FULL BOARD MEETING
November 21, 2013

Sportsmen's Lodge Events Center
Regency Room
4234 Coldwater Canyon Avenue
Studio City, CA 91604

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
P (916) 263-2300 F (916) 263-2140 | www.dbc.ca.gov

BOARD MEETING AGENDA
November 21, 2013

Sportsmen's Lodge Events Center
Regency Room
4234 Coldwater Canyon Avenue
Studio City, CA 91604
(916) 263-2300 (Board Office)

Members of the Board

Huong Le, DDS, MA, President
Fran Burton, Public Member, Vice President
Steven Morrow, DDS, MS, Secretary

Steven Afriat, Public Member
Stephen Casagrande, DDS
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Luis Dominicis, DDS
Judith Forsythe, RDA
Kathleen King, Public Member
Ross Lai, DDS
Meredith McKenzie, Public Member
Thomas Stewart, DDS
Bruce Whitcher, DDS

During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should items not be completed, it is possible that it could be carried over and be heard beginning at 9:00 a.m. on the following day. Anyone wishing to be present when the Board takes action on any item on this agenda must be prepared to attend the two-day meeting in its entirety.

Public comments will be taken on agenda items at the time the specific item is raised. The Board may take action on any item listed on the agenda, unless listed as informational only. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. Time limitations for discussion and comment will be determined by the President. For verification of the meeting, call (916) 263-2300 or access the Board's website at www.dbc.ca.gov. This Board meeting is open to the public and is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Karen M. Fischer, Executive Officer, at 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five business days before the meeting will help to ensure availability of the requested accommodation.

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

Thursday, November 21, 2013

9:00 A.M. MEETING OF THE DENTAL ASSISTING COUNCIL
See attached Dental Assisting Council Meeting Agenda

1:00 P.M. FULL BOARD MEETING – OPEN SESSION

1. Call to Order/Roll Call/Establishment of Quorum

2. Approval of the August 26-27, 2013 Board Meeting Minutes and the October 9, 2013 Teleconference Minutes

3. President's Report

4. Update from the Department of Consumer Affairs' Executive Office

5. Update from the Dental Hygiene Committee of California (DHCC) and an Overview of the Sunset Review Report Submitted to the Legislature November 1, 2013

6. Examinations

    A. Presentation by Dr. Charles Broadbent, Director of Dental Exam Development for the Western Regional Examination Board (WREB)

    B. Discussion and Possible Action on Report Regarding Portfolio Examination Development

        i. Portfolio Examination Audit Handbook

        ii. Portfolio Examiner Calibration/Standardization Training Material

7. Enforcement

    A. Enforcement Program Status

    B. Enforcement Program Statistics

    C. Review of Department of Consumer Affairs Fiscal Year 2013/14 First Quarter Performance Measures

    D. Report on Medical Board of California's Prescribing Task Force

8. Licensing, Certification, and Permits

    A. Review of Dental Licensure and Permit Statistics

    B. Review of General Anesthesia/Conscious Sedation Evaluation Statistics

    C. Update on General Anesthesia/Conscious Sedation Calibration Webinar

D. Capnograph Requirements - Informational Item Only - Report Regarding the Requirement for the Use of Capnography During Sedation and General Anesthesia as it Relates to:

   i. The American Association of Oral and Maxillofacial Surgeons' (AAOMS) Requirements, Effective January 1, 2014; and,

   ii. The Dental Board of California's Requirement (California Code of Regulations, Title 16, Section 1043.3(a)(7)(K))

9. Public Comment of Items Not on the Agenda
   The Board may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

CLOSED SESSION – FULL BOARD
Executive Officer Performance Evaluation
The Board will meet in closed session as authorized by Government Code Section 11126(a)(1).

10. Recess

DENTAL BOARD OF CALIFORNIA
MEETING MINUTES
Monday, August 26, 2013

Department of Consumer Affairs
Hearing Room, HQ2
1747 North Market Blvd., Sacramento, CA, 95834
DRAFT

Members Present
Huong Le, DDS, President
Fran Burton, Public Member, Vice President
Steven Morrow, DDS, MS, Secretary
Steven Afriat, Public Member
Stephen Casagrande, DDS
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Luis Dominicis, DDS
Judith Forsythe, RDA
Kathleen King, Public Member
Ross Lai, DDS
Meredith McKenzie, Public Member
Thomas Stewart, DDS
Bruce Whitcher, DDS

Members Absent
Meredith McKenzie

Staff Present
Karen Fischer, Executive Officer
Jennifer Thornburg, Assistant Executive Officer
Kim Trefry, Enforcement Chief
Dawn Dill, Licensing Manager
Sarah Wallace, Legislative and Regulatory Analyst
Linda Byers, Executive Assistant
Jessica Olney, Licensing Analyst
Spencer Walker, DCA Senior Staff Counsel

Monday, August 26, 2013

1. **Call to Order/Roll Call/Establishment of Quorum**
   Dr. Huong Le, President, called the meeting to order at 1:34 p.m. Dr. Steven Morrow, Secretary, called the roll and a quorum was established.

2. **Approval of the May 16-17, 2013 Board Meeting Minutes**
   Lisa Okamoto, CDHA Government Relations Council Co-Chair, asked that the minutes on page 3 of 4, May 16, 2013, be amended to reflect her correct title.

Motion/ Seconded/Carried (M/S/C) (Afriat/Morrow) to approve the May 16-17, 2013 Dental Board meeting minutes as amended. The motion passed unanimously.

3. **Introduction of New Assistant Executive Officer**
Karen Fischer, Executive Officer, introduced and gave a brief biography of the Dental Board's new Assistant Executive Officer, Jennifer A. Thornburg.

4. **President's Report**
Dr. Huong Le, President reported on the meeting with the Dean from the Universidad De La Salle. She stated that the subcommittee will review the submissions from the Dean and report its findings at the November Board meeting.

Dr. Le reported that she was very proud of the Dental Board staff and their booth at the California Dental Association (CDA) Cares event in San Francisco earlier this month.

5. **Update from the Department of Consumer Affairs' Executive Office**
Christine Lally, Board and Bureau Relations Deputy Director, reported on the Department of Consumer Affairs (DCA) focus on improving communications and resource sharing. She gave an overview of the department's information technology project, BreEZe, and the new timelines for implementation.

6. **Examinations**

A. **Report Regarding the Western Regional Examination Board (WREB) Activities**
Dr. Whitcher gave an overview of the report that was provided. There was discussion surrounding WREB statistics.

B. **Portfolio Examination**

i. **Staff Update on Portfolio Examination Development**
Dr. Casagrande introduced staff and legal counsel who have worked so hard on preparing the regulations needed to implement Portfolio. He reviewed what the Portfolio Examination entails. Dr. Morrow recognized Dr. Roberta Chinn, who has worked on Portfolio since it's inception. There was discussion, questions and answers regarding Portfolio.

ii. **Discussion and Possible Action to Consider Initiation of a Rulemaking Relative to Portfolio Examination Requirements**
Dawn Dill, Licensing Manager, reviewed the written regulatory language provided. Questions were asked and answered. M/S/C (Morrow/Afriat) to accept the proposed revised regulatory language relevant to portfolio examination requirements, and direct staff to take all steps necessary to initiate the formal rulemaking process, including noticing the proposed language for 45-day public comment, setting the proposed language for a public hearing, and authorizing the Executive Officer to make any non-substantive changes to the

rulemaking package, if after the close of the 45-day public comment period and public regulatory hearing, no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and (1) adopt the proposed amendments to California Code of Regulations, Title 16, Sections 1021, 1028, 1028.4, 1028.5, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035; (2) adopt the proposed additions of California Code of Regulations, Title 16, Sections 1032.7, 1032.8, 1032.9, 1032.10, 1032.11; and (3) adopt the proposed repeal of California Code of Regulations, Title 16, Sections 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039; as noticed in the proposed text.

Ladonna Drury Klein, California Association of Dental Assisting Teachers (CADAT), proposed some changes which Spencer Walker, Legal Counsel stated were non-substantive and could be made later by the Executive Officer. There was no further public comment. The motion passed with one abstention.

7. **Legislation and Regulations**

A. 2013 Tentative Legislative Calendar – Information Only
Sarah Wallace, Legislative and Regulatory Analyst, reviewed the calendars provided.

B. Discussion and Possible Action on the Following Legislation:

- **AB 496 (Gordon) Medicine: Sexual Orientation: Gender Identity**
  Sarah Wallace, Legislative and Regulatory Analyst gave an overview of this bill. M/S/C (King/Afriat) to support this bill and send a letter of support to the author.

  There was discussion surrounding the board's position on this bill. Bill Lewis, CDA, explained the task force and the program differences. The motion passed unanimously.

- **AB 512 (Rendon) Healing Arts: Licensure Exemption**
  Ms. Wallace reported that this bill has been chaptered and that the Dental Board has regulations in place. This bill will allow the Board to continue authorizing out-of-state licensed dentists (DDS) to participate in sponsored free health care events until January 1, 2018.

- **AB 836 (Skinner) Dentists: Continuing Education**
  Ms. Wallace reported that the Board took a "support" position at its May meeting and a letter of support was sent to the author.

- **<u>AB 1231 (Perez) Regional Centers: Telehealth and Teledentistry</u>**
  Ms. Wallace reported that this bill was referred to the suspense file. Bill Lewis, CDA, commented that CDA has taken a "support if amended" position. He stated that the consumers of these telehealth and teledentistry services are regional centers, not the public in general. M/S/C (Burton/Dominicis) to continue to watch this bill. There was no further public comment. The motion passed with one abstention.

- **<u>SB 562 (Galgiani) Dentists: Mobile or Portable Dental Units</u>**
  Ms. Wallace gave a summary of the bill. Bill Lewis, CDA, the sponsor of the bill, explained the difference between a mobile dental clinic and a mobile dental unit. Dr. Paul Reggiardo, Public Policy Advocate for the California Society of Pediatric Dentistry (CSPD), commented that CSPD has registered their support of this bill. There was discussion about possible amendments needed in order to support the bill. M/S/C (Casagrande/Dominicis) to support if amended to address the Board's following concerns:

  (1) The June 18th amended version of the bill deleted the provision that specifies that a licensed dentist may operate mobile or portable dental units. The Board respectfully requests clarifying language be added to the bill to specify who may own and operate mobile and portable dental units; this would provide the Board with clear understanding and authority when it promulgates regulations to implement the provisions of this bill.

  (2) The Board supports, in concept, that the registration requirements pertaining to portable dental units should be required for those who regularly operate portable dental units in the practice of dentistry. An amendment to the bill that provides for this concept would provide the Board with the authority to specify registration requirements for portable dental units used on a regular basis when it promulgates regulations to implement the provisions of this bill.

  The motion passed unanimously.

- **<u>SB 821 (Senate BP & ED) Healing Arts</u>**
  Ms. Wallace reported that the provisions in this bill, relating to the Board would change any reference to the Board of Dental Examiners to the Dental Board of California. The Board took a "neutral" position on this bill at its May 2013 meeting and sent a letter of thanks to the author. There was no further action on this bill.

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C. Discussion and Possible Action to Consider Request from the Dental Hygiene Committee of California to Consider Review of Requirement for Annual Review of Infection Control Guidelines

Sarah Wallace, Legislative and Regulatory Analyst, reported that at the May 2013 Dental Board of California (Board) meeting, Michelle Hurlbutt, RDH, President of the Dental Hygiene Committee of California (Committee), reported that the Committee would like to collaborate with the Board in discussing the possibility of amending Business and Professions Code (Code) Section 1680(ad) to require review of the minimum standards for infection control (California Code of Regulations, Title 16, Section 1005 (Section 1005)) on a biennial basis rather than annually.

M/S/C (Casagrande/Afriat) that moving forward, the Board would make a decision, in collaboration with the Dental Hygiene Committee of California, on an annual basis if a review of Section 1005 is warranted. If the Board and Committee make such a determination, the subcommittee would then be directed to conduct the review of Section 1005. There was discussion surrounding the composition of the subcommittee that was appointed by the Board and the Committee. The motion passed unanimously.

D. Discussion of Prospective Legislative Proposals
Stakeholders are encouraged to submit proposals in writing to the Board before or during the meeting for possible consideration by the Board at a future meeting.

Dr. Whitcher submitted a proposal regarding changes to update Business and Professions Code Sections 1647.10-1647.17 for consistency with "American Dental Association Guidelines for Use of Sedation and General Anesthesia by Dentists" for consideration at a future meeting.

E. Update on Pending Regulatory Packages:

Ms. Wallace gave an update on Uniform Standards for Substance Abusing Licensees, Dentistry Fee Increase and Abandonment of Applications.

F. Discussion and Possible Action Regarding a Special Meeting in October to Consider Any Adverse Comments Received Regarding the Board's Proposed Dentistry Fee Increase Rulemaking

Ms. Wallace reported that in the event the Board receives adverse comments in response to the proposed language, and in an effort to keep the rulemaking moving expeditiously, the Board would need to hold a special teleconference meeting in October to consider and respond to adverse comments. Although no adverse comments have been received to date, staff recommends setting a date for a special teleconference meeting with the expectation that adverse comments will be received. This will allow Board members, staff, and stakeholders adequate time make preparations for attending a special teleconference meeting. There was discussion surrounding the proposed dates. The majority chose Wednesday, October 9, 2013 at noon for the special meeting.

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G. Discussion and Possible Action Regarding the Health and Safety Institute's Request to Amend California Code of Regulations, Title 16, Sections 1016 and 1017 such that a Basic Life Support Certification Issued by the American Safety and Health Institute Would Satisfy the Mandatory Certification Requirement for License Renewal

Ms. Wallace gave an overview of the request by the American Safety and Health Institute (ASHI). Joe Rose, ASHI attorney, and Steve Barnett, Vice President, Brand Management – Emergency Care for ASHI, gave an overview of the ASHI programs and their benefits.

M/S/C (Burton/Afriat) to accept staff's recommendation that the petition to amend California Code of Regulations, Title 16, Sections 1016 and 1017 be considered when the Board establishes its rulemaking priorities. Once prioritized, staff recommends a final review of the ASHI, American Red Cross, and American Heart Association certification requirements for Basic Life Support courses prior to promulgation of a proposed rulemaking in the interest of consumer protection.

8. **Public Comment of Items Not on the Agenda**

There was no further public comment.

9. **Recess**

The meeting recessed at 5:15 p.m. to resume at 9:00 a.m. on Tuesday, August 27, 2013.

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DENTAL BOARD OF CALIFORNIA
MEETING MINUTES
Tuesday, August 27, 2013

Department of Consumer Affairs
Hearing Room, HQ2
1747 North Market Blvd., Sacramento, CA, 95834
DRAFT

Members Present
Huong Le, DDS, President
Fran Burton, Public Member, Vice President
Steven Morrow, DDS, MS, Secretary
Steven Afriat, Public Member
Stephen Casagrande, DDS
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDH
Luis Dominicis, DDS
Judith Forsythe, RDA
Kathleen King, Public Member
Ross Lai, DDS
Meredith McKenzie, Public Member
Thomas Stewart, DDS
Bruce Whitcher, DDS

Members Absent
Meredith McKenzie

Staff Present
Karen Fischer, Executive Officer
Jennifer Thornburg, Assistant Executive Officer
Kim Trefry, Enforcement Chief
Lori Reis, Complaint and Compliance Unit Manager
Dawn Dill, Licensing Manager
Nancy Butler, Supervising Investigator I
Karyn Dunn, Investigator
Sarah Wallace, Legislative and Regulatory Analyst
Linda Byers, Executive Assistant
Jocelyn Campos, Discipline Coordinator
Adrienne Mueller, Discipline Coordinator
Genie Albertsen, Budget Analyst
Spencer Walker, DCA Senior Staff Counsel
Greg Salute, Deputy Attorney General

Tuesday, August 27, 2013

10. **Call to Order/Roll Call/Establishment of Quorum**
Dr. Huong Le, President, called the meeting to order at 9:11 a.m. Dr. Steven Morrow, Secretary, called the roll and established a quorum.

The full Board immediately went into Closed Session to deliberate and take action on disciplinary matters and receive advice from counsel on litigation.

The Licensing, Certification, and Permits Committee met in closed Session to deliberate the issuance of new license(s) to replace cancelled license(s).

The full board returned to open session at 12:27 p.m.

11. **Report from the Licensing, Certification and Permits Committee Regarding Closed Session**
Dr. Whitcher, Chair, reported that after review of the materials provided, the Licensing, Certification and Permits Committee recommends that the Board grant issuance of a new license to replace the cancelled license of applicant CLB.

Motioned/Seconded/Carried (M/S/C) (Afriat/Dominicis) to accept the recommendation of the Licensing, Certification and Permits Committee to grant a new license to replace the canceled license of applicant CLB. The motion passed unanimously.

12. **Executive Officer's Report**
Karen Fischer, Executive Officer, introduced the new Assistant Executive Officer, Jennifer Thornburg. She reported that the Board is currently recruiting a Dental Consultant position. She thanked Greg Salute and Teri Lane for their continued outreach efforts to the dental schools. She thanked staff for their participation at the California Dental Association (CDA) Presents event. She reported that the Dental Board was chosen by the Department of Consumer Affairs to participate in a pilot project to create Performance Based Budgets. Additionally, she is participating on a task force for Form 700 – Statement of Economic Interest. She attended the Access to Care Town Hall meeting in Oakland at Dr. Le's clinic where she reported it was like a United Nations meeting with all the languages and translators. She reported that the Dental Board is due to receive $2.7 million this year, the last installment for repayment of the loan the Dental Board made to the General Fund.

13. **Budget Report**
Taylor Schick from the Department of Consumer Affairs (DCA) Budget Office gave an overview and summary of last year's budget. He noted that the Board is expected to receive an increase of $415,000 for its 2013/14 budget to cover the costs incurred to implement new programs such as Cures, Fi$cal and BreEZe. He reported that our regulations to increase license fees has been filed and is expected to be implemented by July 1, 2014. The Board will be reviewing a

proposal in November to raise the statutory cap on all fees. Kathleen King asked for a report on the percentage of costs being recovered from disciplinary actions.

14. **Update from the Dental Hygiene Committee of California (DHCC)**
Michelle Hurlbutt, president of DHCC, reported that their Disciplinary Guidelines have been sent to DCA for approval. They are due for their Sunset Review this November. They have the first phase of a large, three phase regulatory package going out in September. They are pleased with the collaboration with the Dental Board.

15. **Discussion and Possible Action to Extend the Board's Strategic Plan to a Four or Five Year Plan**
Karen Fischer gave an overview of the Strategic Plan and the reasons for requesting to extend the plan to a four year plan.

M/S/C (Morrow/Dominicis) to readopt the Dental Board of California's Strategic Plan as a four year plan which will extend through 2016 and the Board's next legislative review. The motion passed unanimously.

16. **Discussion and Possible Action Regarding 2014 Board Meeting Dates**
Linda Byers, Executive Assistant, gave an overview of the dates proposed for the 2014 Dental Board meetings. There was discussion surrounding different meeting locations. The majority of the Board members agreed to the following dates:

February 27-28, 2014	May 29-30, 2014
August 25-26, 2014	November 6-7, 2014

17. **Discussion and Possible Action Regarding Updating and Revising the Board Member Administrative Procedure Manual**
Linda Byers, Executive Assistant, gave an overview of the Board Member Administrative Procedure Manual and asked that the Board members submit revisions and/or comments to her by the end of September for presentation and adoption by the Board at the November 2013 meeting.

18. **Update on Universidad De La Salle, Bajio**
Dr. Dominicis recused himself and left the room. Karen Fischer gave an update on the University De La Salle and reviewed the information provided. She reported that De La Salle's Dean came to Sacramento to meet with her and they successfully resolved this important issue.

19. **Report from the Dental Assisting Council**
Judith Forsythe, Chair, reported on the previous day's Dental Assisting Council (Council) meeting. The Council requested that the Board consider making Dental Assisting Educational Programs and Courses one of its top regulatory priorities for the 2013/14 fiscal year.

M/S/C (Casagrande/Afriat) to accept the Council report. The motion passed unanimously.

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20. **Discussion and Possible Action Regarding Fiscal Year 2013/14 Regulatory Priorities**
Sarah Wallace, Legislative and Regulatory Analyst, gave an overview of the previous year's regulatory priorities and their progress. There was discussion about priorities for public safety.

M/S/C (Whitcher/Forsythe) that Dental Assisting Educational Programs and Courses be considered the number one regulatory priority for fiscal year 2013/2014 and Licensure by Credential Application requirements be considered the number two regulatory priority. The motion passed unanimously.

21. **Enforcement**

A. Enforcement Program Status
Kim Trefry, Enforcement Chief, gave an overview of the Enforcement Program.

B. Enforcement Program Statistics
Kim Trefry reviewed the statistics provided. There was discussion about the delays in getting hearing dates at the Office of Administrative Hearings.

C. Review of Department of Consumer Affairs Fiscal Year 2012/13 Fourth Quarter Performance Measures
Ms. Trefry reviewed the performance measures. Dr. Whitcher suggested a review of the target dates with revisions and justifications before the next Sunset Review.

D. Impact of Senate Bill 809 (DeSaulnier) Controlled Substances: Reporting
Ms. Trefry gave an overview of the Department of Justice database known as Controlled Substance Utilization Review and Evaluation System (CURES). Sarah Wallace, Legislative and Regulatory Analyst, explained that if SB 809 passes, there will be a $6 annual fee on license renewals for maintenance of CURES. There was discussion surrounding how licensees will be notified.

M/S/C (Forsythe/Dawson) to take a neutral position on this bill. The motion passed unanimously.

E. Diversion Program Report
Lori Reis, Complaint and Compliance Unit Manager, gave an overview of the Diversion Program and reviewed the statistics provided. There was discussion about access to the program.

F. Recommendation for the Appointment of a Northern Diversion Evaluation Committee Member
Ms. Reis provided and overview of the composition of the two Diversion Evaluation Committees (DEC). She reported that the Northern DEC panel interviewed two candidates on June 6, 2013. The panel is recommending

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appointment of James W. Frier, DDS, to fill the dental vacancy on the Northern DEC. Mr. Afriat reported that he had interviewed the candidate personally and was impressed by his credentials.

M/S/C (Afriat/Morrow) to accept the DEC's recommendation to appoint James W. Frier, DDS, to fill the dental vacancy on the Northern Diversion Evaluation Committee. The motion passed unanimously.

G. Recognition of Dr. Graham, Board Subject Matter Expert

Kim Trefry recognized Dr. Graham's contribution to the Enforcement Unit's successful outcome of a very long and egregious case.

Karen Fischer recognized:
Nancy Butler, Supervising Investigator, for 25 years of state service
Shirley Boldrini, who will be retiring after 20 years of state service as an Inspector and Registered Dental Assistant who attends many outreach events and volunteers tirelessly, and
Karyn Dunn, who will be retiring after 19 years of state service as an Investigator and firearms instructor

22. **Licensing, Certification, and Permits**

A. Review of Dental Licensure and Permit Statistics

Dawn Dill, Licensing Manager, gave an overview of the statistics provided.

B. Review of General Anesthesia/Conscious Sedation Evaluation Statistics

Dr. Bruce Whitcher gave an overview of the statistics provided. He reported that the number of evaluations has gone down due to the lack of qualified evaluators. He stated that there is ongoing recruitment for qualified evaluators.

C. Update on General Anesthesia/Conscious Sedation Calibration Webinar

Dr. Whitcher reported that in the past, calibration courses were live courses given in northern and southern California. These courses were accepted for continuing education credit so attendance was good, but very few attendees signed up to be evaluators. He is trying to facilitate the first webinar on Wednesday, September 25, 2013, from 3:30 to 5:30. Ms. Fischer thanked Dr. Whitcher for the many hours he has devoted to this project.

23. **Public Comment of Items Not on the Agenda**

Bill Lewis, CDA, reported that the City of Berkeley is still proposing requiring more informed consent for amalgam use. They may be asking the Board to update the Materials Fact Sheet.

24. **Future Agenda Items**

There were no further requests for future agenda items.

25. **Board Member Comments for Items Not on the Agenda**

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Dr. Casagrande commented that there are new guidelines for the pre-medication of prosthesis patients. He suggested a joint meeting with the Medical Board to discuss the changes.

Dr. Morrow suggested looking into the possibility of changing continuing education requirements to a continued competency type format.

26. **Adjournment**
Dr. Le adjourned the meeting at 3:30 p.m.

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BOARD MEETING TELECONFERENCE
OCTOBER 9, 2013
DRAFT
MEETING MINUTES

Members Present:
Huong Le, DDS, MA, President
Fran Burton, Public Member, Vice President
Steven Morrow, DDS, MS, Secretary
Steven Afriat, Public Member
Stephen Casagrande, DDS
Yvette Chappell-Ingram, Public Member
Katie Dawson, RDHAP
Judith Forsythe, RDA
Ross Lai, DDS
Meredith McKenzie, Public Member
Thomas Stewart, DDS
Bruce Whitcher, DDS

Members Absent:
Luis Dominicis, DDS
Kathleen King, Public Member

Staff Present:
Karen M. Fischer, MPA, Executive Officer
Jennifer Thornburg, Assistant Executive Officer
Sarah Wallace, Legislative and Regulatory Analyst
Linda Byers, Executive Assistant
Spencer Walker, Senior Legal Counsel

Dr. Le, Board President, called the meeting to order at 12:02 and Dr. Morrow, Board Secretary, called the roll by location and established a quorum.

Agenda Item 2(A): Discussion and Possible Action Regarding Comments Received During the 45-Day Public Comment Period and During the Regulatory Hearing for the Board's Proposed Rulemaking to Amend California Code of Regulations, Title 16, Section 1021 Relevant to a Dentistry Fee Increase

Sarah Wallace, Legislative and Regulatory Analyst, explained that at its March 1, 2013 meeting, the Dental Board of California (Board) discussed and approved proposed regulatory language relative to a fee increase for dentists. The Board directed staff to initiate a rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on July 30th. The rulemaking was published in the California Regulatory Notice Register on Friday, August 9th and was noticed on the Board's web site and mailed to interested parties. The 45-day public comment period began on August 9th and ended on September 23rd, and a regulatory hearing was held in Sacramento on September 23rd to receive verbal and written testimony. The Board received comments from the California Dental Association.

Ms. Wallace explained that the California Dental Association (CDA) submitted a letter containing comments in response to the Board's proposed rulemaking to amend California Code of Regulations, Title 16, Section 1021 relative to the dentistry fee increase.

The CDA commented that its membership makes up approximately seventy (70) percent of licensed dentists in California, and that the Board's oversight of the profession is important to its organization. The CDA recognizes and supports the Board's role in the licensure and enforcement of the practice of dentistry that set the standard of professionalism in California. The CDA agrees that it is necessary for the Board to have resources available to carry out its responsibilities, and that those resources must come from the dentists who benefit from the Board's oversight.

The CDA recognized that the Board had not increased the initial licensure and biennial renewal fees since 1998 and that those fees constitute the largest source of the Board's revenue. Additionally, the CDA commented that it recognized that in addition to the impact of inflation, the Board had been given "spending authority" but no direct revenue source to pay for the additional enforcement program expenses that came as part of the Department of Consumer Affairs' Consumer Protection Enforcement Initiative (CPEI). The CDA commented that it believes that consumer protection is the most important responsibility of the Board, and that it has seen demonstrable improvements in the Board's enforcement caseload management that have been a result of the additional staff. The CDA commented that they do not want to see those gains eroded due to insufficient resources.

The CDA acknowledged the primary importance of the Board's enforcement program as the basis for the proposed fee increase, but expressed disappointment that the supporting rulemaking documents did not address basic customer service. The CDA have expressed multiple times in past public discussions that for the majority of dentists who will never face Board disciplinary action, their only contact with the Board is to solicit answers to licensure questions or to rectify paperwork issues. The CDA commented that the Board's customer service track record in recent years has been dismal and that member dentists routinely turn to the CDA to intervene on their behalf when they are unable to reach Board staff by phone or email. The CDA recognized and appreciates that managerial changes made earlier this year have seemed to reduce the frequency of such occurrences. The CDA notes that it would be difficult to explain to member dentists why they should pay an additional $85 in licensure fees when they are unable to reach anyone at the Board to answer basic questions.

The CDA commented that without continued demonstrable and sustained improvements in customer service, it will be difficult, if not impossible, for the CDA to support legislation to increase the statutory cap on initial licensure and biennial renewal fees. The CDA notes that such support would be particularly difficult in 2014, when the current regulatory proposed increase of $85 would just be going into effect. The CDA understands the Board's desire to plan ahead for future fee increases, which would need to be approved via the formal rulemaking process, but is still concerned that 2014 would be too soon to consider additional fee increases without clear evidence that the currently proposed increase will result in overall performance improvements that are visible to the average licensee. The CDA commented that raw numbers alone should

not be used to justify an almost immediate further increase without a thorough examination of the Board's spending priorities and potential for improved efficiencies. The CDA noted that it looks forward to engaging in that discussion with the Board as it moves forward.

The CDA hoped that, in the future, the Board will begin to more carefully forecast its revenue needs on a yearly basis; the CDA believes that dentists would prefer a more incremental approach to fee increases so that this type significant one-time jump would become unnecessary. The CDA recognizes that the board is following the standard budgetary process for all professional licensing boards, but would like to see improved clarity in budget documentation and explanation in the future, so that licensees and Board members may more easily comprehend why fee increases are deemed necessary even when the Board is not spending its entire annual budget augmentation.

Board staff recommended the Board reject these comments because if the Board averts or delays an immediate fee increase, and subsequent fee increase, the Board's State Dentistry Fund will become insolvent and the structural imbalance between its revenue and expenditures will continue to grow.

The Board must assess fees to licensees to sustain the financial resources necessary to carry out the methods of meeting its highest priority of consumer protection. Since 1998, the Board's enforcement program has grown exponentially in (1) response to consumer protection issues that have surfaced, and (2) response to new statutory and regulatory requirements. Over time, the Board has been authorized to increase its staffing resources to meet consumer protection needs in California, without having to increase its licensing fees to offset such expenses; however, the Board cannot continue to absorb additional expenses without increasing fees. In May 2010, the Board's Executive Officer reported at a quarterly meeting, that the Board would need to look at fee increases in Fiscal Year 2012-2013 due to increased enforcement costs.

The CDA's concerns regarding staff resource availability to respond to licensee's questions have been recognized by the Board. However, this proposed fee increase has not been presented as a mechanism to improve customer service. Rather, this fee increase has been proposed to sustain existing resources, especially enforcement related resources. It should be noted that the Board and Executive staff continue to evaluate and develop processes to improve access and communication between staff and licensees on an ongoing basis. Additionally, the Board's Executive Officer maintains open communication with the CDA to address communication issues and immediately resolve CDA members' licensure concerns.

If the Board does not correct the structural imbalance between its revenue and expenditures through this proposed fee increase, and a subsequent fee increase once the Board obtains statutory authority via increasing the fee caps, the Board will be forced to: (1) reduce staffing in licensing and enforcement, and (2) reduce operating resources and equipment to offset expenditures. The Board's licensing and enforcement programs would suffer from reductions in staffing and would result in delayed response times to licensing inquiries, application approvals, processing of consumer complaints, conducting investigations, and referring egregious cases to the Attorney General's Office for prosecution. Such staffing reductions would make

continued demonstrable and sustained improvements in customer service improbable and the Board would be unable to provide efficient and effective consumer protection.

Board staff agrees that "raw numbers alone" do not justify further fee increases, which is the reason that Board staff works in consultation with the Department of Consumer Affairs' Budget Office to continually analyze the condition of the State Dentistry Fund and annual budget appropriations. Board staff has provided budget reports at quarterly Board meetings to indicate the need for a fee increase, including information regarding the condition of the State Dentistry Fund and the annual budget appropriations. The Board has experienced reversions to the State Dentistry Fund at the conclusion of past fiscal years and such reversions have delayed the need for a fee increase. Previous budget reports have clarified that unexpected restrictions on the spending of budget appropriations produce such reversions (e.g. Executive Orders that have resulted in furloughs, hiring freezes, travel restrictions, etc.); therefore, the Board is unable to depend on reversions to justify the further delay of the proposed fee increase. This proposed fee increase is necessary to support the State Dentistry Fund because it is insufficient to be able to sustain the Board's annual budget appropriation.

Board staff recognizes that this proposal equates to a 23% overall increase in biennial renewal fees that have been assessed since 1998. However, Board staff concludes that this proposed fee increase, that is the equivalent to an annual increase in the cost of licensure of less than 0.03% of an average dentist's annual income, is difficult to characterize as a dramatic one-time jump in licensure fees.

The Board's Executive Officer has previously indicated that she will be working with the CDA and other stakeholder groups to address concerns regarding forthcoming fee increases. Additionally, staff will strive to improve the presentation of budget information to maintain transparency so that necessary budgetary changes in the future may be easier to understand and anticipate by Board members, stakeholders, and members of the public.

Motion/Second/Carried (M/S/C) (Burton/Stewart) to accept staff's recommendation to reject the comments made by the California Dental Association. Board members expressed confidence that the Executive Officer and Board staff would continue to work to improve customer service for licensees. Bill Lewis, representative of the CDA, thanked staff for the work done to respond to comments. The motion passed unanimously.

Agenda Item 2(B): Discussion and Possible Action Regarding Adoption of Proposed Amendments to California Code of Regulations, Title 16, Section 1021 Relevant to a Dentistry Fee Increase

M/S/C (Afriat/Burton) to direct staff to take all steps necessary to complete the rulemaking process, including the filing of the final rulemaking package with the Office of Administrative Law and authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendments to California Code of Regulations, Title 16, Section 1021 relevant to the dentistry fee increase as noticed in the proposed text.

Public Comment for Items Not on the Agenda

Mr. Lewis reiterated that the CDA understands that improvement in customer service was not part of the proposed rulemaking but is still concerned that the average dentist's only interaction with the Board is when they have a licensing issue and they experience difficulty in reaching staff. This leads to the CDA hearing from its members regarding such difficulty. Mr. Lewis commented that the CDA may have difficulty with supporting Board legislation to increase the statutorily authorized maximum fee the Board may assess so soon after this proposed fee increase. Mr. Lewis stated that he looked forward to continuing to work with the Board and staff to resolve customer service issues.

M/S/C (Afriat/Dawson) to adjourn the meeting at 12:32 p.m. The motion passed unanimously.

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DENTAL BOARD OF CALIFORNIA
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MEMORANDUM

DATE	October 24, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	**Agenda Item 3:** President's Report

The President of the Dental Board of California, Dr. Huong Le, will provide a verbal report.

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MEMORANDUM

DATE	October 24, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	**Agenda Item 4:** Update from the Department of Consumer Affairs' Executive Office

The Deputy Director of Board and Bureau Relations, Christine Lally, will provide a verbal report.

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MEMORANDUM

DATE	November 12, 2013
TO	Dental Board of California
FROM	Lori Hubble, Executive Officer Dental Hygiene Committee of California
SUBJECT	**Agenda Item 5:** Update from the Dental Hygiene Committee of California and an Overview of the Sunset Review Report Submitted to the Legislature November 1, 2013

1. Update on 2014 Sunset Review

The DHCC is currently in its Sunset Review and has submitted the final report to the Legislature. The Sunset Review Report is on the DHCC website available for public review. The DHCC expects to appear before the Legislature for hearing in March 2014.

Issues that will be addressed in the DHCC's 2014 Sunset Review Report that the DBC may have interest in is:

- Changing the DHCC to a board – because the DHCC operates similarly to a board and has the statutory authority to regulate the profession of dental hygiene, the DHCC determined that the name should reflect its independent programmatic operations;
- The DHCC will pursue legislation to repeal BPC, Sections 1901 (Dental Hygiene Committee of California Created), 1905(a)(8) (Scope of Practice Issues) and 1905.2 (Recommendations on scope of practice issues) that provides jurisdictional language for the DBC;
- The DHCC continues to pursue its own Practice Act known as the Dental Hygiene Practice Act;
- Implement a Statute of Limitations for DHCC Enforcement actions;
- Working to add a manager for programmatic oversight, new staff to address the continuing education program and licensee audits, and the new BreEZe computer system;
- Request an increase to the renewal and delinquent fee statutory maximums for all licensure categories (e.g., RDH, RDHAP, RDHEF, and Fictitious Name Permit);
- Pursue the full utilization of all categories of dental hygienists to meet the needs of the State's citizens – there are statutory restrictions which have been imposed that restrict the full utilization of dental hygienists. Removal of these restrictions [e.g., BPC, Section

1909 (Procedures dental hygienist is authorized to perform under direct supervision) and BPC, Section 1926(d)(Dental health professional in shortage areas)] would allow for greater access to care for the consumer and would enable the skills of the dental hygienists to be used to their full extent without jeopardizing the health and safety of the consumer;

- Implement penalties for failure to report unprofessional conduct as stated in BPC, Section 1950.5 (Unprofessional conduct defined);
- Pursue legislation to enhance the chances for insurance payment for the dental hygiene services rendered (BPC, Section 1928 – Registered Dental Hygienist in Alternative Practice, submitting of insurance);
- Continue the effort to allow for continued competency for dental hygienist in the interest of consumer protection; and
- Pursue and research alternative pathways for licensure. This will require a statutory amendment to BPC, Section 1917(b) (Dental Hygienist requirements for licensure), but the DHCC has identified the need for this action.

2. Next DHCC Meeting is scheduled for December 6 - 7, 2013

For the December 6 – 7, 2013 DHCC meeting, the DHCC subcommittees will meet on Friday, December 6, 2013, and the Full Committee on Saturday, December 7, 2013. The meeting is to be held in Sacramento, and the meeting agenda and materials will be posted on the DHCC website toward the end of the month.

3. DHCC Office Relocation

For the past two years, the DHCC has been researching the possibility of relocating office locations in order to accommodate additional staff, equipment, and supplies. The DCA Facilities Unit recently provided a new office location that is in the Evergreen building and almost twice the size of the current DHCC office. The tentative date for the DHCC to relocate is February 2014, but is dependent on two other DCA programs vacating their respective suites first, and then the DHCC will backfill into one of the vacated suites.

4. DHCC Annual Officer Elections

The DHCC will hold its annual officer elections at the December 2013 meeting.

5. Future Meetings

The DHCC's 2014 meeting, examination, and events calendar will be discussed and approved at the December 2013 meeting.

6. Standing Offer of Collaboration to Dental Board

The DHCC's standing invitation to the DBC is to help forge a constructive, collaborative relationship between the two programs to address any overlapping and/or common issues. We thank you again for allowing DHCC a forum to update our activities to the DBC.

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MEMORANDUM

DATE	November 8, 2013
TO	Dental Board Members
FROM	Linda Byers, Executive Assistant
SUBJECT	**Agenda Item 6A:** Presentation by Dr. Charles Broadbent, Director of Dental Exam Development for the Western Regional Examination Board (WREB)

Dr. Charles Broadbent will give a presentation on the Western Regional Examination (WREB).

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MEMORANDUM

DATE	November 5, 2013
TO	Dental Board Members
FROM	Dawn Dill, Manager, Licensing and Examination Unit
SUBJECT	**Agenda Item 6B: Discussion and Possible Action on Report Regarding Portfolio Examination Development**

Background

Since the August meeting staff has continued to work on the development of materials for the Portfolio Examination. This item is being brought before you as an update to our progress.

As part of the Portfolio Examination development, Dr. Roberta Chinn included an audit process to be used for the Portfolio Examination to ensure compliance with the examination requirements and legislative mandates. Staff has worked with legal counsel to develop an Audit notification letter to be sent to the dental schools and a checklist to be used by the Board auditors when reviewing the Portfolio documents for licensure candidates.

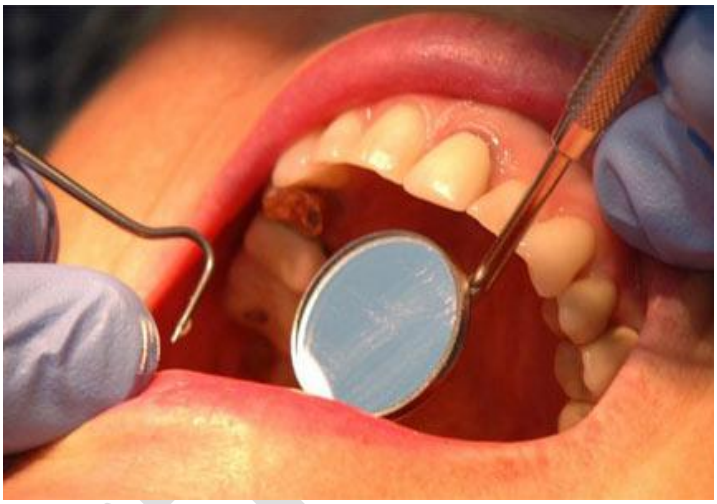
Staff has also been working with the subcommittee to development PowerPoint presentations to be used for calibration/standardization of the portfolio examiners at each dental school for all six competencies. Currently the PowerPoint presentations have been created. Dr. Morrow is reviewing the material and will be adding pictures that have been submitted by the various dental schools for each of the competencies. Each presentation will follow the same format and includes the scoring factors, the case requirements including any patient parameters and the scoring system.

Attached for your review are the finalized Portfolio Examination Audit Process Handbook and the draft of the Direct Restoration presentation.

As we move forward staff will develop a comprehensive implementation plan and will present the plan at a future meeting.

Action Requested:
No action is being requested by staff for this item.

PORTFOLIO EXAMINATION AUDIT PROCESS 2013



(Final Draft 7/13)

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Chapter 1 – Introduction

Purpose of 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 psychometric standards

Standard 3.15 of the Standards for Educational and Psychological Testing[1] state:

"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:

- Oversight of audit process
- Establishment of grading standards necessary for public protection

[1] American Educational Research Association, American Psychological Association, & National Council on Measurement in Education (1999). Standards for Educational and Psychological Testing. Washington, DC: Author.

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- 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 the audit team

The audit team is responsible for verification of the examination process, examination results, collection and evaluation of specific written documentation which respond to a set of standardized audit checklist, 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 student 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 grade worksheets and summary of candidates' competency examinations, the following content specific documentation should be provided at the time of the audit site visit:

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
INDIRECT RESTORATION	• Restorative diagnosis and treatment plan • Preoperative radiographs
REMOVABLE PROSTHODONTICS	• Removable prosthodontic diagnosis and treatment plan • Preoperative radiographs illustrating treatment condition
ENDODONTICS	• Endodontic diagnosis and treatment plan • Preoperative radiographs of treatment site • Postobturation radiographs of treatment site

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PERIODONTICS	• Periodontal diagnosis and treatment plan • Charted pocket readings • Preoperative radiographs including subgingival calculus • Follow-up report

It is anticipated that auditors will be presented with a representative sample of documentation from the candidate competency examination.

Schedule for audits

The Board will conduct audits of the Portfolio competency instructors and examinations every two years (biennially).

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Chapter 2 – School Audit Information

RESOURCES	• 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?
TRAINING AND CALIBRATION OF EXAMINERS	• Who is responsible for the Calibration Training of Board-approved Portfolio examiners?
TEST SECURITY	• Are procedures in place to permit auditors to view patient information for the purposes of the audit? • Are procedures in place to maintain the security of the Portfolio examination materials before, during and after each competency examination? • Are procedures 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	• Are procedures in place to produce reliability statistics for Portfolio examiners? • Are procedures in place to maintain pass/fail statistics for all factors?
INCIDENT REPORTS	• Are procedures 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?

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Chapter 3 – Portfolio Audit Checklist

The audit checklist will be used to determine the standardization of the candidate portfolios at each dental school and must be completed prior to the ending of the site visit.

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Portfolio Examination Audit Checklist

Candidate Name: _____

Candidate ID #: _____

Review of Applicant Portfolio			
Oral Diagnosis and Treatment Planning (ODTP)			
Clinical Experiences			
Does the portfolio include documentation of ODTP for a minimum of twenty (20) cases?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required fifteen (15) scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ *(After three (3) failed attempts remedial education is required.)*		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Does the treatment plan include at least three (3) of the following six (6) disciplines? Mark all that apply: ☐ Periodontics ☐ Endodontics ☐ Operative (direct and indirect restoration ☐ Fixed and removable prosthodontics ☐ Orthodontics ☐ Oral Surgery	Y	N	Comments:
Patient Parameters			
• Maximum of ASA II • Missing or will be missing two or more teeth, not including third molars • At least moderate periodontitus (probing depth of 5mm or more)	*Informational Only*		

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Portfolio Examination Audit Checklist

Elements of ODTP Portfolio			
Does the medical history include: - Evaluations of past illness and conditions, hospitalizations and operations - Allergies - Family history - Social history - Current illnesses and medications and their effect on dental condition	Y	N	Comments:
Does the dental history include: - Age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts	Y	N	Comments:
Documentation of a comprehensive examination for dental treatment provided to patients?	Y	N	Comments:
Documentation the candidate evaluated data to identify problems?	Y	N	Comments:
Documentation the candidate worked up the problems and developed a tentative treatment plan?	Y	N	Comments:
Documentation the candidate developed a final treatment plan?	Y	N	Comments:
Was this a full workup of the case?	Y	N	Comments:
Direct Restoration			
Clinical Experiences			
Does the portfolio include documentation of Direct Restoration clinical experiences for a minimum of sixty (60) restorations?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required seven (7) scoring factors for the Class II amalgam or composite; maximum one slot preparation?	Y	N	Comments:

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Portfolio Examination Audit Checklist

Does the portfolio contain completed grade sheets in the required seven (7) scoring factors for the Class II amalgam or composite or Class III or IV composite?	Y	N	Comments:
How many attempts did the candidate take in order to pass each of the portfolio competency examinations?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Class II Any permanent posterior tooth • More than one test procedure can be performed on a single tooth • Caries a shown on either of the two required radiograph of an unrestored proximal surface must extend to or beyond the dento-enamel junction • Tooth treated must be in occlusion • Must have adjacent tooth to be able to restore proximal contact • Tooth must be asymptomatic with no pulpal or periapical pathology • Tooth with bonded veneer not acceptable Class III/IV Any permanent anterior tooth *(optional)* • Treatment needs to be performed in the sequence described in the treatment plan • Caries shown on radiograph image of an unrestored proximal surface must extend to or beyond dento-enamal junction • Carious lesions must involve the interproximal contact area • Must have adjacent tooth to be able to restore proximal contact • Tooth must be asymptomatic with no pulpal or periapical pathology • Tooth with bonded veneer not acceptable	*Informational Only*		

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Portfolio Examination Audit Checklist

Elements of Direct Restoration			
Includes 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?	Y	N	Comments:
Includes 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?	Y	N	Comments:
Was there a restorative diagnosis and treatment plan?	Y	N	Comments:
Were there preoperative radiographs, E.g., original lesion in Class II, III, IV?	Y	N	Comments:
Indirect Restoration			
Clinical Experiences			
Does the portfolio include documentation of Indirect Restoration clinical experiences for a minimum of fourteen (14) restorations?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required seven (7) scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Was the treatment performed in the sequence described in the treatment plan?	Y	N	Comments:

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Portfolio Examination Audit Checklist

Was the tooth asymptomatic with no pulpal or periapical pathosis?	Y	N	Comments:
Was the tooth in occlusal contact with a natural tooth or permanent restoration?	Y	N	Comments:
Does the restoration include at least one cusp?	Y	N	Comments:
Is there an adjacent tooth in order to restore proximal contact?	Y	N	Comments:
Did the candidate perform any portion of the crown in advance?	Y	N	Comments:
Direct restoration materials which are placed to contribute to the retention and resistance form of the final restoration (build-ups) may be completed ahead of time if needed.	*Informational only*		
Was the restoration completed in the same tooth on the same patient by the same candidate?	Y	N	Comments:
Validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of existing crown.	*Information only*		
Elements of Indirect Restoration			
Includes documentation of the candidate's competency to complete a ceramic onlay or more extensive indirect restoration? 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.	Y	N	Comments:

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Portfolio Examination Audit Checklist

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.			
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
Includes 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.	Y	N	Comments:
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
Includes documentation of the candidate's competency to complete 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	Y	N	Comments:

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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.			
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
Includes documentation of the candidate's competency to complete 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.	Y	N	Comments:
Was the treatment performed in the sequence of the treatment plan?	Y	N	Comments:
A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.	*Informational only*		
Was there a restorative diagnosis and treatment plan?	Y	N	Comments:

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Portfolio Examination Audit Checklist

Were there preoperative radiographs?	Y	N	Comments:
Removable Prosthodontics			
Clinical Experiences			
Does the portfolio include documentation of removable prosthodontics clinical experiences for a minimum of five (5) prostheses?	Y	N	Comments: *One of which may be used for the portfolio competency examination.*
Competency Examination			
Does the portfolio contain completed grade sheets in the required scoring factors for the prosthodontic performed?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Procedures may be performed on patients with supported soft tissue, implants or natural tooth retained overdentures.	*Informational only*		
Elements of Removable Prosthodontics			
Includes documentation of the candidate's competency to: • Develop a diagnosis • Determined treatment options and prognosis for the patient to receive a removable prosthesis	Y	N	Comments:
Includes documentation of the candidate's competency to successfully restore edentulous spaces with removable prostheses?	Y	N	Comments:

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Portfolio Examination Audit Checklist

Includes documentation of the candidate's competency to successfully manage tooth loss transitions with immediate or transitional prostheses?	Y	N	Comments:
Includes documentation of the candidate's competency to successfully manage prosthetic problems?	Y	N	Comments:
Includes documentation of the candidate's competency to successfully direct and evaluate the laboratory services for the prostheses?	Y	N	Comments:
Was there a removable prosthodontic diagnosis and treatment plan?	Y	N	Comments:
Were there preoperative radiographs illustrating the treatment condition?	Y	N	Comments:
Endodontics			
Clinical Experiences			
Does the portfolio include documentation of Endodontic clinical experiences for a minimum of five (5) canals or any combination of canals in three separate teeth?	Y	N	Comments:
Competency Examination			
Does the portfolio contain completed grade sheets in the required ten (10) scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Patient Parameters			
Any tooth to completion by the same candidate on the same patient. Completed case is defined as a tooth with an acceptable and durable coronal seal.	*Information only*		

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Portfolio Examination Audit Checklist

Elements of Endodontics			
Includes documentation of the candidate's competency in applied case selection criteria for endodontic cases?	Y	N	Comments:
Includes documentation of the candidate's competency to perform pretreatment preparation for endodontic treatment?	Y	N	Comments:
Includes documentation of the candidate's competency in performing access openings?	Y	N	Comments:
Includes documentation of the candidate's competency in performing proper cleaning and shaping techniques?	Y	N	Comments:
Includes documentation of the candidate's competency in performing proper obturation protocols?	Y	N	Comments:
Includes documentation of the candidate's competency in demonstrating proper length control of obturation, including achievement of dense obturation of filling material, obturation achieved to a clinically appropriate coronal height?	Y	N	Comments:
Includes documentation that 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?	Y	N	Comments:
Includes documentation of the candidate's competency in providing 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?	Y	N	Comments:
Was there an endodontic diagnosis and treatment plan?	Y	N	Comments:
Were there preoperative radiographs of the treatment site?	Y	N	Comments:
Were there postobturation radiographs of the treatment site?	Y	N	Comments:

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Portfolio Examination Audit Checklist

Periodontics			
Clinical Experiences			
Does the portfolio include documentation of periodontal clinical experiences for a minimum of twenty five (25) cases?	Y	N	Comments:
Competency Examination			
Did the combined clinical experience include a minimum of five (5) quads of scaling and root planing procedures?	Y	N	Comments:
Does the portfolio contain completed grade sheets in the required nine (9) Scoring factors?	Y	N	Comments:
How many attempts did the candidate take in order to pass the portfolio competency examination?	# of attempts_____ (After three (3) failed attempts remedial education is required.)		
Was remediation required?	Y	N	Comments:
If yes above, was remediation form completed?	Y	N	Comments:
Has the case been scored in the following three (3) parts? ☐ Part A Review medical and dental history, radiographic findings, comprehensive periodontal date collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan ☐ Part B Calculus detection, effectiveness of calculus removal ☐ Part C Periodontal re-evaluation	Y	N	*In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.*
Patient Parameters			
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	*Informational only*		

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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	
Calculus detection and periodontal instrumentation (scaling and root planning • 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.	*Informational only*
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	*Informational only*

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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			
Elements of Periodontics			
Includes documentation that the candidate competently performed a comprehensive periodontal examination?	Y	N	Comments:
Includes documentation that the candidate competently diagnosed and developed a periodontal treatment plan that documents the following: ☐ The candidate determined the periodontal diagnosis ☐ The candidate formulated an initial periodontal treatment plan that demonstrated the following: ○ Determined to treat or refer 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	Y	N	Comments:
Includes documentation that the candidate competently performed nonsurgical periodontal therapy that he/she: ☐ Detected supra and subgingival calculus ☐ Performed periodontal instrumentation • Removed calculus • Removed plaque • Removed stains	Y	N	Comments:

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Portfolio Examination Audit Checklist

☐ Demonstrated that the candidate did not inflict excessive soft tissue trauma ☐ Demonstrated that the candidate provided the patient with anesthesia			
Includes documentation that the candidate competently performed a periodontal re-evaluation?	Y	N	Comments:
Was there a periodontal diagnosis and treatment plan?	Y	N	Comments:
Were there charted pocket readings?	Y	N	Comments:
Was there preoperative radiographs?	Y	N	Comments:
Was there a follow-up report?	Y	N	Comments:

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Portfolio Examination Audit Checklist

Narrative (Please print legibly or type. Additional sheets may be attached as necessary)		
Auditors Printed Name:	**Date**	**Signature of Auditor**

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Portfolio Examination

Direct Restoration Competency Examiner Training Course

Portfolio Examination

Direct Restoration competency Portfolio examiners are dental school faculty members who are chosen by their school, approved by the Board, and are trained and calibrated to conduct and grade the Board Portfolio Direct Restoration competency examination.

Portfolio Examination

Each Portfolio examiner will undergo training and calibration in the Board's standardized evaluation system through didactic and experiential methods.

Portfolio Examination

Calibration of Portfolio examiners will be conducted at least annually in conjunction with the usual and customary calibration course given to the school's competency examiners.

Portfolio Examination

All Portfolio examiners will be trained and calibrated to use the same rating criteria.

Direct Restoration Competency

The purpose of the Direct Restoration competency examinations are to assess the candidate's independent ability to restore teeth with interproximal primary carious lesions to optimal form, function and esthetics.

Direct Restoration Competency

- **Seven (7) scoring factors**
- **Two (2) Restorations**
  - **One (1) Class II amalgam or composite; maximum one slot preparation, <u>and</u>**
  - **One (1) Class II amalgam or composite or 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.**

Direct Restoration Competency

- A case presentation for which the proposed treatment is appropriate for the patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Patient Management. The examinee must be familiar with the patient's medical and dental history.

Direct Restoration Competency

- **Implementation of any treatment modifications needed that are consistent with the patient's medical history.**

Direct Restoration Competency

The tooth used for the competency exams must meet the following criteria:

- **A Class II must be performed on any permanent posterior tooth.**
  - **Treatment must 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.**

Direct Restoration Competency

- Caries as shown on either of the two required radiographs of the unrestored proximal surface must extend to or beyond the DEJ.
- The tooth to be treated must be in occlusion.
- The restoration must have an adjacent tooth to be able to restore proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either a natural tooth or a permanent restoration. Provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- The tooth must be asymptomatic with no pulpal or periapical pathology. The tooth cannot be endodontically treated or need endodontic treatment.
- Any tooth with bonded veneer is not acceptable.

Direct Restoration Competency

- **A Class III/IV must be performed on any permanent anterior tooth.**
  - **Treatment must be performed in the sequence described in the treatment plan.**
  - **Caries as shown on either of the two required radiographs of the unrestored proximal surface must extend to or beyond the DEJ.**
  - **Carious lesions must involve the interproximal contact area.**

Direct Restoration Competency

- The restoration must have an adjacent tooth to be able to restore proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either a natural tooth or a permanent restoration. Provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- The tooth must be asymptomatic with no pulpal or periapical pathology. The tooth cannot be endodontically treated or need endodontic treatment.
- The lesion is not acceptable if it is in contact with circumferential decalcification.
- The approach must be appropriate for the lesion.
- Any tooth with bonded veneer is not acceptable.

Direct Restoration Competency

- **Scoring:**
  - **Score of 0 is unacceptable (critical error)**
  - **Score of 1 is unacceptable (multiple major deviations but correctable)**
  - **Score of 2 is unacceptable (one major deviation that is correctable)**
  - **Score of 3 is acceptable (minimum competence)**
  - **Score of 4 is adequate (less than optimal)**
  - **Score of 5 is optimal**
- **A score of "3" is minimum competency.**

Direct Restoration Competency

FACTOR 1:

- **Case Presentation**
  - **Obtains informed consent**
  - **Presents a comprehensive review of medical and dental history.**
  - **Provides rationale for restorative procedures.**
  - **Proposes initial design of preparation and restoration.**
  - **Demonstrates full understanding of the procedure.**

Direct Restoration Competency

FACTOR 2:

- Outline and Extensions
  - Optimal outline and extensions such as:
    - Smooth, flowing
    - Breaks proximal contact as appropriate
    - No damage to adjacent teeth
    - Does not weaken tooth
    - Appropriate cavosurface angles
    - Optimal extension for caries/decalcification
    - Includes the lesion
    - Optimal treatment of fissures
    - Appropriate extension request

Direct Restoration Competency

FACTOR 3:

- Internal form
  - Optimal internal form such as:
    - Optimal pulpal and axial depth
    - Optimal internal refinement
    - Preparation is clean and free of fluids and/or debris
    - Optimal wall relationships
    - All previous restorative material removed
    - Appropriate lines and bases
    - Optimal axio-pulpal line angles
    - Optimal caries removal
    - Appropriate extension requests

Direct Restoration Competency

FACTOR 4:

- **Operative Environment**
  - **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**

Direct Restoration Competency

FACTOR 5:

- Anatomical Form
  - Optimal anatomic form such as:
    - Harmonious and consistent with adjacent tooth structure
    - Contact is closed
    - Interproximal contour and shape are proper
    - Height and shape of marginal ridge is appropriate
    - Interproximal contact area and position are properly restored

Direct Restoration Competency

FACTOR 6:

- **Margins**
  - **No deficiencies or excesses**

Direct Restoration Competency

FACTOR 7:

- **Finish and Function**
  - **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**

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MEMORANDUM

DATE	October 24, 2013
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	**Agenda Item 7A:** Enforcement Program Status

Business Continuity Plan - Update
In response to former Governor Schwarzenegger's Executive Order S-04-06, all state agencies were tasked with the creation of a comprehensive plan to address their recovery response to a major man-made or natural disaster. In 2006, the Dental Board developed their initial plan in compliance with this order.

This year, the board updated the plan to create a more comprehensive document for various threat scenarios to our business. This included adding further detail to the essential functions of each program, their responsibilities in an evacuation scenario, phone trees, reconstitution strategies if the board's business was relocated to another building, and plans for training staff to respond properly if and when necessary.

Southern California Unlicensed Dentistry (SCUD) Task Force
In response to high investigator caseloads combined with the ongoing problem identified in Southern California involving the unlicensed practice of dentistry, the Enforcement Program developed a task force proposal to begin reducing these numbers. This task force became known as "Operation SCUD."

Due to the age of many of these unlicensed cases (some three years or older), combined with the itinerant nature of unlicensed practitioners, it is reasonable to believe that the reported locations of some of these underground offices may have closed, and could result in a case closure. 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 a 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.

Initially, we identified over 100 possible unlicensed cases throughout various counties in southern California. This effort focused on our oldest cases in one county. The results included:

Case Closures: 25 [Allegations were unfounded, or the suspect(s) were gone]
Open Cases: 27 [Pending Further Investigation]
Citations/Arrests: 1
Search Warrants: 9

In addition to the efforts of our sworn investigative staff, our non-sworn Special Investigators also participated in the task force. Staff investigated Aiding and Abetting cases along with several ownership issues. We anticipate repeating this effort one to two times per year.

Seized Dental Equipment Repurposed

After the successful adjudication of several of our previous unlicensed activity cases, the courts provided the board with releases to dispose of dental equipment seized as evidence in our cases. In this instance, the evidence included dental chairs, portable X-ray units, compressors, portable hand-piece units, autoclaves and various hand tools and instruments. Those that are in good condition are donated to local health clinics and charities to assist in providing dental care to consumers in underserved communities both in California and as far abroad as Kenya.

In October, the Orange office donated items to the Orange County Dental Society, *Graceworks* and the Simi Valley Dental Clinic among others.

Vehicles
In October, the Enforcement Program submitted its Vehicle Acquisition Plan to the Department of Consumer Affairs for review and submission to the Department of General Services. In addition to replacement of aging vehicles in the fleet, the board is requesting an increase in its fleet to accommodate the additional sworn and non-sworn Consumer Protection Enforcement Initiative (CPEI) positions which are required to travel in conjunction with their investigative caseload.

Currently the board has 15 vehicles shared between 14 sworn Investigator positions, four non-sworn Special Investigator positions, and two Inspector positions.

Dental Consultant Position
The Department of Consumer Affairs has recently advertised an open examination for the Board's Dental Consultant position. The (FY2010-11) CPEI Budget Change Proposal established this position, but it has remained vacant pending the creation of a new statewide eligibility list. The final filing date for applicants is November 15, 2013.

Staffing
The Sacramento office currently has two Investigator vacancies with two candidates in background. The Inspector position is also currently vacant following a retirement in September.

Carlos Alvarez was re-hired as a sworn Investigator in our Orange enforcement office. Carlos had previously worked for the Dental Board from (April 2012 – April 2013). Carlos had left the board to seek a position with an outside law enforcement agency, but reconsidered and requested reinstatement. His bilingual skills will be a great asset in tackling our remaining unlicensed cases in southern California.

I will be available during the Board meeting to answer any questions or concerns you may have.

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MEMORANDUM

DATE	October 24, 2013
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	**Agenda Item 7B:** Enforcement Statistics (Complaints and Investigations)

Attached please find Complaint Intake and Investigation statistics for the previous five fiscal years, and the current fiscal year to date.Below is a summary of some of the program's trends (as of 9/30/2013):

Complaint & Compliance Unit

Complaints Received
The total number of complaint files received during the first quarter of the fiscal year was **723**, averaging **241** per month.

Pending Cases: 1066
Average caseload per Consumer Services Analyst (CSA) = **236** complaint cases

Complaint Aging

# Months Open	# of Cases	% of Total Cases
0 – 3 Months	644	59%
4 – 6 Months	211	25%
7 – 9 Months	103	12%
10 – 12 Months	75	3%
1 – 3 Years	33	1%

Cases Closed:
The total number of complaint files closed between July 1, 2013 and September30, 2013 was **737,** averaging **245** per month. The previous five-year average is 240 closures per month.

The average number of days a complaint took to close within the last year was **115** days (a 59% increase from last year's average of 72 days). Chart 2 displays the average complaint closure age over the previous five fiscal years.

Investigations

Current Open Caseload:
There are currently approximately **740** open investigative cases, **274** probation cases, and **60** open inspection cases.
Average caseload per full time Investigator = 35 (24 in North, 42 in South)
Average caseload per Special Investigator = 32
Average caseload per Analyst = 24

# Months Open	# of Cases	% of Total Cases
0 – 3 Months	71	10%
4 – 6 Months	96	14%
6 - 12 Months	193	28%
1 – 2 Years	232	33%
2 – 3 Years	81	12%
3+ Years	20	3%

Since our last report in August 2013, the number of cases over one year old has decreased from 49% to 48%.The number of cases in the oldest category (three years and older) has decreased from 21 to 20.

Case Closures:
The total number of investigation cases closed, filed with the AGO or filed with the District/City Attorney during the first quarter of the fiscal year is **227**, an average of **75** per month. The previous five-year average was **73** per month**.** Chart 2 displays the average closure age over the previous five fiscal years.

Of the closures, approximately 12% were referred for criminal action or administrative discipline.

The average number of days an investigation took to complete within the last three months was **438** days. The previous five-year average number of days to close a case is **436** (refer to Chart 2).

Cases Referred for Discipline:
The total number of cases referred to the AGO's during the last three months was **24** (approximately eight referrals per month). The three-month average for a disciplinary case to be completed was **1230** days. Chart 2 displays the average closure age over the previous four fiscal years for cases referred for discipline.

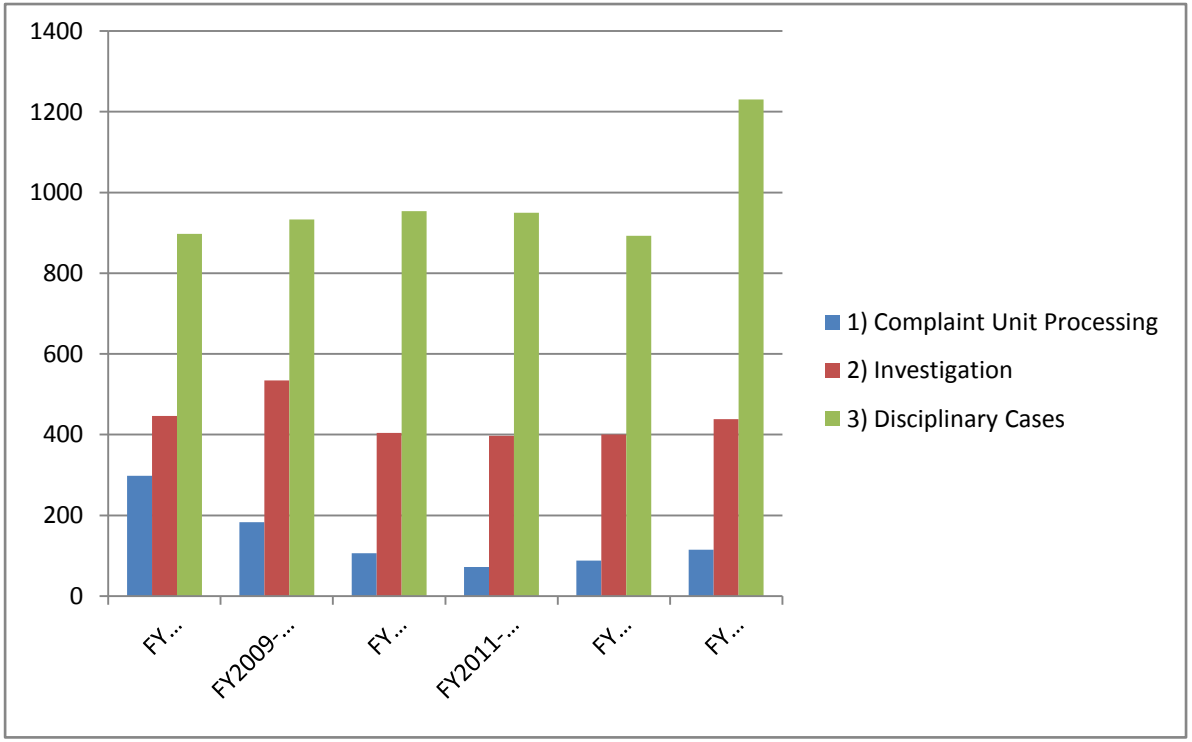
I will be available during the Board meeting to answer any questions or concerns you may have.

Dental Board of California
Enforcement Program

STATISTICAL DESCRIPTION	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 2013-14				
COMPLAINT UNIT						Jul-Sep	Oct - Dec	Jan - Mar	Apr - Jun	YTD
Complaints Received	3254	3013	3056	2813	2868	723				723
Complaints Closed	2915	3246	2987	2409	3067	737				737
Convictions/Arrests	290	177	678	750	1210	162				162
Pending at end of period	1678	1078	491	734	1070	35				35
INVESTIGATIONS										
Cases Opened	755	769	1241	916	719	196				196
Cases Closed	831	651	997	1094	813	227				227
Referred to AG	195	138	144	174	85	24				24
Referred for Criminal	20	11	8	12	19	3				3
Pending at end of period	661	779	995	1025	767	740				740
Citations Issued	11	48	42	15	27	54				54
ATTORNEY GENERAL'S OFFICE										
Cases Pending at AG	232	191	199	229	183	188				188
Administrative Actions:										
Accusation	98	97	90	99	52	22				22
Statement of Issues	36	27	23	41	9	3				3
Petition to Revoke Probation	6	5	5	9	4	4				4
Licensee Disciplinary Actions:										
Revocation	23	39	24	30	27	3				3
Probation	41	66	65	68	51	14				14
Suspension/Probation	1	0	0	2	0	0				0
License Surrendered	6	9	10	6	10	2				2
Public Reprimand	1	8	9	13	11	3				3
Other Action (e.g. exam required, education course, etc.)	6	10	11	8	7	0				0
Accusation Withdrawn	3	8	9	8	10	0				0
Accusation Declined	8	6	6	1	2	0				0
Accusation Dismissed	0	5	0	0	2	0				0
Total, Licensee Discipline	89	151	134	136		22				22
Other Legal Actions:										
Interim Suspension Order Issued	1	1	1	6	5	0				0
PC 23 Order Issued	2	0	0	0	2	0				0

Dental Board of California
Enforcement Program
Chart 2 - Average Case Age

Average Days to Close	FY 2008-09	FY2009-10	FY 2010-11	FY2011-12	FY 2012-13	FY 2013-14
1) Complaint Unit Processing	298	183	106	72	88	115
2) Investigation	446	534	404	397	400	438
3) Disciplinary Cases	897	933	954	950	893	1230



Dental Board of California
Enforcement Program
Case Distribution by Allegation Types

	Fiscal Years					2013-14					
Allegations	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**Jul-Sep**	**Oct - Dec**	**Jan - Mar**	**Apr - Jun**	**Total**	**% of Total**
Substance Abuse, Mental/Physical Impairment	21	10	12	4	7	3				3	0%
Drug Related Offenses	29	29	29	38	33	5				5	1%
Unsafe/Unsanitary Conditions	81	76	70	79	92	30				30	3%
Fraud	102	188	299	123	124	32				32	4%
Non-Jurisdictional	374	438	393	251	217	44				44	5%
Incompetence / Negligence	2211	2123	2076	1540	1459	446				446	50%
Other	315	336	181	266	295	48				48	5%
Unprofessional Conduct	330	385	352	205	219	57				57	6%
Sexual Misconduct	10	21	15	13	14	9				9	1%
Discipline by Another State	15	15	31	25	16	2				2	0%
Unlicensed / Unregistered	126	119	127	111	124	47				47	5%
Criminal Charges	405	206	456	854	1137	162				162	18%
Total	4019	3946	4041	3509	3737	885	0	0	0	885	

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MEMORANDUM

DATE	November 8, 2013
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	**Agenda Item 7C:** First Quarter Performance Measures

Performance measures are linked directly to an agency's mission, vision and strategic objectives/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, some 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

Q1(July through September 2013)

PM1 - Volume:868 Total (709 Consumer complaints, 159 Conviction reports)
Number of complaints and convictions received per quarter

Cycle Time:

- **PM2 Intake - Target: 10 Days** **Q1 Average: 8 Days**
  Average cycle time from complaint receipt, to the date the complaint was acknowledged and assigned to an analyst in the Complaint Unit for processing (This 10 day time frame is mandated by Business and Professions Code section 129 (b)) ;

- **PM3 Intake & Investigation - Target: 270 Days** **Q1 Average: 174 Days**
  Average time from complaint receipt to closure of the investigation process (does not include cases sent to the Attorney General (AG) or other forms of formal discipline);

- **PM4 Formal Discipline - Target: 540 Days** **Q1 Average: 1,230 Days**
  Average number of days to complete the entire enforcement process for cases resulting in formal discipline (Includes intake and investigation by the Board, and prosecution by the AG);

  A number of factors (both internally and externally) can contribute to case aging at the Attorney General's office. Board actions which may extend case aging include when additional investigations are combined with a pending accusation and can set back the overall time to resolve. Amending an accusation or requesting additional expert opinions can also cause delays in case adjudication. Other matters are outside the control of the

Board and include: availability of hearing dates, continuance of hearing dates, changes to opposing party counsel, and requests for a change of venue.

- **PM 7 Probation Intake –Target: 10 Days Q1 Average: 17 Days**
  Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer; and

  Probation Intake measures the time between when the probation monitor is assigned the case file and the date they meet with their assigned probationer to review monitoring terms and conditions. The Board's probation monitors are assigned a case file within a few days of the probationary order being signed. Monitors attempt to schedule their initial meeting on or soon after the effective date of the decision; thereby resulting in a 10 – 20 day intake average. It should also be noted that in some cases, probation monitoring may not take place until an applicant has completed all their licensing requirements, or returned to California (if the applicant is out-of-state). These exceptions may skew this average.

- **PM 8 Probation Violation Response –Target: 15 Days Q1 Average: N/A**
  Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

  The Board did not report any probation violations this quarter.

Department of Consumer Affairs

Dental Board of California

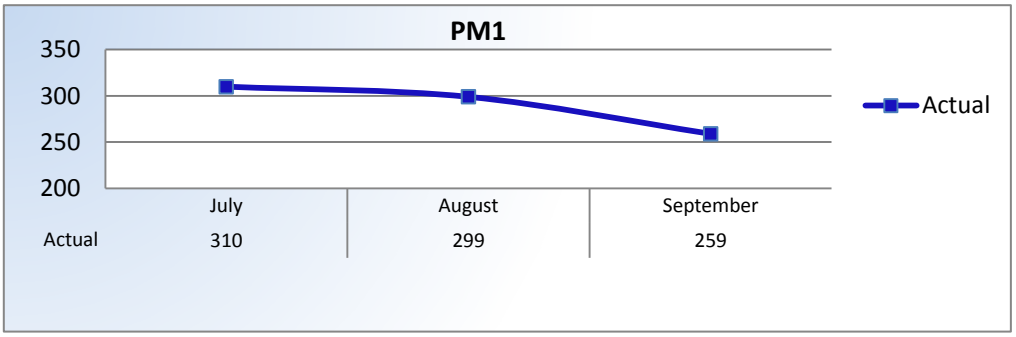
Performance Measures

Q1 Report *(July - September 2013)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

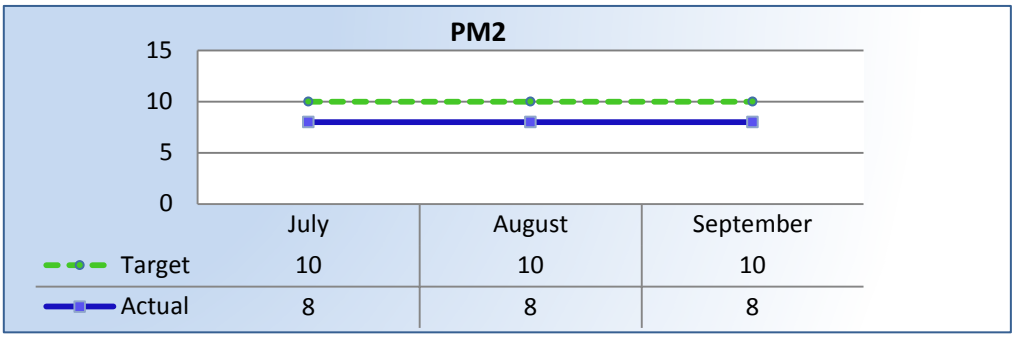


Total Received: 868 Monthly Average: 289

Complaints: 709 | **Convictions**: 159

PM2 | Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

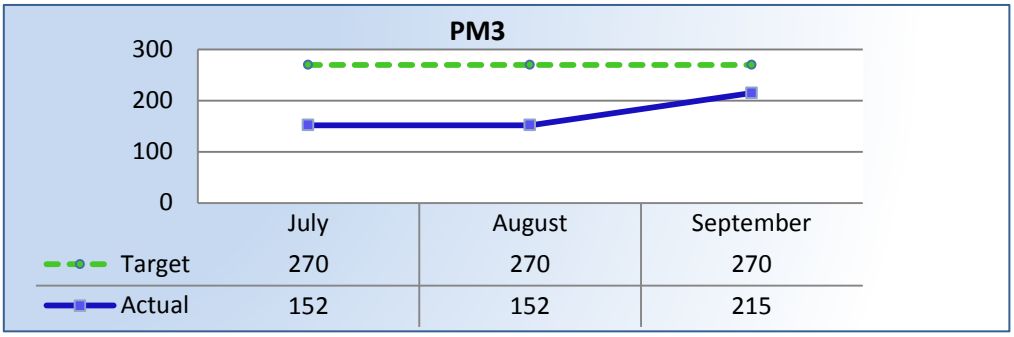


	July	August	September
Target	10	10	10
Actual	8	8	8

Target Average: 10 Days | **Actual Average:** 8 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

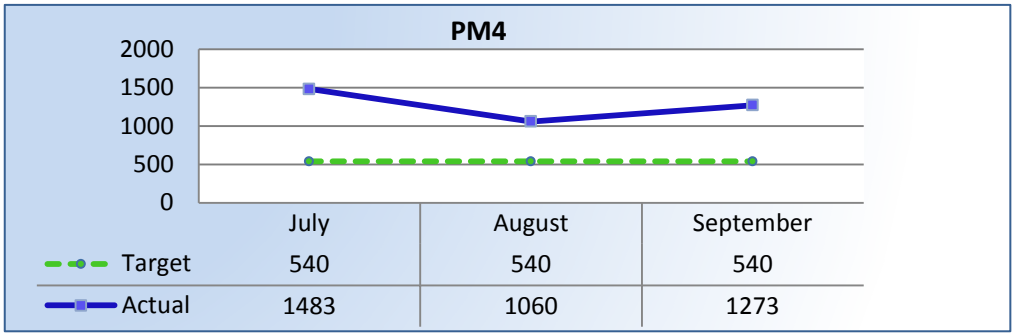


	July	August	September
Target	270	270	270
Actual	152	152	215

Target Average: 270 Days | **Actual Average:** 174 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

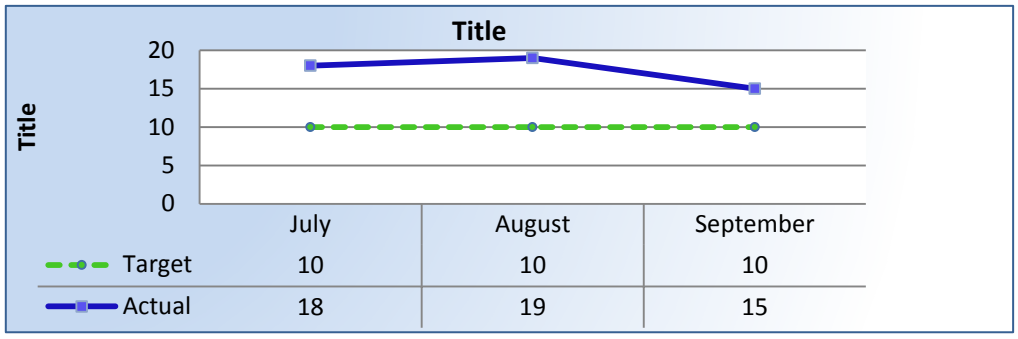


	July	August	September
Target	540	540	540
Actual	1483	1060	1273

Target Average: 540 Days | **Actual Average:** 1,230 Days

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 10 Days | **Actual Average:** 17 Days

PM8 |Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

The Board did not report any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

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MEMORANDUM

DATE	November 8, 2013
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	**Agenda Item 7D:** Report on Medical Board of California's Prescribing Task Force

On September 23, 2013, the Dental Board of California attended the Prescribing Task Force meeting hosted by the Medical Board of California. The task force, created at the Medical Board's April 2013 board meeting, is intended to identify ways to proactively "approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication, and outreach by engaging stakeholders" with a vision to significantly reduce prescription drug overdoses.

The initial objectives of the Prescribing Task Force are to:

1. Identify appropriate patient information that can/should be shared/discussed between the prescriber and the pharmacist.
2. Identify best practices for prescribing, including:
    a. Revisit the current Pain Management Guidelines
    b. Educate prescribers on best practices for prescribing and the public on diversion, disposal and additional information regarding overprescribing and addiction
    c. Develop an outreach plan to provide information to all stakeholders
3. Review the Board's policy on expert reviews for overprescribing cases.

The first meeting, co-chaired by Medical Board Members Barbara Yaroslavsky and Michael Bishop, M.D., was focused on the first objective (appropriate information that can be shared between the prescriber and the pharmacist.) It was well attended by a variety of stakeholders including Pharmacists, prescribers, the DEA, board staff from Medical Board, Pharmacy Board and Nursing Board, the Attorney General's office, and consumer groups including patient advocates, parents against drug abuse and the Center for Public Interest Law.

The meeting started out with a Powerpoint presentation given by Medical Board Deputy Chief, Laura Sweet. Ms. Sweet provided a historical perspective on the changes and influences of the standards of pain management which evolved into the Pain patient's

Bill of Rights, prescribing guidelines, and incorporating pain specialists into their investigative standards.

The presentation was followed by a brief discussion and handout by Supervising Deputy Attorney General Joshua Room covering a precedential decision by the Board of Pharmacy regarding the “corresponding responsibility” a pharmacy/pharmacist owes under California law to determine the legitimate medical purpose of controlled substance prescriptions before dispensing. A published decision by the DEA on the same topic was also shared.

These two presentations led into the broader discussion of where the points of control and responsibility exist between dispensers, prescribers, and patients, and where consensus can be found to make the necessary changes to curtail the problem of overprescribing.

The attendees then broke out into smaller workgroups to identify and discuss shared problems between prescribers and dispensers which can be barriers to the necessary communication to identify prescription abuse. Issues such as how much patient information should be shared between prescribers and dispensers, when does HIIPA apply, and what level of privacy is reasonable given the seriousness of the problem as it currently exists. In general, the groups were able to come to consensus on many of the issues; including the need for broader communication, statewide guidelines, further education, and the potential role CURES could play in the years ahead.

The task force’s next meeting is scheduled to take place sometime in early 2014 and will discuss Best Practices on Prescribing and Pain Management Guidelines.

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MEMORANDUM

DATE	November 7, 2013
TO	Dental Board Members
FROM	Dawn Dill, Manager, Licensing and Examination Unit Dental Board of California
SUBJECT	**Agenda Item 8A: Licensure and Permit Statistics**

Following are statistics of current license/permits by type as of November 3, 2013

	Dental License (DDS)	**Registered Dental Assistant (RDA)**	**Registered Dental Assistant in Extended Functions (RDAEF)**	**Total Licenses**
Active	36,364	34,685	1,325	72,374
Inactive	3,756	8,511	120	12,387
Retired	1,745	10	0	1,755
Disabled Non practice	122	N/A	N/A	122
Renewal in Process	278	643	17	938
Fingerprinting Hold	210	638	27	875
Delinquent	3,381	8,851	172	12,404
Suspended No Coronal Polish/X-ray	N/A	1,336	0	1,336
Total Current Population	45,856	54,674	1,661	102,191
Total Cancelled Since Implementation	12,466	35,543	165	48,174

New RDAEF licenses issued since January 1, 2010 = 170.
Existing RDAEF licenses enhanced since January 1, 2010 = 150.

Dental Licenses Issued via Pathway	Total Issued in 2013	Total Issued in 2012	Total Issued to Date	Date Pathway Implemented
California Exam	0	0	53,977	Prior to 1929
WREB Exam	703	697	5,289	January 1, 2006
Licensure by Residency	165	163	957	January 1, 2007
Licensure by Credential	116	148	2,498	July 1, 2002
LBC Clinic Contract	1	1	25	July 1, 2002
LBC Faculty Contract	0	0	3	July 1, 2002

License/Permit /Certification/Registration Type	Current Active Permits	Delinquent	Total Cancelled Since Implemented
Additional Office Permit	2,248	373	5,368
Conscious Sedation Permit	507	22	334
Continuing Education Registered Provider Permit	1,361	696	1,178
Elective Facial Cosmetic Surgery Permit	26	0	0
Extramural Facility Registration*	142	n/a	n/a
Fictitious Name Permit	5,770	1,043	3,865
General Anesthesia Permit	835	25	773
Mobile Dental Clinic Permit	26	11	28
Medical General Anesthesia Permit	76	29	132
Oral Conscious Sedation Certification (Adult Only 1,121; Adult & Minors 1,228)	2,349	508	137
Oral & Maxillofacial Surgery Permit	87	5	12
Referral Service Registration*	289	n/a	n/a
Special Permits	31	15	153
Dental Sedation Assistant Permit	23	0	0
Orthodontic Assistant Permit	108	2	0

*Current population for Extramural Facilities and Referral Services are approximated because they are not automated programs.

Active Licensed Dentists by County

County	DDS	RDA	RDAEF	Population
Alameda	1,460	1,393	48	1,554,720
Alpine	0	0	0	1,129
Amador	27	65	5	37,035
Butte	164	300	4	221,539
Calaveras	24	66	0	44,742
Colusa	3	22	2	21,411
Contra Costa	1,061	1,585	49	1,079,597
Del Norte	16	44	1	28,290
El Dorado	166	273	14	180,561
Fresno	564	806	17	947,895
Glenn	8	54	3	27,992
Humboldt	92	235	2	134,827
Imperial	42	79	3	176,948

County	(DDS)	RDA	RDAEF	Population
Inyo	12	15	0	18,495
Kern	345	673	41	856,158
Kings	64	132	6	151,364
Lake	26	78	14	63,983
Lassen	32	60	2	33,658
Los Angeles	8,490	5,347	226	9,962,789
Madera	53	148	2	152,218
Marin	340	235	10	256,069
Mariposa	7	15	1	17,905
Mendocino	63	102	8	87,428
Merced	91	196	14	262,305
Modoc	6	8	0	9,327
Mono	1	9	0	14,348
Monterey	297	425	21	426,762
Napa	118	157	3	139,045
Nevada	95	137	3	98,292
Orange	3,759	2,238	69	3,090,132
Placer	453	632	32	361,682
Plumas	16	22	1	19,399
Riverside	1,100	2,063	68	2,268,783
Sacramento	1,096	1,859	92	1,450,121
San Benito	26	99	6	56,884
San Bernardino	1,328	1,756	62	2,081,313
San Diego	2,706	2,971	93	3,177,063
San Francisco	1,262	510	17	825,863
San Joaquin	380	798	40	702,612
San Luis Obispo	234	309	3	274,804
San Mateo	866	857	26	739,311
Santa Barbara	345	349	6	431,249
Santa Clara	2,230	1,932	56	1,837,504
Santa Cruz	200	267	9	266,776
Shasta	132	312	8	178,586
Sierra	3	4	0	3,086
Siskiyou	30	43	1	44,154
Solano	300	674	32	420,757
Sonoma	416	829	35	491,829
Stanislaus	281	700	35	521,726
Sutter	64	135	10	95,022
Tehama	29	68	5	63,406
Trinity	4	7	0	13,526
Tulare	207	414	8	451,977
Tuolumne	57	90	0	54,008
Ventura	640	630	58	835,981
Yolo	118	239	8	204,118
Yuba	11	93	9	72,926

Population is from the US Censes, estimates for 2012. All California 38,041,430.

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MEMORANDUM

DATE	November 21, 2013
TO	Dental Board Members
FROM	Jessica Olney, Associate Governmental Program Analyst
SUBJECT	**Agenda Item 8B:** Review of General Anesthesia/Conscious Sedation/Medical General Anesthesia Evaluation Statistics

2012-2013 Statistical Overviews of the On-Site Inspections and Evaluations Administered by the Board

General Anesthesia Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
October	18	0	0	0	5	1
November	13	0	0	3	3	0
December	5	0	0	3	1	2
January	12	0	0	1	5	2
February	9	0	0	1	4	0
March	13	0	3	4	1	1
April	11	1	2	2	1	2
May	15	0	2	3	1	2
June	2	0	0	0	1	0
July	11	0	0	3	1	1
August	12	0	0	0	1	0
September	10	1	0	2	3	0
October*	15	0	1	1	2	0
November*	13	0	0	1	2	1
Total	**160**	**2**	**8**	**24**	**31**	**11**

***Approximate schedule for October/November

Conscious Sedation Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
October	1	0	1	2	1	4
November	5	1	2	1	0	0
December	1	0	0	0	2	5
January	5	0	0	3	1	1
February	5	0	1	2	0	1
March	4	0	3	0	2	0
April	8	0	1	1	1	4
May	3	0	1	1	1	3
June	0	0	0	0	0	1
July	5	0	0	1	1	0
August	6	0	0	2	0	1
September	2	0	0	1	3	1
October*	3	0	0	3	1	1
November*	9	0	0	0	2	3
Total	**57**	**1**	**9**	**17**	**15**	**25**

*Approximate schedule for October/November

There is a great need for conscious sedation evaluators throughout California. Several evaluations have been postponed recently due to a lack of available evaluators. The Board is actively recruiting for the evaluation program.

Medical General Anesthesia Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
October	0	0	0	1	1	0
November	0	0	0	1	1	0
December	0	0	0	1	0	0
January	0	0	0	0	1	0
February	0	0	0	2	0	0
March	0	0	0	1	0	0
April	0	0	0	1	0	0
May	0	0	0	1	0	1
June	0	0	0	1	0	0
July	0	0	0	1	0	0
August	0	0	0	2	0	0
September	0	0	0	1	0	0
October*	1	0	0	0	0	0
November*	2	0	0	0	0	0
Total	**3**	**0**	**0**	**13**	**3**	**1**

*Approximate schedule for October/November

Evaluators Approved after October 2013

Region	GA	CS	MGA
Northern California	2	2	0
Southern California	1	1	0

Pending Evaluator Applications*

Region	GA	CS	MGA
Northern California	0	0	0
Southern California	6	2	0

*Deficient, or do not meet 3 year requirement.

Current Evaluators per Region

Region	GA	CS	MGA
Northern California	151	67	15
Southern California	197	92	14

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MEMORANDUM

DATE	November 13, 2013
TO	Dental Board Members
FROM	Jessica Olney, Associate Governmental Program Analyst
SUBJECT	**Agenda Item 8C:** Update on General Anesthesia/Conscious Sedation Calibration Webinar

At the August 2013 Board meeting, Dr. Whitcher reported that he had been developing a webinar for the General Anesthesia/Conscious Sedation Calibration Course. In the past, this calibration course has been offered by the Board once a year at one location in the north and one location in the south.

Licensing staff had intended to host a webinar in the fall of 2013, however due to scheduled and unscheduled absences that occurred in September, the licensing staff was redirected to assist in another area and therefore the launch of the webinar has been postponed until a future date can be determined.

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MEMORANDUM

DATE	November 1, 2013
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	**Agenda Item 8D:** Capnograph Requirements – Information Item Only Report Regarding the Requirements for the Use of Capnography During Sedation and General Anesthesia

Background:
Board staff has been receiving inquiries from dental offices asking if there are new capnography equipment requirements that become effective January 2014, and whether they are applicable to only Oral and Maxillofacial Surgeon (OMS) offices or all dental offices. Board staff has become aware that the American Association of Oral and Maxillofacial Surgeons have adopted new capnography equipment for their members that will become effective in January 2014. In an effort to clarify the Board's capnography equipment requirements versus those of the American Association of Oral and Maxillofacial Surgeons', the following information has been provided:

i. Use of Capnography During Sedation and General Anesthesia as it Relates to the Dental Board of California's Requirement (California Code of Regulations, Title 16, Section 1043.3(a)(7)(K)):
California Requirements
The equipment required for patients undergoing conscious sedation and anesthesia in California are specified in Section 1043.3 of Title 16 of the California Code of Regulations. Pursuant to subsection 1043.7(a)(7)(K), a capnograph and temperature measuring device are required for intubated patients receiving general anesthesia; this subsection specifically states that the capnograph and temperature measuring device are not required for conscious sedation. The Board does not have any new capnography equipment requirements effective in 2014.

ii. Use of Capnography During Sedation and General Anesthesia as it Relates to the American Association of Oral and Maxillofacial Surgeons' (AAOMS) Requirements, Effective January 1, 2014:
The American Association of Oral and Maxillofacial Surgeons' (AAOMS) Clinical Practice Guidelines, "Anesthesia in Outpatient Facilities" (Parameters of Care, 5th Ed., 2012) state that "use of capnography for patients under moderate sedation, deep sedation, and general anesthesia should be instituted in OMS practice and used on

these patients effective January 2014 unless precluded or invalidated by the nature of the patient, procedure, or equipment. It is anticipated that this implementation date will allow adequate time for the refinement of materials and methods so as to optimize the use of capnography in an open system."

To maintain membership in the AAOMS all Members and Fellows are required to follow AAOMS standards and guidelines such as the Parameters of Care. If not, they may be subject to discipline or suspension of their AAOMS membership status.

Action Requested:
No action necessary.