive Assistant
Linda Byers
624-110-1728-001

(3.0)
Executive Officer
Karen Fischer
624-110-8840-001

Staff Services Manager II (Managerial)
VACANT
(D. Johnson 12/08/12)
(rcls from 4802-001)
624-110-4969-001

ENFORCEMENT DIVISION

(4.0)
Supervising Investigator II
Kimberly Trefry
624-110-8597-003

Dental Consultant
Richard Liebig
624-110-7843-002
Dental Consultant
VACANT
(R. Liebig 12/25/12)
(CPEI/BCP)
7843-003

Office Technician (Typing)
Barbara de Helena
624-110-1139-805

ADMINISTRATION

(3.8)
Staff Information Systems Analyst
Joe Muncie
1312-001
Associate Governmental Program Analyst
Paula Fernandez
5393-008
Associate Governmental Program Analyst
Sarah Wallace
(incumbent is FT)
5393-801 (.8)
Associate Governmental Program Analyst
F. Genie Albertsen
5393-802

(10.5)
Staff Services Manager I
Dawn Dill
624-110-4800-002

Customer Service and Support Unit
Office Assistant (General)
Joshua Bennett
1441-005
Office Assistant (Typing)
Julie Parmley
1379-999

Licensing and Examination Unit
Associate Governmental Program Analyst
Jessica Olney
5393-803
Staff Services Analyst
Jeane Ward
5157-003
Staff Services Analyst
Jennifer Jackson
5157-004
Staff Services Analyst
Neloofar Forget
(Incumbent is .5)
5157-008 (.5)
Staff Services Analyst
Rosa Mata
(Incumbent in Orange FO)
5157-013
Staff Services Analyst
Eric Rivera
5157-017
Office Technician (Typing)
Isis Stanley
1139-007
Office Technician (Typing)
Jeff Pennington
(rcls frm 5157-016)
1139-018
Office Assistant (General)
Patrice Powe
1441-001
Office Technician (Typing)
Tara Yoshikawa
1139-999

(9.0)
Dental Assisting Program
Associate Governmental Program Analyst
Marla Rocha
210-5393-001
Associate Governmental Program Analyst
Sharon Langness
210-5393-800
Management Services Technician
Gordon Redoble
210-5278-003
Management Services Technician
Shalisa Stiger
210-5278-004
Management Services Technician
Tina Vallery
210-5278-005
Office Technician (Typing)
Jessica Cate
210-1139-004
Office Technician (General)
Joseph Crawford
210-1138-001
Office Assistant (Typing)
Dorothy Perez
210-1379-003
Office Assistant (General)
Kelly Raper
210-1441-001

ENFORCEMENT

(7.0)
Staff Services Manager I
April Alameda
624-110-4800-003

Investigative Analysis Unit
Special Investigator
Shannan Borton
8612-006
Special Investigator
Dawn Kammerer
8612-008
Associate Governmental Program Analyst
Bernal Vaba
5393-808
Associate Governmental Program Analyst
Sean Cogan
5393-809
Associate Governmental Program Analyst
Sheila Keechel
5393-810
Staff Services Analyst
A. Scott Vice
5157-015
Associate Governmental Program Analyst
(Retired Annuitant)
Dominique Bach
5393-907

(7.5)
Staff Services Manager I
Lori Reis
624-110-4800-001

Complaint and Compliance Unit
Associate Governmental Program Analyst
Oralia Moya
5393-007 **(span)**
Associate Governmental Program Analyst
Linda Garcia
5393-805
Associate Governmental Program Analyst
Wendy Schmidt
5393-806
Staff Services Analyst
Jacqueline Byrnes
(Incumbent is .5)
5157-001 (.5)
Staff Services Analyst
Laura Fisher
5157-012
Office Technician (Typing)
Andraya Barnard
1139-010
Office Technician (Typing)
Tina Wilson
1139-012
Staff Services Analyst (Retired Annuitant)
Joan Hawkins
5157-907
Staff Services Analyst (Retired Annuitant)
Linda Pyle
5157-907
Office Technician (Typing)
Lori Wallace
6 mo LT–exp.06/30/2013
1139-907
Office Technician (Typing)
VACANT
24 mo LT–exp.06/25/15
1139-907 (.5)

(7.0)
Supervising Investigator I
Nancy Butler
624-110-8596-004

Sacramento FO
Investigator
Karyn Dunn
8610-002
Investigator
Geno Davis
8610-010
Investigator
Adam Iremonger
8610-011
Investigator
Kelly Silva
(CPEI/BCP)
8610-012
Investigator
VACANT
(K. Dunn 10/31/09
rcls frm 8595-020)
8610-015
Inspector II
Shirley Boldrini
8833-007

(8.0)
Supervising Investigator I
Theresa Lane
624-110-8596-003

Orange FO
Investigator
Shannon Reza
(Incumbent is .5)
8610-003
Investigator
Stephen Nicas
8610-004
Investigator
Denise Macy
8610-005
Investigator
Kaycee Hunter
8610-007
Investigator
VACANT
(C. Alvarez 04/12/13)
8610-013
Special Investigator
Vicki Furtek
8612-003
Office Technician (Typing)
Jimmy Zermeno
1139-001 **(span)**

(7.0)
Supervising Investigator I
Vicki Williams
624-110-8596-005

Orange FO
Investigator
Russ Predmore
8610-001
Investigator
Monica Ackerson
8610-008 **(span)**
Investigator
VACANT
(V. Williams 06/10/11)
8610-009
Investigator
Patrick Morrissey
8610-014
Special Investigator
Bernice Santa Ana
8612-007
Inspector II
Dwaylon Calhoun
8833-002

(2.5)
Discipline Coordination Unit
Associate Governmental Program Analyst
VACANT
(K. Fischer 12/05/12)
5393-009 (.5)
Associate Governmental Program Analyst
Jocelyn Campos
5393-804
Associate Governmental Program Analyst
Adrienne Mueller
5393-813 **(span)**
Staff Services Analyst (Retired Annuitant)
Anita Dowty
5157-907

DENTAL BOARD LEGEND

Executive Officer – 1
SSM II – 1
Supv Investigator II – 1
Dental Consultant – 2
Supv Investigator I –3
Staff Svs Mgr I – 3
Investigator - 14
Special Investigator – 4
Inspector II – 2
SISA – 1
AGPA – 14.3
SSA – 7
EA – 1
MST – 3
OT (T) – 7 + 1.5 Blkt + 1 Blkt 999
OT (G) – 1
OA (T) – 1 + 1 Blkt 999
OA (G) – 3
Retired Annuitant – 4

Black = **Filled**
Red = **Vacant**
Green = **CPEI/BCP FY 10/11 (Included in 69.3)**
Lt. Blue = **Blanket/Temporary Position (Not included in 69.3)**
Purple = **Blanket 999/Permanent Position (Not included in 69.3)**

Karen Fischer, Executive Officer _____ Date _____

Personnel Office _____ Date _____

June 30, 2014

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL BOARD OF CALIFORNIA

Org Chart
FY 2013-2014
Authorized Positions 69.3

Filled:	61.3
Vacant:	8.0
Blanket:	7.0
Blanket 999:	2.0

OPERATIONS DIVISION

Executive Assistant
Linda Byers
624-110-1728-001

(3.0)
Executive Officer
Karen Fischer
624-110-8840-001

Associate Governmental Program Analyst
(Retired Annuitant)
Denise Johnson
624-110-5393-907

Staff Services Manager II (Managerial)
Sarah Wallace
624-110-4969-001

ENFORCEMENT DIVISION

(4.0)
Supervising Investigator II
Kimberly Trefry
624-110-8597-003

Dental Consultant
VACANT
(R. Liebig 04/30/14)
624-110-7843-002
Dental Consultant
Richard Liebig
(CPEI/BCP)
7843-003

Office Technician (Typing)
Barbara de Helena
624-110-1139-805

ADMINISTRATION

(3.8)
Associate Information Systems Analyst
Nasir Samad
1470-001
Associate Governmental Program Analyst
Paula Fernandez
5393-008
Associate Governmental Program Analyst
Michael Placencia
(incumbent is FT)
5393-801 (.8)
Associate Governmental Program Analyst
Sharon Langness
5393-802

LICENSING & EXAMINATION

(10.5)
Staff Services Manager I
Dawn Dill
624-110-4800-002

Customer Service and Support Unit
Office Assistant (General)
VACANT
(J. Bennett 04/30/14)
1441-005
Office Assistant (Typing)
Julie Parmley
1379-999

Licensing and Examination Unit
Associate Governmental Program Analyst
Jessica Olney
5393-803
Staff Services Analyst
VACANT
(D.J. Ward 03/31/14)
5157-003
Staff Services Analyst
Jennifer Jackson
5157-004
Staff Services Analyst
Neloofar Forget
(Incumbent is .5)
5157-008 (.5)
Staff Services Analyst
Rosa Mata
(Incumbent in Orange FO)
5157-013
Staff Services Analyst
VACANT
(A. Colangelo 05/06/14)
5157-017
Office Technician (Typing)
Isis Stanley
1139-007
Office Technician (Typing)
Jeff Pennington
1139-018
Program Technician
Leslie Kihara
9927-001
Program Technician II
Joshua Bennett
9928-999

(9.0)
Dental Assisting Program
Associate Governmental Program Analyst
VACANT
(M. Rocha 04/30/14)
210-5393-001
Associate Governmental Program Analyst
Marla Rocha
210-5393-800
Management Services Technician
Gordon Redoble
210-5278-003
Management Services Technician
Shalisa Stiger
210-5278-004
Management Services Technician
Tina Vallery
210-5278-005
Office Technician (Typing)
Jessica Cate
210-1139-004
Office Technician (General)
Joseph Crawford
210-1138-001
Office Assistant (Typing)
Dorothy Perez
210-1379-003
Office Assistant (General)
Jessica Lopez
210-1441-xxx
Management Services Technician
Ashlee Hedgecock
(24 mo LT–exp.12/31/15)
210-5278-907

ENFORCEMENT

(7.0)
Staff Services Manager I
April Alameda
624-110-4800-003

Investigative Analysis Unit
Special Investigator
Shannan Borton
8612-006
Special Investigator
Dawn Kammerer
8612-008
Associate Governmental Program Analyst
Bernal Vaba
5393-808
Associate Governmental Program Analyst
VACANT
(S. Cogan 05/30/14)
5393-809
Associate Governmental Program Analyst
Sheila Keechel
5393-810
Staff Services Analyst
A. Scott Vice
5157-015
Associate Governmental Program Analyst
(Retired Annuitant)
Dominique Bach
5393-907
Associate Governmental Program Analyst
(Retired Annuitant)
Kathleen Bazil
5393-907

(7.5)
Staff Services Manager I
Lori Reis
624-110-4800-001

Complaint and Compliance Unit
Associate Governmental Program Analyst
Oralia Moya
5393-007 **(span)**
Associate Governmental Program Analyst
Linda Garcia
5393-805
Associate Governmental Program Analyst
F. Genie Albertsen
5393-806
Staff Services Analyst
Jacqueline Byrnes
(Incumbent is .5)
5157-001 (.5)
Staff Services Analyst
Laura Fisher
5157-012
Office Technician (Typing)
Robin Matson
1139-010
Office Technician (Typing)
Tina Wilson (.5)
Lori Wallace (.5)
1139-012
Staff Services Analyst (Retired Annuitant)
Joan Hawkins
5157-907
Staff Services Analyst (Retired Annuitant)
Linda Pyle
5157-907

(7.0)
Supervising Investigator I
Nancy Butler
624-110-8596-004

Sacramento FO
Investigator
VACANT
(K. Dunn 01/03/14)
8610-002
Investigator
Ryan Blonien
8610-010
Investigator
Adam Iremonger
8610-011
Investigator
Kelly Silva
(CPEI/BCP)
8610-012
Investigator
VACANT
(K. Dunn 10/31/09 rcls frm 8595-020)
8610-015
Inspector I
D. Mike Morshed
8834-001

(8.0)
Supervising Investigator I
Theresa Lane
624-110-8596-003

Orange FO
Investigator
Shannon Reza
(Incumbent is .5)
8610-003
Investigator
Stephen Nicas
8610-004
Investigator
Denise Macy
8610-005
Investigator
Kaycee Hunter
8610-007
Investigator
Carlos Alvarez
8610-013
Special Investigator
Vicki Furtek
8612-003
Office Technician (Typing)
Jimmy Zermeno
1139-001 **(span)**

(7.0)
Supervising Investigator I
Vicki Williams
624-110-8596-005

Orange FO
Investigator
Russ Predmore
8610-001
Investigator
Monica Ackerson
8610-008 **(span)**
Investigator
Fernando Espinoza
8610-009
Investigator
Patrick Morrissey
8610-014
Special Investigator
Bernice Santa Ana
8612-007
Inspector II
Dwaylon Calhoun
8833-002

(2.5)
Discipline Coordination Unit
Associate Governmental Program Analyst
Joan Robbins
5393-009 (.5)
Associate Governmental Program Analyst
Jocelyn Campos
5393-804
Associate Governmental Program Analyst
Adrienne Mueller
5393-813 **(span)**
Staff Services Analyst (Retired Annuitant)
Anita Dowty
5157-907

DENTAL BOARD LEGEND

Executive Officer – 1
SSM II – 1
Supv Investigator II – 1
Dental Consultant – 2
Supv Investigator I –3
Staff Svs Mgr I – 3
Investigator - 14
Special Investigator – 4
Inspector I – 1
Inspector II – 1
AISA – 1
AGPA – 14.3
SSA – 7
EA – 1
MST – 3 + 1 Blkt
PT – 1
PT II – 1 Blkt 999
OT (T) – 7
OT (G) – 1
OA (T) – 1 + 1 Blkt 999
OA (G) – 2
Retired Annuitant – 6

Black = Filled
Red = Vacant
Green = CPEI/BCP FY 10/11 (Included in 69.3)
Lt. Blue = Blanket/Temporary Position (Not included in 69.3)
Purple = Blanket 999/Permanent Position (Not included in 69.3)

_____ _____
Karen Fischer, Executive Officer Date

_____ _____
Personnel Office Date

Section 13
Board Specific Issues

DIVERSION

Discuss the Dental Board's diversion program, the extent to which it is used, the outcomes of those who participate, the overall costs of the program compared with its successes.

Diversion Evaluation Committee (DEC)

1. DCA contracts with a vendor to perform probation monitoring services for licensees with substance abuse problems, why does the Dental Board use DEC? What is the value of a DEC?

Legislation in 1982 mandated the Dental Board of California (Board) to seek ways and means to identify and rehabilitate licensees whose competency may be impaired due to abuse of dangerous drugs or alcohol. Given the authority to establish one or more committees to carry out this mandate, the Board established two (2) such committees, one each in Southern and Northern California.

Following the guidelines established by the Board, each DEC has the authority to evaluate program participant eligibility. All decisions regarding program participants are made by the DEC in consultation with the Contractor (currently MAXIMUS, Inc.) and the Diversion Program Manager (DPM). All decisions made by the DEC are final.

Responsibilities of the DEC members include, but are not limited to the following:

- Attend all DEC meetings as scheduled.
- Interview and evaluate licensees requesting admission to the program~~,~~ to determine their eligibility to participate.
- Review information regarding program participants.
- Consider recommendations made by the DPM and any consultant to the Committee.
- Determine when a participant is a risk to the public and if/when a licensee may safely continue, or resume the practice of dentistry.
- Establish supervision and surveillance of program participants by developing formal treatment and rehabilitation contracts.
- Assess participant progress and amend contracts accordingly.
- Determine when participants are to be terminated from the program for reasons other than successful completion.
- Other related duties at the direction of the board or program manager, as the Board may establish by regulation.

2. What is the membership/makeup composition?

Board regulations have established that each committee is to consist of six members: three (3) licensed dentists, one (1) licensed dental auxiliary, one (1) public member and

one (1) licensed physician or psychologist. All must be experienced or knowledgeable in chemical dependency either through education, training, experience or personal recovery.

3. Did the Dental Board have any difficulties with scheduling DEC meetings? If so, describe why and how the difficulties were addressed.

There were no scheduling issues during the previous four fiscal years. To avoid any potential conflicts, aAll meeting dates are initially selected by MAXIMUS, Inc., and then submitted to the DPM and the committee members for approval.~~to avoid conflicts~~. With mutual acceptance, meetings are prescheduled one (1) year in advance. This allows committee members, the DPM and participants sufficient time to calendar the date(s). Early scheduling provides the best opportunity to secure a state-rate for out-of-town meetings, which benefits the Board.

4. Does the DEC comply with the Open Meetings Act?

Yes, the DPM prepares an agenda, publicly notices each meeting at least ten (10) calendar days before the meeting and sends the agenda via USPS to all interested parties. Meeting notices and the agenda are also noticed via the Board's website. An open session is always scheduled at the beginning of each meeting to allow public comment.

5. How many meetings held in each of the last three fiscal years?

Meetings are scheduled on a quarterly basis; the Southern DEC meets in Los Angeles and the Northern DEC in Sacramento.

DEC Meetings	FY 11-12	FY 12-13	FY 13-14
N DEC -Sacramento	4	4	4
S DEC – Los Angeles	4	4	4

6. Who appoints the members?

The DPM initiates the recruitment process for an applicant or applicants when vacancies occur on either Committee, by putting a notice on the home page of the Board's website. Applicants are scheduled for a face-to-face interview with the Committee having ~~with~~ the vacancy, and after the initial screening by the Committee and the DPM, a recommendation is presented to the Board's Diversion Liaison for consideration. The Liaison conducts a telephone interview and if he/she concurs with the recommendation, the recommended appointment is presented to the Board for final consideration and action.

7. How many cases (average) at each meeting?

There are on average, twelve (12) to fourteen (14) participants at each meeting.

8. How many pending? Are there backlogs?

There is no backlog. Participants are usually seen for the first time within the first three to four months of acceptance into the program, and then are seen again based on the frequency determined by the Committee.

9. What is the cost per meeting? Annual Cost?

The cost for the meeting location and any travel/lodging expense incurred by the Contractor is borne by the Contractor. The Board reimburses only the DEC members and ~~the~~ DPM for meals, incidentals, and travel/lodging expenses. Reimbursement is for actual costs up to the maximum reimbursement allowed while on travel status.

Currently, the Department of Consumer Affairs (DCA) is in a contract with MAXIMUS, Inc. on behalf of the participating DCA boards/bureaus. The Dental Board is billed monthly by ~~the~~ MAXIMUS based upon the number of participants in the program, less the cost to the participants which is paid directly to MAXIMUS.

10. How is DEC used? What types of cases are seen by the DECs?

A licensee may contact the Diversion Program as a self-referral, a Board referral as the result of an investigation, or as a Board probation referral. DEC members are responsible for reviewing the history and profiles of all potential participants for consideration into the program and determining if they are eligible to participate in the program, or if they do not meet the criteria. Upon acceptance into the program, DEC members are responsible for developing individual treatment plans that provide both structured support during a participant's recovery and strict monitoring to ensure California dental consumers are not at risk from impaired licensees. Careful consideration is given in designing a plan that not only includes the appropriate means of rehabilitation, but also considers the participant's ability to pay for such treatment. For example, in cases when a participant is so toxic that he/she presents a risk to self or to the public, suspension from work with outpatient treatment and other structured support may be the treatment plan, as opposed to suspension with more costly in-patient treatment.

Upon entering the program, each new participant is assigned a DEC Case Consultant. The case consultant is a DEC member who is responsible for closely following the recovery progress of each of his/her assigned participants. The consultant is responsible for leading the DEC interview when his/her assigned participants appear before the full committee.

Each participant must attend DEC meetings where face to face interviews are held to monitor a participant's appearance and conduct. During the meetings, DEC members will also consider participant requests for contract changes. Some examples include requests to: reduce or exchange health support group/AA/NA meetings, schedule vacation trips, increase work hours, change work site monitor(s). DEC members might also increase or

decrease body fluid testing times and order back-to-back and/or additional weekend tests as deemed necessary, suspend from practice, or mandate inpatient treatment.

Decisions to terminate a participant from the program are also made by the DEC. The committee shall determine, based upon the recommendation of both the DPM and the assigned case consultant, whether to terminate participation in the program. Termination can be for any of the following reasons:

- Licensee failed to comply with the treatment program designated by the committee
- Licensee tested positive on more than one occasion and failed to derive benefit, and the DEC determines the public to be at risk. The DEC terminates the participant from the program and refers the licensee back to the Board for formal discipline.

Successful completion of the program is granted by the DEC if the participant has demonstrated the following:

- The ability to refrain from the use of alcohol and drugs
- A sound understanding of addiction
- A commitment to recovery
- An acceptable relapse prevention plan, and
- A transition period of at least one year (the last year of the five year program in which the participant can choose to reduce the amount of health support group and AA/NA meetings they attend~~)~~. This is the time during transition that the participant proves to the DEC that they are in full recovery.
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DIVERSION	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
New Participants total	9	13	11	12
Self-Referral	*1*	3	2	4
Informal/Investigative	*2*	6	4	5
Probation	6	4	5	3
Successful Completions	6	6	8	4
Participants (close of FY)	52	53	48	46
Terminations for Public Threat	1	4	1	1
Non-compliance Terminations	2	0	1	0
Drug Tests Ordered	1359	1320	1247	1097
Positive Drug Tests	12	39	27	14

11. How many DEC recommendations have been rejected by the Dental Board in the past four fiscal years (broken down by year)?

As stated previously, all decisions regarding *program participants* are made by the DEC in consultation with the Contractor and the DPM, and all such decisions are final.

In at least the past four fiscal years, there has not been ~~even~~ one occasion when the Board rejected a recommendation from the Committee regarding the appointment of a new Committee member.