



**FULL BOARD MEETING
November 22, 2013**



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



BOARD MEETING AGENDA
November 22, 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 Dominicus, 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.

Friday, November 22, 2013

8:30 A.M. OPEN SESSION - FULL BOARD

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

CLOSED SESSION – FULL BOARD

Deliberate and Take Action on Disciplinary Matters

The Board will meet in closed session as authorized by Government Code §11126(c)(3).

CLOSED SESSION – LICENSING, CERTIFICATION, AND PERMITS COMMITTEE Issuance of New License(s) to Replace Cancelled License(s)

The Committee will meet in closed session as authorized by Government Code §11126(c)(2) to deliberate on applications for issuance of new license(s) to replace cancelled license(s).

RETURN TO OPEN SESSION – FULL BOARD

12. Report from the Licensing, Certification and Permits Committee Regarding Closed Session
The Board may take action on recommendations by the Licensing Certification and Permits Committee regarding issuance of new license(s) to replace cancelled license(s).
13. Executive Officer's Report
14. Budget Report
15. Update and Revision of the Board Member Administrative Procedure Manual
16. Diversion Program
 - A. Diversion Program Background
 - B. Presentation by Maximus Regarding the Dental Board of California
 - C. Presentation by the California Dental Association (CDA) of its Well-Being Program
 - D. Diversion Program Statistics
17. Legislation
 - A. 2014 Tentative Legislative Calendar – Information Only
 - B. Discussion and Possible Action Regarding 2013 End-of-Year Legislative Summary Report

- AB 258 (Chavez, Chapter 227, Statutes of 2013) State Agencies: Veterans
 - AB 512 (Rendon, Chapter 111, Statutes of 2013) Healing Arts: Licensure Exemption
 - AB 836 (Skinner, Chapter 299, Statutes of 2013) Dentists: Continuing Education
 - SB 562 (Galgiani, Chapter 624, Statutes of 2013) Dentists: Mobile or Portable Dental Units
 - SB 809 (DeSaulnier, Chapter 400, Statutes of 2013) Controlled Substances: Reporting
 - SB 821 (Senate Business, Professions and Economic Development Committee, Chapter 473, Statutes of 2013) Healing Arts
- C. Update Regarding Previously Approved Legislative Proposal Regarding Delegation of Authority to Accept the Findings of any Commission or Accreditation Agency Approved by the Board and Adopt those Findings as its Own Relating to the Approval of Foreign Dental Schools
- D. Discussion and Possible Action Regarding Legislative Proposals for 2014:
- i. Amendment of Business and Professions Code §1724 Relating to Increasing the Statutorily Authorized Maximum for Dentistry Fees
 - ii. Amendments to the Dental Practice Act (Business and Professions Code §1600 et seq.) for Inclusion in the Healing Arts Omnibus Bill
- E. Discussion and Possible Action Regarding Future Proposal to Amend Business and Professions Code §§1646 to 1647.26 Relating to General Anesthesia, Conscious Sedation, and Oral Conscious Sedation
- F. 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
- G. Update on Pending Regulatory Packages:
- i. Uniform Standards for Substance Abusing Licensees (California Code of Regulations, Title 16, Sections 1018 and 1018.01);
 - ii. Dentistry Fee Increase (California Code of Regulations, Title 16, Section 1021);
 - iii. Portfolio Examination Requirements (California Code of Regulations, Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2,

1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033, 1033.1, 1034, 1034.1, 1035, 1035.1, 1035.2, 1036, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039)

- iv. Abandonment of Applications (California Code of Regulations, Title 16, Section 1004)

H. Discussion and Possible Action Regarding Filing a Section 100 “Change without Regulatory Effect” with the Office of Administrative Law to Amend California Code of Regulations, Title 16, Section 1065 Relating to Notice to Consumers of Licensure by the Dental Board

- 18. Report from the Dental Assisting Council
The Board may take action on any items listed on the attached Dental Assisting Council Meeting Agenda.
- 19. Election of Board Officers for 2014
- 20. 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)).
- 21. Future Agenda Items
Stakeholders are encouraged to propose items for possible consideration by the Board at a future meeting.
- 22. Board Member Comments for Items Not on the Agenda
The Board may not discuss or take action on any matter raised during the Board Member Comments 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)).
- 23. Adjournment



MEMORANDUM

DATE	October 17, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	Agenda Item 12: Report from the Licensing, Certification and Permits Committee Regarding Closed Session

Dr. Whitcher, Chair of the Licensing, Certification and Permits Committee, will provide recommendations to the Board based on the outcome of the Closed Session meeting to grant a new license(s) to replace a cancelled license(s).



MEMORANDUM

DATE	November 14, 2013
TO	Dental Board of California
FROM	Karen Fischer, Executive Officer
SUBJECT	Agenda Item 13: Executive Officer's Report

This report is intended to provide Board Members with an administrative update on the Executive Officer activities and communications, including management of board operations since the last quarterly meeting held in August, 2013. No action is needed at this time. However, Board members are encouraged to comment on any item.

Administrative Update:

- Testified before the Senate Committee on Budget and Fiscal Review regarding the special fund loan to the general fund. Board and Bureaus scheduled to receive repayment during fiscal year 13-14 were asked general questions regarding fund conditions and expenditures. The Dental Board loaned the general fund \$10,000,000 (\$5 million in 2002 and \$5 million in 2003). The balance of the loan, \$2.7 million, is expected to be repaid by June 2014.
- Administered the Oath of Office to newly appointed Diversion Evaluation Committee member Dr.Frier.
- Board President and Executive Officer attended the Dental Hygiene Committee of California meeting in San Francisco. Reported on the items that had been discussed at the Board's August meeting.
- Attended the Registered Dental Assistant in Extended Functions examination which was held at Sacramento City College. Met the examiners and proctors and observed the examination process.
- Teleconference with Dr. Conrado Barzaga, Executive Director, Center for Oral Health. The Center for Oral Health is conducting research on the existing oral health infrastructure in California. He was asking for assistance in accessing the raw data collected through the Dental Healthcare Workforce Survey. A follow-up meeting may be scheduled.

- Attended a meeting with the Department of Consumer Affairs (DCA) Legal Department regarding its decision to rescind a prior legal decision relating to social couponing and advertising.
- Met with the Executive Officer and staff of the Board of Vocational Nursing to discuss telephone issues.
- Staff participated in the Prescribing Task Force hosted by the Medical Board of California.
- Teleconference with DCA Director Brown, Board/Committee Chairs, and Executive Officers.
- Attended teleconference meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee.
- Attended special teleconference meeting of the Dental Board to discuss comments received for the fee increase regulatory package.
- Attended the Executive Officers meeting hosted by Steve Sands, Executive Director of the Contractors State Licensing Board. Featured speakers included James Goldstene, Undersecretary, Business, Consumer Services and Housing Agency, Alfredo Terrazas, Senior Assistant Attorney General, Bill Gage, Senate Business, Professions and Economic Development Committee, and Hank Dempsey, Assembly Business, Professions and Consumer Protection Committee
- Met with DCA Deputy Director of Office of Information Services to discuss assistance with IT functions during the recruitment of a staff information system analyst person to fill the vacancy created when Joe Muncie retired. Discussed updating the duty statement to reflect new duties anticipated with the transition to BreZE and website design in order to recruit qualified candidates to fill this vacancy.
- Staff attended meet and greet with DCA Legislative and Policy Review (LPR) Unit. The DCA Budget unit also joined the meeting. Discussed how best to work together when legislation (relative to the Dental Board) is working its way through the process.
- Staff met with the Board's Legislative Committee Chair to discuss moving forward with seeking authors for Board legislation in 2014.
- Met with CDA – Vice President of Governmental Affairs, Director of Policy Development and Public Policy, and the Regulatory Manager to discuss increased communication strategies.
- Met with the Executive Officer of the Veterinary Medical Board to discuss budget issues.
- Meet regularly with the Executive Director of the Medical Board of California to discuss issues of mutual interest.
- Meet regularly with the Executive Officer of the Dental Hygiene Committee to discuss issues of mutual interest.
- Teleconference with DCA Legislative Unit and Board Executive Officers regarding the implementation of SB 809 relating to CURES.

BreEZe Update

The Department of Consumer Affairs (DCA) launched its new on-line program for licensing and enforcement (BreEZe) on October 8, 2013 for the Release 1 Boards listed below. Although the Dental Board will begin utilizing this new system during Release 2, (which is scheduled to occur during 2014) all Boards and Bureaus within DCA were required to suspend operations such as processing any applications, renewals, or enforcement tracking, and scheduling examinations for several days before and after the October 8th launch date. The Board made every effort to encourage licensees to renew early by posting an announcement on its website and sending email blasts to website subscribers. In addition, the California Dental Association (CDA) and the California Association of Dental Assisting Teachers (CADAT) assisted in getting the word out to their members to renew early. I am pleased to report that there were no significant issues during this transition period.

As a reminder, BreEZe will improve data quality, replace old technology, and bring DCA's services to the web for customer self-service. The services that will be available on-line are:

- File a Complaint
- Public License Search
- Apply for a License
- Renew a License
- Subscribe to License Status Changes
- License Maintenance

Release 1 Boards/Bureaus/Committees:

Barbering and Cosmetology, Board of
Behavioral Sciences, Board of
Naturopathic Medicine Committee
Medical Board of California
Osteopathic Medical Board of California
Physician Assistant Board
Podiatric Medicine, Board of
Psychology, Board of
Registered Nursing, Board of
Respiratory Care Board

Staff will continue to update Board Members on the progress of the Department wide transition to the improved on-line system as new information becomes available.

Controlled Substance Utilization Review and Evaluation System (CURES) Update

At the August 2013 Board meeting, Kim Trefry, Enforcement Chief, gave a detailed report on the Department of Justice database called CURES. Please refer to that report for additional information. (August 16, 2013 Meeting, Agenda Item 21(D)) She reported that this database, in conjunction with the Prescription Drug Monitoring Program (PDMP), was an attempt to identify solutions to the programmatic challenges facing the monitoring and enforcement of triplicate prescription requirements. In July of 2012, the

Department of Consumer Affairs (DCA) was advised that there would not be adequate funding to support the continuation of the program without support for emergency legislation. The DOJ thus proposed *CURES 2.0* to combine CURES and the PDMP into one system, while upgrading and enhancing the features.

The DOJ created a plan for the *replacement* of the current system to include a two year transition between the old system and the new system. In early 2013, the Board was notified of new appropriations for the funding of *CURES 2.0*. The Board will appropriate \$578,000 for the development of *CURES 2.0*. DCA continues to negotiate with DOJ on the plan to move forward with developing the new system.

In the meantime, Senate Bill 809 (DeSaulnier) was signed by the Governor and establishes a funding mechanism to update and maintain the CURES and PDMP. The cost to dentists will be an annual fee of \$6. It is anticipated that this fee will be collected at the time of renewal, and therefore licensees will see an increase in the licensure renewal fee of \$12 – going from \$365 to \$377. The \$12 will go directly into a fund established by DCA, solely for the purpose of the CURES maintenance. Since the legislation is effective April 1, 2014. License renewals with an expiration date of April 30, 2014 will be mailed out in January, 2014 and will reflect this additional fee. Board staff is in the process of developing outreach material to distribute to licensees in December notifying them of this new law. Staff will continue to participate in implementation meetings with DCA.

Staffing Report

Staffing changes that occurred since August 2013.

Administration Unit (1 vacancy): The Staff Information Systems Analyst (SISA) informed management of his retirement the same day he retired. The Board is currently working with DCA/Office of Information Services to evaluate the position and duties. Once determined, recruitment will be initiated.

Dental Licensing & Examination Unit (1 vacancy): One of the Staff Services Analysts (SSA) voluntarily separated from State service and recruitment has been initiated.

Dental Assisting Unit (1 vacancy): As the result of a medical action, the Office Assistant (OA) in the receptionist position has been placed on administrative time off; once termination is finalized, recruitment will be initiated. Additionally, this program has 2 Management Services Technicians (MST) that serve as exam technicians. Both are currently out on a medical leave of absence with anticipated return dates of 12/2013 and 01/2014. Due to these absences, the Board has requested and received approval to hire a 24 month limited term/full time position and recruitment has been initiated.

Complaint & Compliance Unit (1 vacancy): One of the Associate Governmental Program Analysts (AGPA) has transferred to another State department and the Board is currently working with DCA/Office of Human Resources to evaluate the position and duties. Once determined, recruitment will be initiated.

Investigative Analysis Unit: This unit is currently fully staffed.

Sacramento Enforcement Field Office (3 vacancies): The Inspector II (INS II) has retired and recruitment is currently in progress. Additionally, there are 2 Investigator (INV) positions that are currently being recruited for and are in the background phase. The Board also anticipates an Investigator retirement in January 2014 and will soon initiate recruitment for this vacancy.

Orange Enforcement Field Office: This office is currently fully staffed.

Dental Consultants (1 vacancy): Of the 2 Dental Consultant (DC) positions at the Board, 1 remains vacant as a result of the lack of a current exam list. In an effort to create such a list, Board staff has consulted with DCA/Selection Services and an Exam Bulletin was posted with a final file date of 11/15/13. This list is anticipated to be available for use in January 2014.



MEMORANDUM

DATE	November 14, 2013
TO	Dental Board Members
FROM	Genie Albertsen Budget/Contract/Procurement Analyst
SUBJECT	Agenda Item 14: Budget Report

The Board manages two separate funds: 1) Dentistry Fund, and 2) Dental Assisting Fund. The funds are not comingled. The following is intended to provide a summary of expenses for the first quarter of fiscal year (FY) 2013-14 for the Dentistry and Dental Assisting funds.

Dentistry Fund Overview

First Quarter Expenditure Summary for Fiscal Year 2013-14

The first quarter expenditure projections are based upon the budget report released by the Department of Consumer Affairs in mid-October through September 30. The Board spent roughly \$2.8 million of its total \$11.8 appropriation. Approximately \$1.4 million was spent for Personnel Services; and roughly \$1.4 million for Operating Expense & Equipment (OE&E).

For comparison purposes, last year at this time the Board had spent roughly \$2.6 million of its (FY) 2012-13 Dentistry budget appropriation. Approximately \$1.2 million of the expenditures was Personnel Services, and roughly \$1.3 million of the expenditures was OE&E.

Fund Title	Appropriation	Expenditures Through 9-30-13
Dentistry Fund	\$11,825,000	\$2,829,000

Analysis of Fund Condition

The Analysis of Fund Condition displays three fiscal years and projects the Dentistry Fund's fiscal solvency for future years. In addition to the Board's operating appropriation, the Fund Condition includes several additional funding appropriations including:

- Controlled Substances Utilization and Evaluation System (CURES)

- ✓ \$578,000 in 2013-14

In early 2013, the Board was notified of new appropriations for the funding of *CURES 2.0*. The Department of Justice created a plan for the *replacement* of the current system to include a two year transition between the old system and the new system. This is separate from the proposal in SB 809 (DeSaulnier) (Chapter 740, Statutes of 2013) which only addresses ongoing maintenance needs of the system. Currently, there are five healing arts boards within DCA that provide the DOJ funding for CURES. The Dental Board's portion is \$578,000 in 2013-14.

- Financial Information System for California (FI\$Cal)

- ✓ \$53,000 in 2013-14

It's a business transformation project for state government in the areas of budgeting, accounting, procurement, and cash management. The project will prepare the state systems and workforce to function in an integrated financial management system environment. To ensure the success of the project, the Partner Agencies have entered into a Memorandum of Understanding (MOU) signed by the State Controller, the State Treasurer, and the Directors of the Departments of Finance and General Services. The MOU demonstrates support for the project at the highest levels of these organizations and provides the framework for this project. FI\$Cal is an historic partnership of the Department of Finance, the State Controller's Office, the State Treasurer's Office and the Department of General Services.

- Mobile or Portable Dental Clinics (SB 562)

- ✓ \$45,000 in 2014-15

CDA sponsored SB 562 (Chapter 740, Statutes of 2013) to provide the Board with the statutory authority to require registration of portable dental units and to eliminate the restriction on the number of mobile or portable dental units a dentist may operate. By eliminating the restriction on the number of units that may be operated, the CDA intended to encourage access to care by allowing dentists to cover multiple sites with multiple units. Additionally, this bill further specified the registration and compliance requirements that will need to be included in the Board's regulations relative to the registration of mobile and portable dental units.

Dental Assisting Fund Overview

First Quarter Expenditure Summary for Fiscal Year 2013-14

The first quarter expenditure projections are based upon the budget report released by the Department of Consumer Affairs in mid-October through September 30. The Board spent roughly \$447,000 of its total \$1.8 appropriation. Approximately \$152,000 was spent for Personnel Services; and roughly \$296,000 for Operating Expense & Equipment (OE&E).

Fund Title	Appropriation	Expenditures Through 9-30-13
Dental Assisting	\$1,851,000	\$447,000

Analysis of Fund Condition

The Analysis of Fund Condition displays three fiscal years and projects the Dental Assisting Fund's fiscal solvency for future years. In addition to the Board's operating appropriation, the Fund Condition includes funding appropriation of \$8,000 for FI\$Cal.

The current Analysis of Fund Condition shows that Dental Assisting will end 2014-15 with a balance of \$2.4 million.

Enforcement Cost Recovery & Citation Summary

The following information is provided in response to a request for information by a board member at the August 2013 meeting:

Cost Recovery Outcomes

Beginning in July 2013, the Enforcement Program began tracking the results of our cost recovery efforts. In general, enforcement staff track their investigative time worked and the Subject Matter Expert costs, and submit these hours to the Attorney General's (AG) office along with their completed investigative case. These hours are combined with the time invested by the AG's office and are considered the costs of the case. These costs, along with other terms and conditions of the disciplinary outcome may be negotiated and result in a lesser amount returned to the board.

Since the beginning of the fiscal year, our overall cost averages have been:

Expense	Amount
Investigations	\$ 5,216
Subject Matter Expert	\$ 1,597
Attorney General	\$ 7,687
Total	\$14,280

Our average cost recovery ordered is \$8,350 or 58% of our actual costs.

Case dispositions can be determined in several ways, which can affect our ability to request and receive cost recovery. The table below provides further detail as to the degree of cost recovery that has been obtained based upon the manner in which the case was adjudicated:

Type of Case (# of Cases)	Actual Costs	Cost Recovery Ordered	% of Actual Cost
Stipulated Settlements (26)	\$378,086	\$235,299	62%
Proposed Decisions (6)	\$ 76,335	\$ 30,472	39%
Total (32)	\$454,421	\$265,771	58%

The outcome of the decision, whether to grant probation or revoke the license further affects our ability to collect these monies from the disciplined licensee. Of the 32 instances listed above, one license was revoked and three were surrendered. The cost recovery owed in these cases totaled over \$56,000. None of this is likely to be reimbursed to the board unless a licensee petitions and is granted reinstatement.

Citation Efforts and Revenues

Compliance with the use of administrative citations is also being tracked. Beginning in June 2012, nine administrative citations were issued with fine amounts ranging from zero (no fine) to \$1,000 (per violation). The total amount collected is \$11,100.

**DENTAL BOARD - FUND 0741
BUDGET REPORT
FY 2013-14 EXPENDITURE PROJECTION**

September 30, 2013

OBJECT DESCRIPTION	FY 2012-13		FY 2013-14				
	ACTUAL	PRIOR YEAR	BUDGET	CURRENT YEAR	PERCENT	PROJECTIONS	UNENCUMBERED
	EXPENDITURES (MONTH 13)	EXPENDITURES 9/30/2012	STONE 2013-14	EXPENDITURES 9/30/2013	SPENT	TO YEAR END	BALANCE
PERSONNEL SERVICES							
Salary & Wages (Staff)	3,224,188	815,942	3,734,005	874,870	23%	3,731,876	2,129
Statutory Exempt (EO)	236,291	24,705	103,608	23,952	23%	95,808	7,800
Temp Help (Expert Examiners)	0		40,000	0	0%	0	40,000
Physical Fitness Incentive	5,200	1,300	0	910		5,200	(5,200)
Temp Help Reg (907)	144,012	50,293	222,403	75,660	34%	164,581	57,822
Temp Help (Exam Proctors)	0		45,447	0	0%	0	45,447
BL 12-03 Blanket	8,519			12,854		12,854	(12,854)
Board Member Per Diem (901, 920)	16,600	800	45,950	3,900	8%	17,000	28,950
Committee Members (911)	5,600	800	58,686	700	1%	4,200	54,486
Overtime	41,676	13,166	25,208	2,001	8%	40,000	(14,792)
Staff Benefits	1,520,752	369,140	1,818,320	421,707	23%	1,798,848	19,472
TOTALS, PERSONNEL SVC	5,202,838	1,276,146	6,093,627	1,416,554	23%	5,870,367	223,260
OPERATING EXPENSE AND EQUIPMENT							
General Expense	108,558	26,010	58,821	17,675	30%	106,000	(47,179)
Fingerprint Reports	24,890	5,096	25,777	3,283	13%	39,300	(13,523)
Minor Equipment	14,558		0	234	#DIV/0!	0	0
Printing	44,381	12,622	42,134	10,244	24%	36,000	6,134
Communication	60,733	7,321	33,020	6,902	21%	57,000	(23,980)
Postage	73,968	14,555	59,435	17,405	29%	88,000	(28,565)
Insurance	2,775		2,100	0	0%	2,775	(675)
Travel In State	103,511	11,575	108,976	17,155	16%	103,000	5,976
Travel, Out-of-State	209		0			1,000	(1,000)
Training	4,648	1,750	6,907	500	7%	3,000	3,907
Facilities Operations	399,772	348,808	360,656	398,631	111%	400,000	(39,344)
C & P Services - Interdept.	46,077	45,055	102,086	40,132	39%	46,000	56,086
C & P Services - External	194,668	176,094	297,146	141,442	48%	156,300	140,846
DEPARTMENTAL SERVICES:							
OIS Pro Rata	472,181	129,960	629,144	157,286	25%	629,144	0
Admin/Exec	600,857	161,518	653,908	163,477	25%	653,908	0
Interagency Services	0		881	0	0%	0	881
IA w/ OER	23,330		0			23,330	(23,330)
DOI-ProRata Internal	25,531	6,458	21,028	5,257	25%	21,028	0
Public Affairs Office	31,983	9,231	29,561	7,390	25%	29,561	0
CCED	41,860	11,091	28,218	7,055	25%	28,218	0
INTERAGENCY SERVICES:							
Consolidated Data Center	19,721	2,490	17,517	4,001	23%	24,000	(6,483)
DP Maintenance & Supply	10,450		11,118	13	0%	10,000	1,118
Central Admin Svc-ProRata	506,464	126,616	530,145	132,536	25%	530,145	0
EXAMS EXPENSES:							
Exam Supplies	0		43,589	0	0%	0	43,589
Exam Freight	0		166	0	0%	0	166
Exam Site Rental	0		196,586	0	0%	0	196,586
C/P Svcs-External Expert Administration	142,763	30,131	6,709	19,998	298%	94,800	(88,091)
C/P Svcs-External Expert Examiners	0		238,248	0	0%	0	238,248
C/P Svcs-External Subject Matter	1,259					0	0
OTHER ITEMS OF EXPENSE:							
Tort Pymts-Punitive	14,518	3,446	661	2,066	313%	8,300	(7,639)
ENFORCEMENT:							
Attorney General	1,151,154	162,221	1,778,310	175,138	10%	1,050,828	727,482
Office Admin. Hearings	183,978	3,722	406,720	0	0%	180,000	226,720
Court Reporters	12,596	315		1,444		6,000	(6,000)
Evidence/Witness Fees	408,706	36,989	243,959	72,263	30%	433,500	(189,541)
DOI - Investigative			14,792	3,698	25%	14,792	0
Vehicle Operations	58,434	4,332	9,055	6,916	76%	60,000	(50,945)
Major Equipment	97,704		41,000	0	0%	50,000	(9,000)
TOTALS, OE&E	4,884,737	1,337,406	5,998,373	1,412,141	24%	4,885,929	1,112,444
TOTAL EXPENSE	10,087,575	2,613,552	12,092,000	2,828,695	47%	10,756,296	1,335,704
Sched. Reimb. - Fingerprints	(22,393)	(4,753)	(53,000)	(3,626)	7%	(53,000)	0
Sched. Reimb. - Other	(11,550)	(2,665)	(214,000)	(3,585)	2%	(214,000)	0
Unsched. Reimb. - External/Private	(44,863)	(10,788)		(12,538)			0
Probation Monitoring Fee - Variable	(105,674)	(18,052)		(23,956)			0
Invest Cost Recover FTB Collection	(15,999)						0
Unsched. External/Other	(5,748)						0
Unsched. - Investigative Cost Recovery	(283,747)	(45,637)		(58,370)			0
NET APPROPRIATION	9,597,602	2,531,657	11,825,000	2,726,621	23%	10,489,296	1,335,704
SURPLUS/(DEFICIT):							11.3%

0741 - Dental Board of California

Analysis of Fund Condition

Prepared 11/1/13

(Dollars in Thousands)

	Actual 2012-13	Budget Act CY 2013-14	BY 2014-15
BEGINNING BALANCE	\$ 6,180	\$ 4,772	\$ 3,123
Prior Year Adjustment	\$ 133	\$ -	\$ -
Adjusted Beginning Balance	\$ 6,313	\$ 4,772	\$ 3,123
REVENUES AND TRANSFERS			
Revenues:			
125600 Other regulatory fees	\$ 106	\$ 72	\$ 86
125700 Other regulatory licenses and permits	\$ 744	\$ 745	\$ 751
SB 562	\$ -	\$ -	\$ 20
125800 Renewal fees	\$ 7,183	\$ 7,226	\$ 7,241
SB 562	\$ -	\$ -	\$ -
125900 Delinquent fees	\$ 63	\$ 64	\$ 66
131700 Misc. Revenue from Local Agencies	\$ -	\$ -	\$ -
141200 Sales of documents	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 17	\$ -	\$ -
150500 Interest Income From Interfund Loans	\$ -	\$ -	\$ -
160400 Sale of fixed assets	\$ 3	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 3	\$ -	\$ -
161400 Miscellaneous revenues	\$ 2	\$ -	\$ -
164300 Penalty Assessments	\$ -	\$ -	\$ -
Totals, Revenues	\$ 8,121	\$ 8,107	\$ 8,164
Transfers from Other Funds			
F00001 Repayment Per Item 1250-011-0741, Budget Act of 2003	\$ -	\$ 2,700	\$ -
Totals, Revenues and Transfers	\$ 8,121	\$ 10,807	\$ 8,164
Totals, Resources	\$ 14,434	\$ 15,579	\$ 11,287
EXPENDITURES			
Disbursements:			
0840 State Controller (State Operations)	\$ 7	\$ -	\$ -
8880 Financial Information System of California (State Operations)	\$ 57	\$ 53	\$ -
1110 Program Expenditures (State Operations)	\$ 9,598	\$ 11,825	\$ 11,825
SB 562 Mobile or Portable Dental Clinics	\$ -	\$ -	\$ 45
CURES	\$ -	\$ 578	\$ -
Total Disbursements	\$ 9,662	\$ 12,456	\$ 11,870
FUND BALANCE			
Reserve for economic uncertainties	\$ 4,772	\$ 3,123	\$ -583
Months in Reserve	4.6	3.2	-0.6

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.
- B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1
- C. ASSUMES INTEREST RATE AT 0.3%.

**DENTAL ASSISTING PROGRAM - FUND 3142
BUDGET REPORT
FY 2012-13 EXPENDITURE PROJECTION**

September 30, 2013

OBJECT DESCRIPTION	FY 2011-12		FY 2012-13				
	ACTUAL	PRIOR YEAR	BUDGET	CURRENT YEAR	PERCENT	PROJECTIONS	UNENCUMBERED
	EXPENDITURES	EXPENDITURES	STONE	EXPENDITURES			
(MONTH 13)	9/30/2012	2013-14	9/30/2013	SPENT	TO YEAR END	BALANCE	
PERSONNEL SERVICES							
Salary & Wages (Staff)	286,169	73,766	398,462	84,300	21%	337,200	61,262
Temp Help (Exam Proctors)	196		0			0	0
Board Member Per Diem (901, 920)	1,500		0	800		1,500	(1,500)
Overtime	37,524	10,003	0	10,663		40,000	(40,000)
Staff Benefits	152,711	47,809	209,732	55,792	27%	223,168	(13,436)
TOTALS, PERSONNEL SVC	478,100	131,578	608,352	151,555	25%	601,868	6,484
OPERATING EXPENSE AND EQUIPMENT							
General Expense	5,438	1,383	33,053	1,716	5%	6,700	26,353
Fingerprint Reports	0		7,780	0	0%	0	7,780
Minor Equipment			5,000	0		0	5,000
Printing	23,470	1,192	19,001	807	4%	15,900	3,101
Communication	95	7	9,500	4	0%	100	9,400
Postage	21,004	5,788	35,991	3,857	11%	22,400	13,591
Insurance						0	0
Travel In State	52,494	17,729	28,056	17,073	61%	62,500	(34,444)
Training	0		4,119	0	0%	500	3,619
Facilities Operations	35,866	31,341	63,950	59,219	93%	38,470	25,480
C & P Services - Interdept.	0		288,439	0	0%	0	288,439
C & P Services - External	0	14,825	23,532	0	0%	2,800	20,732
DEPARTMENTAL SERVICES:							
OIS ProRata	165,801	52,195	272,050	68,072	25%	272,050	0
Admin/Exec	74,232	19,723	91,881	22,958	25%	91,881	0
Interagency Services	0		72,554	0	0%	0	72,554
IA w/ OER	29,408		0			37,208	(37,208)
DOI-ProRata Internal	2,500	788	2,937	734	25%	2,937	0
Public Affairs Office	4,993	1,115	4,134	1,033	25%	4,134	0
CCED	5,172	1,349	3,517	879	25%	3,517	0
INTERAGENCY SERVICES:							
Consolidated Data Center	0		1,576	0	0%	0	1,576
DP Maintenance & Supply	0		1,369	0	0%	0	1,369
Statewide ProRata	73,015	17,298	67,323	16,831	25%	67,323	0
EXAMS EXPENSES:							
Exam Supplies	9,853		3,946	0	0%	14,000	(10,054)
Exam Site Rental - State Owned	26,010	4,205		11,810		47,200	(47,200)
Exam Site Rental - Non State Owned	46,495	20,010	69,939	0	0%	41,300	28,639
C/P Svcs-External Expert Administration	10,860	1,355	30,877	15,375	50%	25,000	5,877
C/P Svcs-External Expert Examiners	0	40,364	47,476	0	0%	0	47,476
C/P Svcs-External Expert Examiners						0	0
C/P Svcs-External Subject Matter	177,084			30,976		123,900	(123,900)
OTHER ITEMS OF EXPENSE:							
	0		285	0	0%	0	285
ENFORCEMENT:							
Attorney General	257,788	44,920	67,536	44,775	66%	257,000	(189,464)
Office Admin. Hearings	0		2,740		0%	0	2,740
Evidence/Witness Fees	0		87		0%	0	87
TOTALS, OE&E	1,021,578	275,587	1,258,648	296,119	24%	1,136,820	121,828
TOTAL EXPENSE	1,499,678	407,165	1,867,000	447,674	48%	1,738,688	128,312
Sched. Reimb. - Fingerprints	(1,690)	(637)	(13,000)	(294)	2%	(2,303)	(10,697)
Sched. Reimb. - Other	(1,205)		(3,000)		0%	(705)	(2,295)
NET APPROPRIATION	1,496,783	406,528	1,851,000	447,380	24%	1,735,680	115,320
SURPLUS/(DEFICIT):							6.2%

3142 - Dental Assisting Program Analysis of Fund Condition

Prepared 11/1/13

(Dollars in Thousands)

	Actual 2012-13	Budget Act CY 2013-14	BY 2014-15
BEGINNING BALANCE	\$ 2,445	\$ 2,724	\$ 2,582
Prior Year Adjustment	\$ -11	\$ -	\$ -
Adjusted Beginning Balance	<u>\$ 2,434</u>	<u>\$ 2,724</u>	<u>\$ 2,582</u>
REVENUES AND TRANSFERS			
Revenues:			
125600 Other regulatory fees	\$ 15	\$ 15	\$ 16
125700 Other regulatory licenses and permits	\$ 417	\$ 394	\$ 397
125800 Renewal fees	\$ 1,245	\$ 1,228	\$ 1,244
125900 Delinquent fees	\$ 68	\$ 67	\$ 66
141200 Sales of documents	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 8	\$ 8	\$ 7
160400 Sale of fixed assets	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ -	\$ 1	\$ 1
161400 Miscellaneous revenues	\$ 5	\$ 4	\$ 4
164300 Penalty Assessments	\$ -	\$ -	\$ -
Totals, Revenues	<u>\$ 1,758</u>	<u>\$ 1,717</u>	<u>\$ 1,735</u>
Totals, Revenues and Transfers	<u>\$ 1,758</u>	<u>\$ 1,717</u>	<u>\$ 1,735</u>
Totals, Resources	<u>\$ 4,192</u>	<u>\$ 4,441</u>	<u>\$ 4,317</u>
EXPENDITURES			
Disbursements:			
0840 State Controller (State Operations)	\$ 2	\$ -	\$ -
8880 Financial Information System for CA (State Operations)	\$ 8	\$ 8	\$ -
1110 Program Expenditures (State Operations)	\$ 1,458	\$ 1,851	\$ 1,888
Total Disbursements	<u>\$ 1,468</u>	<u>\$ 1,859</u>	<u>\$ 1,888</u>
FUND BALANCE			
Reserve for economic uncertainties	<u>\$ 2,724</u>	<u>\$ 2,582</u>	<u>\$ 2,429</u>
Months in Reserve	17.6	16.4	15.1

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ONGOING.
- B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1.
- C. ASSUMES INTEREST RATE AT 0.3%.



MEMORANDUM

DATE	November 14, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	Agenda Item 15: Discussion and Possible Action Regarding Updating and Revising the Board Member Administrative Procedure Manual

The Board Member Administrative Procedure Manual is designed for Board members as a ready reference of the Department of Consumer Affairs (DCA) and Board policies, the intent of which is to guide the actions of the Board members and ensure the Board functions effectively and efficiently.

The manual was last adopted by the Board in January 2006.

A draft of this document was distributed to Board Members in August for review and comment. Staff revised the draft to include those comments as well as staff recommendations.

Action: Staff recommends adoption pending legal review.

**~~Board Member~~
~~Administrative~~ Board Policy and
Procedure Manual**



**Dental
Board of
California**

**Adopted by the Board
1/27/2006**

Dental Board of California
2005 Evergreen Street, Ste 1550
1432 Howe Avenue, Suite 85
Sacramento, CA 95825-3241 95815-3831
www.dbc.ca.gov

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Board Member Administrative Procedure Manual

Dental Board of California

CHAPTER 1. INTRODUCTION

Overview

The Dental Board of California (DBC) was created by the California Legislature in 1885. Today the DBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), ~~part of the one of eight departments within the State and Consumer Services Agency Business, Consumer Services, and Housing Agency under the aegis of the Governor.~~ DBC's highest priority is protection of the public while exercising its licensing, regulatory, and disciplinary functions. If protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. While DCA provides administrative oversight and support services, DBC has policy autonomy and sets its own policies, procedures, and initiates its own regulations. ~~DCA~~ The Executive Branch is responsible for consumer protection and representation through the regulation of licensed professions and the provision of consumer services. While the DCA provides administrative oversight and support services, DBC has policy autonomy and sets its own policies, procedures, and initiates its own regulations.

The DBC is presently comprised of ~~44~~ 15 members. The composition of the Board is defined in Business and Professions Code Sections 1601 and 1603 ~~as follows: of the and includes~~ eight dentists appointed by the Governor, one of whom must be a member of a faculty of any California dental college and one shall be a dentist practicing in a nonprofit community clinic; ~~four~~ five public members, ~~two~~ three appointed by the Governor, one by the Speaker of the Assembly and one by the Senate Rules Committee; one licensed dental hygienist appointed by the Governor; and one licensed dental assistant appointed by the Governor. Board members may serve up to two four-year terms. Board members ~~fill non-salaried positions~~ serve without a salary, but are ~~paid~~ compensated \$100 per day for each meeting day and are reimbursed for travel expenses (B&P Code § 1615).

This policy and procedure manual is provided to Board members as a ready reference ~~of for~~ for important laws, regulations, DCA policies, and Board policies ~~in order to~~ to help guide the actions of the Board members and ensure Board effectiveness and efficiency.

Definitions:

B&PBPC	Business and Professions Code
CCR	California Code of Regulation
CLEAR	Council on Licensure Enforcement and Regulations
DCA	Department of Consumer Affairs
EO	Executive Officer
SAM	State Administrative Manual
President	Where the term "President" is used in this manual, it will be assumed to include "his or her designee"

Board Member Administrative Procedure Manual Dental Board of California

General Rules of Conduct:

Board members shall not speak or act for the Board without proper authorization.

Board members shall maintain the confidentiality of confidential documents and information.

Board members shall commit the time and necessary to prepare for Board responsibilities.

Each Board member shall recognize the equal role and responsibilities of all Board members.

Board members shall act fairly, be nonpartisan, impartial and unbiased in their role of protecting the public.

Board members shall treat all applicants and licensees in a fair and impartial manner.

Board members' actions shall serve to uphold the principle that the Board's primary mission is to protect the public.

Board members shall not use their positions on the Board for personal, familial or financial gain.

CHAPTER 2. BOARD MEETING PROCEDURES

Frequency of Meetings

(Board Policy)

The board shall meet regularly ~~once each year in San Francisco and once each year in Los Angeles~~ and at such other times and places as the board may designate, for the purpose of transacting its business.

Special meetings may be held at such times as the board may elect or on the call of the president of the board, or of not less than four members thereof. (B&P Code Section 1608)

~~Due notice~~ Notice of each meeting and the time and place thereof shall be given in accordance with the Bagley-Keene Open Meeting Act (Gov. Code § 11120 et seq).

Board Member Attendance at Board Meetings

(Board Policy)

Board members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President or the Executive Officer and request to be excused from the meeting.

Board Meetings

(Government Code Section 11120 et seq.)

Meetings are subject to all provisions of the Bagley-Keene Open Meeting Act. This act governs meetings of the state regulatory boards and meetings of committees of those boards where the committee consists of more than two members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included in the agenda.

Communications

(Bagley-Keene Open Meeting Act – 2013)

A majority of the members of a state body shall not, outside of a meeting, use a series of communications of any kind, directly or through intermediaries, to discuss, deliberate, or take action on any item of business that is within the subject matter of the state body.

Committees

(Board Policy)

The Examination and Enforcement Committees are standing committees that meet on the first day of the board meeting to consider issues and make recommendations to the full Board. Executive Committee meetings, ad hoc, or

Board Member Administrative Procedure Manual Dental Board of California

task force committee meetings, regulatory, or informational hearings may be at the call of the Board President as deemed necessary.

Dental Assisting Council *(B & P Code Section 1742)*

As a result of the Sunset Review process, legislation was signed by Governor Edmund G. Brown Jr. (SB 540, Chapter 385, 2011 statutes) which requires the Dental Board of California (Board) to establish a seven member Dental Assisting Council (Council) which will consider all matters relating to dental assistants in California and will make appropriate recommendations to the Board and the standing Committees of the Board. The members of the Council shall include the registered dental assistant member of the Board, another member of the Board, and five registered dental assistants.

Public Participation

Public participation is encouraged throughout the public portion of the meetings. The chairs of the respective committees, as well as the Board President, acknowledge comments from the audience during general discussion of agenda items. In addition, each Board agenda includes public comment as a standing item of the agenda. This standing agenda item allows the public to request ~~issues~~ items to be placed on future agendas or to discuss any issue of concern to them.

If the agenda contains matters that are appropriate for closed session, the agenda shall cite the particular statutory section and subdivision authorizing the closed session.

Quorum *(B&P Code Section 1610)*

~~Eight of the members of the Board constitute a quorum of the Board for the transaction of business at any meeting. The concurrence of a majority of those members of the Board present and voting at a meeting duly held at which a quorum is present shall be necessary to constitute an act or decision of the Board.~~

Agenda Items *(Board Policy)*

Board meetings generally involve:

- Changes in general policy and statutes
- Content and administration of examinations
- Adoption or deletion of regulations
- Approval of fee schedules
- Appeals
- Changes to procedural and operational activities

Board Member Administrative Procedure Manual Dental Board of California

- Enforcement issues such as, acceptance/denial of Administrative Law Judge decisions, stipulations and advancement of cases to the Office of Administrative Hearings
- Committee member approval
- Acceptance or denial of committee recommendations

Any Board member may submit, for consideration, items for a Board meeting agenda to the Board President and Executive Officer 30 days prior to the meeting. The Board President and Executive Officer, in consultation with legal counsel, will review and approve items submitted for consideration.

Notice of Meetings

(Government Code Section 11120 et seq.)

According to the Open Meeting Act, meeting notices ~~(including agendas for Board meetings)~~ must include the agenda and shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include a staff person's name, work address and work telephone number who can provide further information prior to the meeting.

Notice of Meetings to be posted on the Internet

(Government Code Section 11125)

Notice and the agenda shall be given and also be made available on the Internet at least 10 days in advance of the meeting, and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices are available.

Record of Meetings

(Board Policy)

The minutes are a summary, not a transcript, of each Board meeting. They shall be prepared by Board staff and submitted for review by the Board members at the next Board meeting. Board minutes shall be approved at the next scheduled meeting of the Board. When approved, the minutes shall serve as the official record of the meeting.

Board meetings are webcast in real time when webcasting resources are available. Archived copies of the webcast are available on the Board's website approximately 30 days after the meeting is held.

Tape Recording

(Board Policy)

~~The open Public meetings are tape-recorded for staff purposes. Tape r~~Recordings may be disposed of erased upon Board approval of the minutes or

Board Member Administrative Procedure Manual Dental Board of California

30 days after the recording. Tapes CD copies are available, upon request, for Board members not able to attend a meeting.

Meeting Rules *(16 CCR § 1002)*

~~The Board uses~~Board meetings are conducted following Robert's Rules of Order, to the extent that it does not conflict with state law (e.g., Bagley-Keene Open Meeting Act), as a guide when conducting the meetings.

Use of Electronic Devices During Meetings *(Bagley-Keene)*

Board members should not text or email one another during an open a meeting on any matter within the Board's jurisdiction. Using electronic devices to communicate secretly in such a manner would violate the Open Meeting Act. Where laptops are used by the Board members at the meeting because the Board provides materials electronically, the Board President shall make an announcement at the beginning of the meeting as to the reason for the use of laptops.

CHAPTER 3. TRAVEL AND SALARY POLICIES AND PROCEDURES

Travel Approval

(DCA Memorandum 96-01)

Board members shall have Board President approval for all travel except for regularly scheduled Board and committee meetings to which the Board member is assigned.

Travel Arrangements

(Board Policy)

Board members are encouraged to coordinate with the Executive Assistant on travel arrangements and lodging accommodations.

Out-of-State Travel

(SAM Section 700 et seq.)

For out-of-state travel, Board members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled and must be approved by the Governor's Office.

Travel Claims

(SAM Section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Assistant maintains these forms and completes them as needed. It is advisable for Board members to submit their travel expense forms immediately after returning from a trip and not later than two weeks following the trip.

In order for the expenses to be reimbursed, Board members shall follow the procedures contained in DCA Departmental Memoranda which are periodically disseminated by the Director and are provided to Board members.

Per Diem Salary

(B&P Code Section 103)

B&P Code Section 103 regulates compensation in the form of per diem salary and reimbursement of travel and other related expenses for Board members. ~~In relevant part, this~~ This section provides for the payment of per diem salary for Board members "for each day actually spent in the discharge of official duties," and provides that the Board member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Board Member Administrative Procedure Manual Dental Board of California

Per Diem Salary (Board Policy)

Accordingly, ~~the~~ The following general guidelines shall ~~be adhered~~ apply to ~~in~~ the payment of per diem salary, or reimbursement for travel:

1. No per diem salary or reimbursement for travel-related expenses shall be paid to Board members except for attendance at official Board or committee meetings. Attendance at gatherings, events, hearings, conferences or meetings other than official Board or committee meetings shall be approved in advance by the Board President. The Executive Officer shall be notified of the event and approval shall be obtained from the Board President prior to Board member's attendance.
2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board meeting or committee meeting to the conclusion of that meeting.

Where it is necessary for a Board member to leave early from a meeting, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

For Board-specified work, Board members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorize attendance at other gatherings, events, meetings, hearings, or conferences, and committee work. That work does not include preparation time for Board or committee meetings. Board members cannot claim per diem salary for time spent traveling to and from a Board or committee meeting.

CHAPTER 4. SELECTION OF OFFICERS AND COMMITTEES

Officers of the Board (B&P Code Section 1606)

The Board shall elect from its members a President, a Vice President, and a Secretary.

Election of Officers (Board Policy)

It is board policy to elect officers at the final meeting of the calendar year for service during the next calendar year, unless otherwise decided by the board.

Officer Vacancies (Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers shall then serve the remainder of the term.

Committee Appointments (Board Policy)

The President shall establish committees, whether standing or special, as he or she deems necessary. The composition of the committees and the appointment of the members shall be determined by the Board President in consultation with the Vice President, Secretary and the Executive Officer. When committees include the appointment of non-Board members, all ~~impacted~~ affected parties should be considered. The Board President shall strive to appoint board members to a minimum of one standing committee.

Attendance at Committee Meetings (Board Policy)

If a Board member wishes to attend a meeting of a committee of which he or she is not a member, that Board member cannot participate or vote during the committee meeting, and must not sit on the ~~dais~~ Dais.

Board Member Administrative Procedure Manual Dental Board of California

Creation of Task Forces (Board Policy)

It is the policy of the Board that:

- 1) task forces will be appointed sparingly as the exception rather than the rule and only when the Board finds it cannot address a specific and well defined issue through the existing committee structure;
- 2) task force members may be appointed by a committee chair but must be approved by the full Board;
- 3) the charge given to the task force will be clear, specific, in writing and presented to the Board at the time of appointment;
- 4) task forces, of three or more members, appointed by the Board are subject to the same open meeting laws as the Board (as required by Government Code Section 11121);
- 5) all task forces shall give staff at least 20 days advance notice of the time, place and general agenda for any task force meeting;
- 6) task forces will meet and report regularly and provide the Board with minutes after every meeting;
- 7) no task force recommendation will be the basis for Board action in the absence of a formal written report from the task force to the Board.

CHAPTER 5. BOARD ADMINISTRATION AND STAFF

Board Administration

(DCA Reference Manual)

Board members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Officer.

Board Budget

(Board Policy)

The Executive Officer shall serve as the Board's budget liaison with staff and shall assist staff in the monitoring and reporting of the budget to the Board. The Executive Officer or the Executive Officer's designee will attend and testify at legislative budget hearings and shall communicate all budget issues to the Administration and Legislature.

Strategic Planning

(Board Policy)

The Executive Committee shall have overall responsibility for the Board's Strategic Planning Process. The Vice President shall serve as the Board's strategic planning liaison with staff and shall assist staff in the monitoring and reporting of the strategic plan to the Board. The Board will conduct an annual strategic planning session and may utilize a facilitator to conduct the strategic planning process.

Legislation

(Board Policy)

~~In the event~~ When time constraints preclude Board action, the Board delegates the authority to the Executive Officer and the Chair of the Legislative Committee ~~the authority~~ to take action on legislation that would change the Dental Board of California's Dental Practice Act, or which impacts a previously established Board policy or affects the public's health, safety or welfare. Prior to taking a position on legislation, the Executive Officer shall consult with the Board President and Legislative Committee Chair. The Board shall be notified of such action as soon as possible.

Board Member Administrative Procedure Manual Dental Board of California

Communications with Other Organizations and Individuals (Board Policy)

The official spokesperson for the Dental Board of California is the President. The President may designate the Executive Officer, the Chief of Enforcement, or other board members, or staff to speak to the media on behalf of the Board. The Department of Consumer Affairs should be notified of any contacts by the media.

It is the policy of the Dental Board of California to accommodate speaking requests from all organizations, schools, consumer groups, or other interested groups, whenever possible. If the Board representative is addressing a dental school or group of potential candidates for licensure, the program must be open to all interested parties. The President may authorize board members to speak to schools, organizations, consumer groups, or other interested groups upon request by members or written requests from said schools, organizations or groups.

Media Inquiries (Board Policy)

If a member of the Board receives a media call, the Member should promptly refer the caller to the Department of Consumer Affairs Public Information Officer who is employed to interface with all types of media on any type of inquiry. It is required that members make this referral as the power of the Board is vested in the Board itself and not with any individual Board Member. Expressing a personal opinion can be misconstrued as a Board policy or position and may be represented as a position that the Board has taken on a particular issue when it has not.

A Board Member who receives a call should politely thank the caller for the call, but state that it is the Board's policy to refer all callers to the Public Information Officer. The Board Member should then send an email to the Executive Officer indicating they received a media call and relay any information supplied by the caller.

Executive Officer Evaluation (Board Policy)

The Board shall evaluate ~~annually~~ the performance of the Executive Officer annually.

Board Staff (DCA Reference Manual)

Employees of the Board, with the exception of the Executive Officer, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this

Board Member Administrative Procedure Manual Dental Board of California

complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Officer. Consequently, the Executive Officer shall solely be responsible for all day-to-day personnel transactions.

Business Cards *(Board Policy)*

Business cards will be provided to each Officer of the Board member with the Board's office address, telephone and fax number, and Web site address. A Board member's Officer's business address, telephone and fax number, and e-mail address may be listed on the card at the member's request.

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Dental Board of California**

CHAPTER 6. OTHER POLICIES AND PROCEDURES

Mandatory Training
(DCA Policy)

State law requires board members within the Department of Consumer Affairs to complete training in several important areas, including ethics, conflict of interest laws, sexual harassment prevention and Board Member Orientation Training.

Ethics Orientation

http://www.dcaboardmembers.ca.gov/training/ethics_orientation.shtml
(Government Code §53234)

California law requires all appointees to take an ethics orientation within the first six months of their appointment and to repeat this ethics orientation every two years throughout their term.

The training includes important information on activities or actions that are inappropriate or illegal. For example, generally public officials cannot take part in decisions that directly affect their own economic interests. They are prohibited from misusing public funds, accepting free travel and accepting honoraria. There are limits on gifts.

An online, interactive version of the training is available on the Attorney General's Web site at <http://oag.ca.gov/ethics>. An accessible, text-only version of the materials is also available at the Attorney General's Web site.

Conflict of Interest

http://www.dcaboardmembers.ca.gov/member_info/conflict_interest.shtml
(Government Code §81000)(California Code of Regulations, §18730)

The Department of Consumer Affairs will make and retain a copy of the statements from members of the boards, commission, committees and subcommittees and make them available for public inspection. It will forward the original statement to the Fair Political Practices Commission.

Information on specific topics can be found at:

http://www.dcaboardmembers.ca.gov/member_info/conflict_interest.shtml

Sexual Harrassment Prevention

http://www.dcaboardmembers.ca.gov/training/harassment_prevention.shtml
(Government Code §12950.1)

All new board members are required to attend at least two hours of classroom or other interactive training and education regarding sexual harassment prevention within six months of their appointment. The Equal Employment Opportunity (EEO) Office is responsible for ensuring that all board members complete their required training. A copy of your certificate of proof of training must be sent to the EEO Office. Please identify which Board/Committee/Commission you serve on.

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For information on how to receive Sexual Harrassment Prevention Training contact:

Equal Employment Opportunity Office
1625 N. Market Blvd, Ste N330
Sacramento, CA 95834
(916) 574-8280 (916) 574-8604 Fax

Board Member Orientation
(B & P Code Section 453)

Every newly appointed board member is required to complete a training and orientation program offered by the Department of Consumer Affairs (DCA) within one year of assuming office. The training covers the functions, responsibilities and obligations that come with being a member of a DCA board.

For more information and assistance with scheduling training, please contact:

Deanna Marino Robinson
SOLID Training Solutions
1747 North Market Blvd, Ste. 270
Sacramento, CA 95834
(916) 574-8320
deanna.marino.robinson@dca.ca.gov

Board Member Disciplinary Actions
(Board Policy)

The Board may censure a member if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as President of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members
(B&P Code Section 1605)

The Governor has the power to remove from office at any time any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct. The Governor may also remove from office a Board member whom directly or indirectly discloses examination questions to an applicant for examination for licensure. That member would also be subject to a misdemeanor violation (B&P Code 123).

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Resignation of Board Members (Government Code Section 1750)

In the event that it becomes necessary for a Board member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. State law requires written notification. A copy of this letter shall also be sent to the director of the Department, the Board President, and the Executive Officer.

Conflict of Interest (Government Code Section 87100)

No Board member may make, participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board member who has a financial interest shall disqualify him or herself from making or attempting to use his or her official position to influence the decision. Any Board member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Officer, or the Board's legal counsel.

Contact with Candidates (Board Policy)

Board members shall not intervene on behalf of a candidate for licensure for any reason. They should forward all contacts or inquiries to the Executive Officer or Board staff.

Gifts from Candidates (Board Policy)

Gifts of any kind to Board members or the staff from candidates for licensure with the Board shall not be permitted.

Request for Records Access (Board Policy)

No Board member may access the file of a licensee or candidate without the Executive Officer's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the DBOC's office.

Ex Parte Communications (Government Code Section 11430.10 et seq.)

The Government Code contains provisions prohibiting *ex parte* communications. An "ex parte" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

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“While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication.”

Board members are prohibited from an *ex parte* communication with Board enforcement staff while a proceeding is pending.

Occasionally an applicant who is being formally denied licensure, or a licensee against whom disciplinary action is being taken, will attempt to directly contact Board members. If the communication is written, the person should read only far enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, they should reseal the documents and send them to the Chief of Enforcement.

If a Board member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person they cannot speak to them about the matter. If the person insists on discussing the case, he or she should be told that the Board member would be required to excuse him or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the agency’s assigned Legal Office attorney.

Roles and Responsibilities of Board Officers/Committee Chairs (Board Policy)

President

- Acts as spokesperson for the Dental Board (attends legislative hearings and testifies on behalf of the Board, attends meetings with stakeholders and Legislators on behalf of Board, talks to the media on behalf of the Board, and signs letters on behalf of the Board).
- Meets and/or communicates with the Executive Officer (EO) on a regular basis.
- Provides oversight to the Executive Officer in performance of the EO duties.
- Approves leave requests, verifies accuracy and approves timesheets, approves travel and signs travel expense claims for the EO.
- Coordinates the EO annual evaluation process including contacting DCA Office of Human Resources to obtain a copy of the Executive Officer Performance Evaluation Form, distributes the evaluation form to members, and collates the ratings and comments for discussion.
- Communicates with other Board Members for Board business.

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- Authors a president's message for every quarterly board meeting and published newsletters.
- Approves Board Meeting agendas.
- Chairs and facilitates Board Meetings.
- Chairs the Executive Committee.
- Signs specified full board enforcement approval orders.
- Establishes Committees and appoints Chairs and members.
- Establishes 2-Person subcommittees to research policy questions when necessary.

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee.
- Coordinates the revision of the Board's Strategic Plan.

Secretary

- Calls the roll at each Board meeting and reports that a quorum has been established.
- Is a member of Executive Committee.

Committee Chair

- Reviews agenda items with EO and Board President prior to Committee meetings.
- Approves the Committee agendas.
- Chairs and facilitates Committee meetings.
- Reports the activities of the Committee to the full Board.

**~~Board Member~~
~~Administrative~~ Board Policy and
Procedure Manual**



**Dental
Board of
California**

**Adopted by the Board
1/27/2006**

Dental Board of California
2005 Evergreen Street, Ste 1550
1432 Howe Avenue, Suite 85
Sacramento, CA 95825-3241 95815-3831
www.dbc.ca.gov

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Board Member Administrative Procedure Manual

Dental Board of California

CHAPTER 1. INTRODUCTION

Overview

The Dental Board of California (DBC) was created by the California Legislature in 1885. Today the DBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), ~~part of the one of eight departments within the State and Consumer Services Agency Business, Consumer Services, and Housing Agency under the aegis of the Governor.~~ DBC's highest priority is protection of the public while exercising its licensing, regulatory, and disciplinary functions. If protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount. While DCA provides administrative oversight and support services, DBC has policy autonomy and sets its own policies, procedures, and initiates its own regulations. ~~DCA~~ The Executive Branch is responsible for consumer protection and representation through the regulation of licensed professions and the provision of consumer services. While the DCA provides administrative oversight and support services, DBC has policy autonomy and sets its own policies, procedures, and initiates its own regulations.

The DBC is presently comprised of ~~44~~ 15 members. The composition of the Board is defined in Business and Professions Code Sections 1601 and 1603 ~~as follows: of the and includes~~ eight dentists appointed by the Governor, one of whom must be a member of a faculty of any California dental college and one shall be a dentist practicing in a nonprofit community clinic; ~~four~~ five public members, ~~two~~ three appointed by the Governor, one by the Speaker of the Assembly and one by the Senate Rules Committee; one licensed dental hygienist appointed by the Governor; and one licensed dental assistant appointed by the Governor. Board members may serve up to two four-year terms. Board members ~~fill non-salaried positions~~ serve without a salary, but are ~~paid~~ compensated \$100 per day for each meeting day and are reimbursed for travel expenses (B&P Code § 1615).

This policy and procedure manual is provided to Board members as a ready reference of for important laws, regulations, DCA policies, and Board policies ~~in order to~~ to help guide the actions of the Board members and ensure Board effectiveness and efficiency.

Definitions:

B&PBPC	Business and Professions Code
CCR	California Code of Regulation
CLEAR	Council on Licensure Enforcement and Regulations
DCA	Department of Consumer Affairs
EO	Executive Officer
SAM	State Administrative Manual
President	Where the term "President" is used in this manual, it will be assumed to include "his or her designee"

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General Rules of Conduct:

Board members shall not speak or act for the Board without proper authorization.

Board members shall maintain the confidentiality of confidential documents and information.

Board members shall commit the time and necessary to prepare for Board responsibilities.

Each Board member shall recognize the equal role and responsibilities of all Board members.

Board members shall act fairly, be nonpartisan, impartial and unbiased in their role of protecting the public.

Board members shall treat all applicants and licensees in a fair and impartial manner.

Board members' actions shall serve to uphold the principle that the Board's primary mission is to protect the public.

Board members shall not use their positions on the Board for personal, familial or financial gain.

CHAPTER 2. BOARD MEETING PROCEDURES

Frequency of Meetings

(Board Policy)

The board shall meet regularly ~~once each year in San Francisco and once each year in Los Angeles~~ and at such other times and places as the board may designate, for the purpose of transacting its business.

Special meetings may be held at such times as the board may elect or on the call of the president of the board, or of not less than four members thereof. (B&P Code Section 1608)

~~Due notice~~ Notice of each meeting and the time and place thereof shall be given in accordance with the Bagley-Keene Open Meeting Act (Gov. Code § 11120 et seq).

Board Member Attendance at Board Meetings

(Board Policy)

Board members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President or the Executive Officer and request to be excused from the meeting.

Board Meetings

(Government Code Section 11120 et seq.)

Meetings are subject to all provisions of the Bagley-Keene Open Meeting Act. This act governs meetings of the state regulatory boards and meetings of committees of those boards where the committee consists of more than two members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included in the agenda.

Communications

(Bagley-Keene Open Meeting Act – 2013)

A majority of the members of a state body shall not, outside of a meeting, use a series of communications of any kind, directly or through intermediaries, to discuss, deliberate, or take action on any item of business that is within the subject matter of the state body.

Committees

(Board Policy)

The Examination and Enforcement Committees are standing committees that meet on the first day of the board meeting to consider issues and make recommendations to the full Board. Executive Committee meetings, ad hoc, or

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task force committee meetings, regulatory, or informational hearings may be at the call of the Board President as deemed necessary.

Dental Assisting Council (*B & P Code Section 1742*)

As a result of the Sunset Review process, legislation was signed by Governor Edmund G. Brown Jr. (SB 540, Chapter 385, 2011 statutes) which requires the Dental Board of California (Board) to establish a seven member Dental Assisting Council (Council) which will consider all matters relating to dental assistants in California and will make appropriate recommendations to the Board and the standing Committees of the Board. The members of the Council shall include the registered dental assistant member of the Board, another member of the Board, and five registered dental assistants.

Public Participation

Public participation is encouraged throughout the public portion of the meetings. The chairs of the respective committees, as well as the Board President, acknowledge comments from the audience during general discussion of agenda items. In addition, each Board agenda includes public comment as a standing item of the agenda. This standing agenda item allows the public to request ~~issues~~ items to be placed on future agendas or to discuss any issue of concern to them.

If the agenda contains matters that are appropriate for closed session, the agenda shall cite the particular statutory section and subdivision authorizing the closed session.

Quorum (*B&P Code Section 1610*)

~~Eight of the members of the Board constitute a quorum of the Board for the transaction of business at any meeting. The concurrence of a majority of those members of the Board present and voting at a meeting duly held at which a quorum is present shall be necessary to constitute an act or decision of the Board.~~

Agenda Items (*Board Policy*)

Board meetings generally involve:

- Changes in general policy and statutes
- Content and administration of examinations
- Adoption or deletion of regulations
- Approval of fee schedules
- Appeals
- Changes to procedural and operational activities

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- Enforcement issues such as, acceptance/denial of Administrative Law Judge decisions, stipulations and advancement of cases to the Office of Administrative Hearings
- Committee member approval
- Acceptance or denial of committee recommendations

Any Board member may submit, for consideration, items for a Board meeting agenda to the Board President and Executive Officer 30 days prior to the meeting. The Board President and Executive Officer, in consultation with legal counsel, will review and approve items submitted for consideration.

Notice of Meetings

(Government Code Section 11120 et seq.)

According to the Open Meeting Act, meeting notices ~~(including agendas for Board meetings)~~ must include the agenda and shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include a staff person's name, work address and work telephone number who can provide further information prior to the meeting.

Notice of Meetings to be posted on the Internet

(Government Code Section 11125)

Notice and the agenda shall be given and also be made available on the Internet at least 10 days in advance of the meeting, and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices are available.

Record of Meetings

(Board Policy)

The minutes are a summary, not a transcript, of each Board meeting. They shall be prepared by Board staff and submitted for review by the Board members at the next Board meeting. Board minutes shall be approved at the next scheduled meeting of the Board. When approved, the minutes shall serve as the official record of the meeting.

Board meetings are webcast in real time when webcasting resources are available. Archived copies of the webcast are available on the Board's website approximately 30 days after the meeting is held.

Tape Recording

(Board Policy)

~~The open Public meetings are tape-recorded for staff purposes. Tape r~~Recordings may be disposed of erased upon Board approval of the minutes or

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30 days after the recording. Tapes CD copies are available, upon request, for Board members not able to attend a meeting.

Meeting Rules *(16 CCR § 1002)*

~~The Board uses~~Board meetings are conducted following Robert's Rules of Order, to the extent that it does not conflict with state law (e.g., Bagley-Keene Open Meeting Act), as a guide when conducting the meetings.

Use of Electronic Devices During Meetings *(Bagley-Keene)*

Board members should not text or email one another during an open a meeting on any matter within the Board's jurisdiction. Using electronic devices to communicate secretly in such a manner would violate the Open Meeting Act. Where laptops are used by the Board members at the meeting because the Board provides materials electronically, the Board President shall make an announcement at the beginning of the meeting as to the reason for the use of laptops.

CHAPTER 3. TRAVEL AND SALARY POLICIES AND PROCEDURES

Travel Approval

(DCA Memorandum 96-01)

Board members shall have Board President approval for all travel except for regularly scheduled Board and committee meetings to which the Board member is assigned.

Travel Arrangements

(Board Policy)

Board members are encouraged to coordinate with the Executive Assistant on travel arrangements and lodging accommodations.

Out-of-State Travel

(SAM Section 700 et seq.)

For out-of-state travel, Board members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled and must be approved by the Governor's Office.

Travel Claims

(SAM Section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Assistant maintains these forms and completes them as needed. It is advisable for Board members to submit their travel expense forms immediately after returning from a trip and not later than two weeks following the trip.

In order for the expenses to be reimbursed, Board members shall follow the procedures contained in DCA Departmental Memoranda which are periodically disseminated by the Director and are provided to Board members.

Per Diem Salary

(B&P Code Section 103)

B&P Code Section 103 regulates compensation in the form of per diem salary and reimbursement of travel and other related expenses for Board members. ~~In relevant part, this~~ This section provides for the payment of per diem salary for Board members "for each day actually spent in the discharge of official duties," and provides that the Board member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

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Per Diem Salary (Board Policy)

Accordingly, ~~the~~ The following general guidelines shall ~~be adhered~~ apply to ~~in~~ the payment of per diem salary, or reimbursement for travel:

1. No per diem salary or reimbursement for travel-related expenses shall be paid to Board members except for attendance at official Board or committee meetings. Attendance at gatherings, events, hearings, conferences or meetings other than official Board or committee meetings shall be approved in advance by the Board President. The Executive Officer shall be notified of the event and approval shall be obtained from the Board President prior to Board member's attendance.
2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board meeting or committee meeting to the conclusion of that meeting.

Where it is necessary for a Board member to leave early from a meeting, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

For Board-specified work, Board members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorize attendance at other gatherings, events, meetings, hearings, or conferences, and committee work. That work does not include preparation time for Board or committee meetings. Board members cannot claim per diem salary for time spent traveling to and from a Board or committee meeting.

CHAPTER 4. SELECTION OF OFFICERS AND COMMITTEES

Officers of the Board (B&P Code Section 1606)

The Board shall elect from its members a President, a Vice President, and a Secretary.

Election of Officers (Board Policy)

It is board policy to elect officers at the final meeting of the calendar year for service during the next calendar year, unless otherwise decided by the board.

Officer Vacancies (Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers shall then serve the remainder of the term.

Committee Appointments (Board Policy)

The President shall establish committees, whether standing or special, as he or she deems necessary. The composition of the committees and the appointment of the members shall be determined by the Board President in consultation with the Vice President, Secretary and the Executive Officer. When committees include the appointment of non-Board members, all ~~impacted~~ affected parties should be considered. The Board President shall strive to appoint board members to a minimum of one standing committee.

Attendance at Committee Meetings (Board Policy)

If a Board member wishes to attend a meeting of a committee of which he or she is not a member, that Board member cannot participate or vote during the committee meeting, and must not sit on the ~~days~~ Dias.

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Creation of Task Forces (Board Policy)

It is the policy of the Board that:

- 1) task forces will be appointed sparingly as the exception rather than the rule and only when the Board finds it cannot address a specific and well defined issue through the existing committee structure;
- 2) task force members may be appointed by a committee chair but must be approved by the full Board;
- 3) the charge given to the task force will be clear, specific, in writing and presented to the Board at the time of appointment;
- 4) task forces, of three or more members, appointed by the Board are subject to the same open meeting laws as the Board (as required by Government Code Section 11121);
- 5) all task forces shall give staff at least 20 days advance notice of the time, place and general agenda for any task force meeting;
- 6) task forces will meet and report regularly and provide the Board with minutes after every meeting;
- 7) no task force recommendation will be the basis for Board action in the absence of a formal written report from the task force to the Board.

CHAPTER 5. BOARD ADMINISTRATION AND STAFF

Board Administration

(DCA Reference Manual)

Board members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Officer.

Board Budget

(Board Policy)

The Executive Officer shall serve as the Board's budget liaison with staff and shall assist staff in the monitoring and reporting of the budget to the Board. The Executive Officer or the Executive Officer's designee will attend and testify at legislative budget hearings and shall communicate all budget issues to the Administration and Legislature.

Strategic Planning

(Board Policy)

The Executive Committee shall have overall responsibility for the Board's Strategic Planning Process. The Vice President shall serve as the Board's strategic planning liaison with staff and shall assist staff in the monitoring and reporting of the strategic plan to the Board. The Board will conduct an annual strategic planning session and may utilize a facilitator to conduct the strategic planning process.

Legislation

(Board Policy)

~~In the event~~ When time constraints preclude Board action, the Board delegates the authority to the Executive Officer and the Chair of the Legislative Committee ~~the authority~~ to take action on legislation that would change the Dental Board of California's Dental Practice Act, or which impacts a previously established Board policy or affects the public's health, safety or welfare. Prior to taking a position on legislation, the Executive Officer shall consult with the Board President and Legislative Committee Chair. The Board shall be notified of such action as soon as possible.

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Communications with Other Organizations and Individuals *(Board Policy)*

The official spokesperson for the Dental Board of California is the President. The President may designate the Executive Officer, the Chief of Enforcement, or other board members, or staff to speak to the media on behalf of the Board. The Department of Consumer Affairs should be notified of any contacts by the media.

It is the policy of the Dental Board of California to accommodate speaking requests from all organizations, schools, consumer groups, or other interested groups, whenever possible. If the Board representative is addressing a dental school or group of potential candidates for licensure, the program must be open to all interested parties. The President may authorize board members to speak to schools, organizations, consumer groups, or other interested groups upon request by members or written requests from said schools, organizations or groups.

Media Inquiries *(Board Policy)*

If a member of the Board receives a media call, the Member should promptly refer the caller to the Department of Consumer Affairs Public Information Officer who is employed to interface with all types of media on any type of inquiry. It is required that members make this referral as the power of the Board is vested in the Board itself and not with any individual Board Member. Expressing a personal opinion can be misconstrued as a Board policy or position and may be represented as a position that the Board has taken on a particular issue when it has not.

A Board Member who receives a call should politely thank the caller for the call, but state that it is the Board's policy to refer all callers to the Public Information Officer. The Board Member should then send an email to the Executive Officer indicating they received a media call and relay any information supplied by the caller.

Executive Officer Evaluation *(Board Policy)*

The Board shall evaluate ~~annually~~ the performance of the Executive Officer annually.

Board Staff *(DCA Reference Manual)*

Employees of the Board, with the exception of the Executive Officer, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this

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complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Officer. Consequently, the Executive Officer shall solely be responsible for all day-to-day personnel transactions.

Business Cards
(Board Policy)

Business cards will be provided to each Officer of the Board member with the Board's office address, telephone and fax number, and Web site address. A Board member's Officer's business address, telephone and fax number, and e-mail address may be listed on the card at the member's request.

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CHAPTER 6. OTHER POLICIES AND PROCEDURES

Mandatory Training
(DCA Policy)

State law requires board members within the Department of Consumer Affairs to complete training in several important areas, including ethics, conflict of interest laws, sexual harassment prevention and Board Member Orientation Training.

Ethics Orientation

http://www.dcaboardmembers.ca.gov/training/ethics_orientation.shtml
(Government Code §53234)

California law requires all appointees to take an ethics orientation within the first six months of their appointment and to repeat this ethics orientation every two years throughout their term.

The training includes important information on activities or actions that are inappropriate or illegal. For example, generally public officials cannot take part in decisions that directly affect their own economic interests. They are prohibited from misusing public funds, accepting free travel and accepting honoraria. There are limits on gifts.

An online, interactive version of the training is available on the Attorney General's Web site at <http://oag.ca.gov/ethics>. An accessible, text-only version of the materials is also available at the Attorney General's Web site.

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http://www.dcaboardmembers.ca.gov/training/harassment_prevention.shtml
(Government Code §12950.1)

All new board members are required to attend at least two hours of classroom or other interactive training and education regarding sexual harassment prevention within six months of their appointment. The Equal Employment Opportunity (EEO) Office is responsible for ensuring that all board members complete their required training. A copy of your certificate of proof of training must be sent to the EEO Office. Please identify which Board/Committee/Commission you serve on.

Board Member Administrative Procedure Manual Dental Board of California

For information on how to receive Sexual Harrassment Prevention Training contact:

Equal Employment Opportunity Office
1625 N. Market Blvd, Ste N330
Sacramento, CA 95834
(916) 574-8280 (916) 574-8604 Fax

Board Member Orientation
(B & P Code Section 453)

Every newly appointed board member is required to complete a training and orientation program offered by the Department of Consumer Affairs (DCA) within one year of assuming office. The training covers the functions, responsibilities and obligations that come with being a member of a DCA board.

For more information and assistance with scheduling training, please contact:

Deanna Marino Robinson
SOLID Training Solutions
1747 North Market Blvd, Ste. 270
Sacramento, CA 95834
(916) 574-8320
deanna.marino.robinson@dca.ca.gov

Board Member Disciplinary Actions
(Board Policy)

The Board may censure a member if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as President of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members
(B&P Code Section 1605)

The Governor has the power to remove from office at any time any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct. The Governor may also remove from office a Board member whom directly or indirectly discloses examination questions to an applicant for examination for licensure. That member would also be subject to a misdemeanor violation (B&P Code 123).

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Resignation of Board Members (Government Code Section 1750)

In the event that it becomes necessary for a Board member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. State law requires written notification. A copy of this letter shall also be sent to the director of the Department, the Board President, and the Executive Officer.

Conflict of Interest (Government Code Section 87100)

No Board member may make, participate in making or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board member who has a financial interest shall disqualify him or herself from making or attempting to use his or her official position to influence the decision. Any Board member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Officer, or the Board's legal counsel.

Contact with Candidates (Board Policy)

Board members shall not intervene on behalf of a candidate for licensure for any reason. They should forward all contacts or inquiries to the Executive Officer or Board staff.

Gifts from Candidates (Board Policy)

Gifts of any kind to Board members or the staff from candidates for licensure with the Board shall not be permitted.

Request for Records Access (Board Policy)

No Board member may access the file of a licensee or candidate without the Executive Officer's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the DBOC's office.

Ex Parte Communications (Government Code Section 11430.10 et seq.)

The Government Code contains provisions prohibiting *ex parte* communications. An "ex parte" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

Board Member Administrative Procedure Manual Dental Board of California

“While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication.”

Board members are prohibited from an *ex parte* communication with Board enforcement staff while a proceeding is pending.

Occasionally an applicant who is being formally denied licensure, or a licensee against whom disciplinary action is being taken, will attempt to directly contact Board members. If the communication is written, the person should read only far enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, they should reseal the documents and send them to the Chief of Enforcement.

If a Board member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person they cannot speak to them about the matter. If the person insists on discussing the case, he or she should be told that the Board member would be required to excuse him or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the agency’s assigned Legal Office attorney.

Roles and Responsibilities of Board Officers/Committee Chairs (Board Policy)

President

- Acts as spokesperson for the Dental Board (attends legislative hearings and testifies on behalf of the Board, attends meetings with stakeholders and Legislators on behalf of Board, talks to the media on behalf of the Board, and signs letters on behalf of the Board).
- Meets and/or communicates with the Executive Officer (EO) on a regular basis.
- Provides oversight to the Executive Officer in performance of the EO duties.
- Approves leave requests, verifies accuracy and approves timesheets, approves travel and signs travel expense claims for the EO.
- Coordinates the EO annual evaluation process including contacting DCA Office of Human Resources to obtain a copy of the Executive Officer Performance Evaluation Form, distributes the evaluation form to members, and collates the ratings and comments for discussion.
- Communicates with other Board Members for Board business.

Board Member Administrative Procedure Manual Dental Board of California

- Authors a president's message for every quarterly board meeting and published newsletters.
- Approves Board Meeting agendas.
- Chairs and facilitates Board Meetings.
- Chairs the Executive Committee.
- Signs specified full board enforcement approval orders.
- Establishes Committees and appoints Chairs and members.
- Establishes 2-Person subcommittees to research policy questions when necessary.

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee.
- Coordinates the revision of the Board's Strategic Plan.

Secretary

- Calls the roll at each Board meeting and reports that a quorum has been established.
- Is a member of Executive Committee.

Committee Chair

- Reviews agenda items with EO and Board President prior to Committee meetings.
- Approves the Committee agendas.
- Chairs and facilitates Committee meetings.
- Reports the activities of the Committee to the full Board.



MEMORANDUM

DATE	October 25, 2013
TO	Dental Board Members
FROM	Lori Reis, Diversion Program Manager
SUBJECT	Agenda Item 16: Diversion Program

A. OVERVIEW

Board's Authority

The Dental Board of California (Board) is the only state agency authorized to issue dental licenses and to enforce standards to protect California's dental consumers from incompetent dental practitioners. To help meet these responsibilities, the Board has a legislative mandate (Business and Professions Code section 1695) to establish a diversion program.

Program Goals

The program's goal is the early identification and rehabilitation of licensees whose competency may be impaired due to abuse of alcohol or dangerous drugs so that they may be returned to the practice of dentistry in a manner that will not endanger the public health and safety.

The Board acknowledges and recognizes dental professionals may not be able to safely practice dentistry due to drugs and/or alcohol dependencies. The diversion program is a confidential program that permits those licensed dentists and allied dental health professionals who meet eligibility criteria the opportunity to recover without the loss of a license to practice.

By implementing a diversion program, the Board is able to more closely monitor the recovery progress of known chemically impaired licensees, thereby enhancing the Board's mission to provide consumer protection.

Applicant Eligibility

Any California licensed dentist or allied dental health professional experiencing an alcohol and/or drug abuse problem, and who has not been convicted of the sales of narcotics or other dangerous drugs, may apply for admission into the program. Licensees may apply as a self-referral, or at the request of Board investigators, or in compliance with Board orders of probation.

Diversion Evaluation Committee

The Board is authorized to establish Diversion Evaluation Committees (DEC's) comprised of members with "experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse." (CCR section 1020.4). The Board currently has established two such committees; a Northern DEC and a Southern DEC. Each committee consists of six members: three licensed dentists, one licensed dental auxiliary, one public member, and one licensed physician or psychologist. These committees assist the Board in the evaluation of licensees who may be impaired due to the abuse of alcohol or dangerous drugs. Each DEC meets for one to two day sessions on a quarterly basis. DEC members are compensated by the Board pursuant to Business and Professions Code section 103 - \$100 for each day worked. Travel, lodging and meal expenses are also provided by the Board.

Mission Statement

The mission of the DEC is to implement the intent of the legislature, and seek ways to identify and assist in the rehabilitation of licensees whose competency may be impaired due to the abuse of alcohol and dangerous drugs.

Diversion Program Manager

The Diversion Program Manager (DPM) is employed by the Board to provide management oversight for the diversion program in a manner that assures public safety yet encourages rehabilitation of California dental professionals. The DPM provides ongoing direction to program staff, the DEC's, the Service Provider, and the Health Support Group leaders.

Service Provider (Currently MAXIMUS, Inc.)

The service provider is required to have demonstrated expertise and knowledge in chemical dependency, treatment of impaired health care professionals, and the ability to provide professional preventative health care service, including confidential assessment, referral and monitoring prior to being awarded a contract.

B. MAXIMUS, Inc. PRESENTATION

The Department of Consumer Affairs has contracted with MAXIMUS, Inc. to provide confidential intervention, assessment, referral, and monitoring services. Founded in 1975 with the single mission of "Helping Government Serve the People", MAXIMUS has served thousands of local, state, and federal government clients with unwavering integrity, and an unmatched commitment to quality. MAXIMUS is a team of dedicated, talented, and conscientious professions, who through their daily efforts in the support of the government improve the lives of individuals and families across the country.

Virginia (Ginny) L. Matthews, RN, BSN, MBA, Project Manager from MAXIMUS will provide an overview of MAXIMUS, Inc.

C. CALIFORNIA DENTAL ASSOCIATION (CDA) WELLBEING PRESENTATION

The CDA Well-Being Program exists to assist dental professionals who suffer from alcohol and/or chemical dependency. It's also a referral source for other disorders such as Bi-Polar, depression, diabetes, glaucoma, Parkinson's, sexual addiction, sexual boundary issues and more.

Assistance is offered through component and regional well-being committees who encourage an individual to seek treatment in order to preserve their life, privilege to practice dentistry and maintain public safety.

Curtis Vixie, DDS, serves as a volunteer on the Northern California wellbeing committee as well as the Board's Southern California DEC. Dr. Vixie will provide an overview of CDA's wellbeing program and discuss the similarities/differences between the Board's DEC and CDA's wellbeing program.

Attachments: Business and Professions Code Sections 1695-1699
California Code of Regulations Sections 1020.1.-1020.9.

D. DIVERSION STATISTICS JULY-SEPTEMBER 2013

JULY

- Intakes Into Program: One (1) self-referral
- Participant's County of Residence: Riverside
- Gender: Female
- Worksite of Practice Setting: Dental Private Practice
- Specialty at Intake: General Dentist
- Presenting Problem at Intake: Alcohol
- Marital Status: Divorced
- Closed Cases: 0
- Active Participants: 35

AUGUST

- Intakes Into Program: 0
- Closed: 0
- Active Participants: 35

SEPTEMBER

- Intakes Into Program: 0
- Closed: 2 (1) Completed
(1) Withdrawn Post DEC
- Participants at Beginning of Month: 35
- Participants at End of Month: 33

The Board continues recruitment for the following positions:

Southern DEC – one (1) Dental Auxiliary
Northern DEC – one (1) Dentist
one (1) Licensed Physician or Psychologist

The next DEC meeting is scheduled for December 5, 2013 in Northern CA.

ACTION REQUESTED

None

ATTACHMENT

BUSINESS AND PROFESSIONS CODE SECTIONS 1695-1699

1695. It is the intent of the Legislature that the Board of Dental Examiners of California seek ways and means to identify and rehabilitate licentiates whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licentiates so afflicted may be treated and returned to the practice of dentistry in a manner which will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Dental Examiners of California shall implement this legislation in part by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions.

1695.1. As used in this article:

- (a) "Board" means the Board of Dental Examiners of California.
- (b) "Committee" means a diversion evaluation committee created by this article.
- (c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

1695.2. One or more diversion evaluation committees is hereby created in the state to be established by the board. The board shall establish criteria for the selection of the committee. No board member shall serve on any committee.

1695.3. Each member of a committee shall receive per diem and expenses as provided in Section 103.

1695.4. The board shall administer the provisions of this article.

1695.5.

- (a) The board shall establish criteria for the acceptance, denial, or termination of licentiates in a diversion program. Unless ordered by the board as a condition of licentiate disciplinary probation, only those licentiates who have voluntarily requested diversion treatment and supervision by a committee shall participate in a diversion program.
- (b) A licentiate who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).
- (c) A licentiate under current investigation by the board may also request entry into the diversion program by contacting the board's Diversion Program Manager. The Diversion Program Manager may refer the licentiate requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licentiate to enter into the diversion program, the Diversion Program Manager may require the licentiate, while undercurrent investigation for any violations of the Dental Practice Act or other violations, to execute a statement of understanding that states that the licentiate understands that his or her violations of the Dental Practice Act or other statutes that would otherwise be the basis for discipline, may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a licentiate are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1681, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the licentiate is accepted into the board's diversion program and successfully completes the requirements of the program. If the licentiate withdraws or is terminated from the program by a diversion evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(e) Neither acceptance nor participation in the diversion program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licentiate for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) If a licentiate withdraws or is terminated from the diversion program for failure to comply or is determined to be a threat to the public or his or her own health and safety, all diversion records for that licentiate shall be provided to the board's enforcement program and may be used in any disciplinary proceeding. If a licentiate in a diversion program tests positive for any banned substance, the board's diversion program manager shall immediately notify the board's enforcement program and provide the documentation evidencing the positive test result to the enforcement program. This documentation may be used in a disciplinary proceeding.

(g) Any licentiate terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the diversion program. A licentiate who has been under investigation by the board and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the board.

1695.6. A committee created under this article operates under the direction of the program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those licentiates who request to participate in the diversion program according to the guidelines prescribed by the board and to make recommendations. In making the recommendations, a committee shall consider the recommendations of any licentiates designated by the board to serve as consultants on the admission of the licentiate to the diversion program.

(b) To review and designate those treatment facilities to which licentiates in a diversion program may be referred.

(c) To receive and review information concerning a licentiate participating in the program.

(d) To consider in the case of each licentiate participating in a program whether he or she may with safety continue or resume the practice of dentistry.

(e) To perform such other related duties, under the direction of the board or program manager, as the board may by regulation require.

1696. Notwithstanding the provisions of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session to consider reports pertaining to any licentiate requesting or participating in a diversion program. A committee shall only convene in closed session to the extent that it is necessary to protect the privacy of such a licentiate.

1697. Each licentiate who requests participation in a diversion program shall agree to cooperate with the treatment program designed by the committee and approved by the program manager and to bear all costs related to the program, unless the cost is waived by the board. Any failure to comply with the provisions of a treatment program may result in termination of the licentiate's participation in a program.

1698.

(a) After the committee and the program manager in their discretion have determined that a licentiate has been rehabilitated and the diversion program is completed, the committee shall purge and destroy all records pertaining to the licentiate's participation in a diversion program.

(b) Except as authorized by subdivision (f) of Section 1695.5, all board and committee records and records of proceedings pertaining to the treatment of a licentiate in a program shall be kept confidential and are not subject to discovery or subpoena.

1699. The board shall provide for the representation of any person making reports to a committee or the board under this article in any action for defamation for reports or information given to the committee or the board regarding a licentiate's participation in the diversion program.

CALIFORNIA CODE OF REGULATIONS SECTIONS 1020.1.-1020.8.

Section 1020.1. Criteria for Admission.

An applicant shall meet the following criteria for admission to the Impaired Licentiate Program.

(a) Is a California licensed dentist or dental auxiliary.

(b) Resides in California.

(c) Is found to abuse narcotics, dangerous drugs or alcohol in a manner which may affect the licentiate's ability to practice safely or competently.

(d) Has voluntarily requested admission to the program.

(e) Agrees to undertake any medical and/or psychiatric examinations ordered to evaluate the application for participation in the program.

(f) Cooperates with the program by providing medical information, disclosure authorizations and releases of liability as may be necessary for participation in the program.

(g) Agrees in writing to cooperate and comply with all elements of the treatment program designed by a diversion evaluation committee and to bear all the costs of such program.

(h) Has not been convicted of a crime involving the sale of narcotics or dangerous drugs.

Section 1020.2. Causes for Denial of Admission.

A diversion evaluation committee may deny an applicant admission to the program for any of the following reasons:

- (a) The applicant does not meet the requirements set forth in Section 1020.1.
- (b) The committee determines that the applicant will not substantially benefit from participation in the program or that the applicant's participation in the program creates too great a risk to the public health, safety or welfare.

Section 1020.3. Termination from the Program.

(a) A diversion evaluation committee may terminate a licentiate's participation in the program for any of the following reasons:

- (1) The licentiate has successfully completed the treatment program prescribed by the committee.
- (2) The committee votes to terminate participation for one of the following causes:
 - (A) The licentiate has failed to comply with the treatment program designated by the committee.
 - (B) The licentiate has failed to comply with any of the requirements set forth in Section 1020.1.
 - (C) Any cause for denial of an applicant set forth in Section 1020.2.
 - (D) The committee determines that the licentiate has not substantially benefited from participation in the program or that the licentiate's continued participation in the program creates too great a risk to the public health, safety or welfare.
- (b) The committee shall determine, based upon the recommendation of both the program manager and a consultant, whether to terminate participation in the program. The committee's decision on termination shall be final.

Section 1020.4. Diversion Evaluation Committee Membership.

- (a) A diversion evaluation committee shall consist of six members: three licensed dentists, one licensed dental auxiliary, one public member, and one licensed physician or psychologist.
- (b) Each committee member shall have experience or knowledge in the evaluation or management of persons who are impaired due to alcohol or drug abuse.
- (c) Each member of the committee shall be appointed by the board and shall serve at the board's pleasure. Members of a committee shall be appointed for a term of four years, and each member shall hold office until the appointment and qualification of his or her successor or until one year shall have elapsed since the expiration of the term for which he or she was appointed, whichever first occurs. No person shall serve as a member of the committee for more than two terms.

Section 1020.5. Diversion Evaluation Committee Duties and Responsibilities.

A diversion evaluation committee shall have the following duties and responsibilities in addition to those set forth in Section 1695.6 of the Code:

- (a) To consider recommendations of the program manager and any consultant to the committee;
- (b) To set forth in writing for each licensee in a program a treatment and rehabilitation program established for that licensee with the requirements for supervision and surveillance.

Section 1020.6. Committee Consultants.

A Diversion Evaluation Committee (DEC) may utilize one or more chemical dependency treatment service providers or licensed physicians or psychologists who are competent in their field or specialty and who have demonstrated expertise in the diagnosis and treatment of substance abuse.

Section 1020.7. Procedure for Review of Applicants.

- (a) A diversion evaluation committee consultant and/or program manager shall interview each applicant who requests admission to the program.
- (b) The consultant shall interview the applicant and initiate such clinical assessments as necessary to determine applicant eligibility to participate in the program. The program manager may request such other information, authorizations, and releases necessary for participation in the program.
- (c) The program manager and the consultant who interview and assess the applicant shall each make a recommendation to the committee whether the applicant should be admitted to the program.
- (d) The committee's decision on admission to the program shall be final.

Section 1020.8. Confidentiality of Records.

Note: Authority cited: Sections 1614 and 1695.4, Business and Professions Code.
Reference: Section 1698, Business and Professions Code.



MEMORANDUM

DATE	November 7, 2013
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17A: 2014 Tentative Legislative Calendar – Information Only

Background

The 2014 Tentative Legislative Calendar is enclosed for informational purposes

Action Requested:

No action necessary.

2014 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICES OF THE SECRETARY OF THE SENATE & THE ASSEMBLY CHIEF CLERK
October 22, 2013

DEADLINES

JANUARY						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY						
S	M	T	W	TH	F	S
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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MARCH						
S	M	T	W	TH	F	S
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23	24	25	26	27	28	29
30	31					

APRIL						
S	M	T	W	TH	F	S
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13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY						
S	M	T	W	TH	F	S
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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

- Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 6** Legislature Reconvenes (J.R. 51(a)(4)).
- Jan. 10** Budget must be submitted by Governor (Art. IV, Sec. 12(a)).
- Jan. 17** Last day for **policy committees** to hear and report to Fiscal committees fiscal bills introduced in their house in 2013 (J.R. 61(b)(1)).
- Jan. 20** Martin Luther King, Jr. Day.
- Jan. 24** Last day for any committee to hear and report to the **Floor** bills introduced in their house in 2013 (J.R. 61(b)(2)). Last day to submit **bill requests** to the Office of Legislative Counsel.
- Jan. 31** Last day for each house to **pass bills introduced in 2013** in their House (Art. IV, Sec. 10(c)), (J.R. 61(b)(3)).

- Feb. 17** President's Day.
- Feb. 21** Last day for bills to be **introduced** (J.R. 61(b)(4)), (J.R. 54(a)).

- Mar. 31** Cesar Chavez Day

- Apr. 10** **Spring Recess** begins at end of this day's session (J.R. 51(b)(1)).
- Apr. 21** Legislature reconvenes from **Spring Recess** (J.R. 51(b)(1)).

- May 2** Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).
- May 9** Last day for **policy committees** to hear and report to the floor **non-fiscal** bills introduced in their house (J.R. 61(b)(6)).
- May 16** Last day for **policy committees** to meet prior to June 2 (J.R. 61(b)(7)).
- May 23** Last day for **fiscal committees** to hear and report to the floor Bills introduced in their house (J.R. 61(b)(8)). Last day for **fiscal Committees** to meet prior to June 2 (J.R. 61 (b)(9)).
- May 26** Memorial Day
- May 27 - 30 Floor Session Only.** No committee may meet for any purpose (J.R. 61(b)(10)).
- May 30** Last day for bills to be **passed out of the house of origin** (J.R. 61(b)(11)).

2014 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICES OF THE SECRETARY OF THE SENATE & THE ASSEMBLY CHIEF CLERK
October 22, 2013

Page 1 of 2

JUNE						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

- June 2** Committee meetings may resume (J.R. 61(b)(12)).
- June 15** Budget must be **passed** by **midnight** (Art. IV, Sec. 12(c)(3)).
- June 26** Last day for a legislative measure to qualify for the November 4 general election ballot (Election code Sec. 9040).
- June 27** Last day for **policy committees** to meet and report bills (J.R. 61(b)(13)).

JULY						
S	M	T	W	TH	F	S
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13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

- July 3** **Summer Recess** begins at the end of this day's session if Budget Bill has been passed (J.R. 51(b)(2)).
- July 4** Independence Day

AUGUST						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

- Aug. 4** Legislature reconvenes from **Summer Recess** (J.R. 51(b)(2)).
- Aug. 15** Last day for **fiscal committees** to meet and report bills to the Floor (J.R. 61(b)(14)).
- Aug. 18 – 31 Floor Session only.** No committees, other than conference committees and Rules committee, may meet for any purpose (J.R. 61(b)(15)).
- Aug. 22** Last day to **amend bills** on the Floor (J.R. 61(b)(16)).
- Aug. 31** Last day for **each house to pass bills** (Art. IV, Sec. 10(c)), (J.R. 61(b)(17)). **Final recess** begins at the end of this day's session (J.R. 51(b)(3)).

IMPORTANT DATES OCCURRING DURING FINAL RECESS

2014

- Sept. 30 Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor's possession on or after Sept. 1 (Art. IV, Sec. 10(b)(2)).
- Nov. 4 General Election
- Nov. 30 Adjournment Sine Die at midnight (Art. IV, Sec. 3(a)).
- Dec. 1 12 m. convening of 2015-16 Regular Session (Art. IV, Sec. 3(a)).

2015

- Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 5 Legislature reconvenes (JR 51(a)(1)).



MEMORANDUM

DATE	November 6, 2013
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17B: 2013 End-of-Year Legislative Summary Report

Background

Throughout 2013, staff tracked several bills that would impact the Dental Board and healing arts boards in general. Board members and staff have actively partaken in this year's Legislative Session by communicating with Legislators and their staff, and taking positions on proposed bills. The bills that the Committee and the Board have followed include:

- AB 18 (Pan) Individual Health Care Coverage
- AB 50 (Pan) Health Care Coverage: Medi-Cal Eligibility
- AB 186 (Maienschein) Professions and Vocations: Military Spouses: Licenses
- AB 258 (Chavez) State Agencies: Veterans
- AB 291 (Nestande) California Sunset Review Commission
- AB 318 (Logue) Dental Care: Telehealth
- AB 496 (Gordon) Medicine: Sexual Orientation: Gender Identity
- AB 512 (Rendon) Healing Arts: Licensure Exemption
- AB 771 (Jones) Public Health: Wellness Programs
- AB 809 (Logue) Healing Arts: Telehealth
- AB 827 (Hagman) Department of Consumer Affairs
- AB 836 (Skinner) Dentists: Continuing Education
- AB 851 (Logue) Dentistry: Licensure and Certification Requirements
- AB 1174 (Bocanegra) Oral Health: Virtual Dental Homes
- AB 1231 (Perez) Regional Centers: Telehealth and Teledentistry
- SB 456 (Padilla) Health Care Coverage
- SB 532 (De Leon) Professions and Vocations: Military Spouses
- SB 562 (Galgiani) Dentists: Mobile or Portable Dental Units
- SB 690 (Price) Licenses
- Senate Bill 809 (DeSaulnier) Controlled Substances
- SB 821 (Senate Business, Professions and Economic Development Committee) Healing Arts

The following bills were held in committees and did not meet the required legislative deadlines to progress forward:

- AB 18 (Pan) Individual Health Care Coverage
- AB 186 (Maienschein) Professions and Vocations: Military Spouses: Licenses
- AB 496 (Gordon) Medicine: Sexual Orientation: Gender Identity

The following bills were vetoed by Governor Brown:

- AB 50 (Pan) Health Care Coverage: Medi-Cal Eligibility
- AB 1231 (Perez V.) Regional Centers: Telehealth and Teledentistry

The following bills have been designated as 2-year bills and will be taken up again by the Legislature in 2014:

- AB 291 (Nestande) California Sunset Review Commission
- AB 318 (Logue) Dental Care: Telehealth
- AB 771 (Jones) Public Health: Wellness Programs
- AB 809 (Logue) Healing Arts: Telehealth
- AB 827 (Hagman) Department of Consumer Affairs
- AB 851 (Logue) Dentistry: Licensure and Certification Requirements
- AB 1174 (Bocanegra) Oral Health: Virtual Dental Homes
- SB 456 (Padilla) Health Care Coverage
- SB 532 (De Leon) Professions and Vocations: Military Spouses
- SB 690 (Price) Licenses

Staff will continue to monitor these two-year bills and will provide reports at upcoming meetings.

The following includes summaries of the bills that have been signed by Governor Brown and will become effective on January 1, 2014:

AB 258 Chavez (Chapter 227, Statutes of 2013)

STATE AGENCIES: VETERANS

On or after July 1, 2014, every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran is required to request that information only in the following format: "Have you ever served in the United State military?"

The Board will need to implement the provisions of this bill by updating forms, publications, and its Web site. It is currently unknown how many forms and publications may require updating; however, staff estimates it to be a minimal amount.

AB 512 Rendon (Chapter 111, Statutes of 2013)

HEALING ARTS: LICENSURE EXEMPTION

Existing law, Business and Professions Code Section 901, provides an exemption for a health care practitioner, licensed or certified in another state, from the licensing and regulatory requirements of the applicable California healing arts board. To be exempted from California licensure

requirements, a health care practitioner must provide services at a sponsored healthcare event to uninsured or underinsured people on a short-term, voluntary basis. Section 901 requires the out-of-state health care practitioner to seek authorization from the applicable healing arts board in California and provides the regulatory framework for the approval of an out-of-state health care practitioner and a sponsoring entity to seek approval from the applicable healing arts boards. Each individual healing arts board was responsible for promulgating regulations to specify the requirements for the approval of an out-of-state practitioner and a sponsoring entity. Existing law specifies that the Section 901 would be repealed on January 1, 2014 unless a later enacted statute deletes or extends the repeal date. This bill extends the repeal date of Section 901 until January 1, 2018.

The Board will be able to continue registering out-of-state dentists for participation in sponsored free health care events until January 1, 2018. There are no additional implementation concerns.

AB 836

Skinner (Chapter 299, Statutes of 2013)

DENTISTS: CONTINUING EDUCATION

The Board requires licensees to complete continuing education hours as a condition of license renewal. The Board is authorized to, by regulation, reduce the renewal fee for a licensee who has practiced dentistry for 20 years or more in California, has reached the age of retirement under the federal Social Security Act, and customarily provides his or her services free of charge to any person, organization, or agency.

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

The Board took a “support” position at its May 2013 meeting.

The Board will need to promulgate regulations to implement the provisions of this bill. The rulemaking process may take anywhere from twelve to eighteen months.

SB 562

Galgiani (Chapter 624, Statutes of 2013)

DENTISTS: MOBILE OR PORTABLE DENTAL UNITS

Existing law authorizes a dentist to operate one mobile dental clinic or unit that is registered and operated in accordance with regulations adopted by the board. Existing law exempts specified mobile units from those requirements. Other provisions of existing law, the Mobile Health Care Services Act, require, subject to specified exemptions, licensure by the State Department of Health Care Services to operate a mobile service

unit. This bill eliminates the one mobile dental clinic or unit limit and requires a mobile dental unit or a dental practice that routinely uses portable dental units, as defined, to be registered and operated in accordance with the regulations of the board. The bill requires any regulations adopted by the board pertaining to these matters to require the registrant to identify a licensed dentist responsible for the mobile dental unit or portable practice, and to include requirements for availability of follow-up and emergency care, maintenance and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties.

The Board took a “support if amended” position at its August 2013 meeting.

The Board will need to promulgate regulations to implement the provisions of this bill. The rulemaking process may take anywhere from twelve to eighteen months.

SB 809

DeSaulnier (Chapter 400, Statutes of 2013)

CONTROLLED SUBSTANCES: REPORTING

Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill establishes the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES. Beginning April 1, 2014, this bill requires an annual fee of \$6 to be assessed on specified licensees, including licensees authorized to prescribe, order, administer, furnish, or dispense controlled substances, and require the regulating agency of each of those licensees to bill and collect that fee at the time of license renewal. The bill authorizes the Department of Consumer Affairs to reduce, by regulation, that fee to the reasonable cost of operating and maintaining CURES for the purpose of regulating those licensees, if the reasonable regulatory cost is less than \$6 per licensee. The bill requires the proceeds of the fee to be deposited into the CURES Fund for the support of CURES. The bill permits specified insurers, health care service plans, qualified manufacturers, and other donors to voluntarily contribute to the CURES Fund, as described.

Existing law requires the Medical Board of California (MBC) to periodically develop and disseminate information and educational materials regarding various subjects, including pain management techniques, to each licensed physician and surgeon and to each general acute care hospital in California. This bill additionally requires the MBC to periodically develop

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

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

Board staff is currently working with the Department of Consumer Affairs to determine the actions necessary to implement the provisions of this bill.

SB 821 Senate Business, Professions and Economic Development Committee
(Chapter 473, Statutes of 2013)

HEALING ARTS

This bill makes several non-controversial minor, non-substantive or technical changes to various provisions pertaining to the healing arts boards within the Department of Consumer Affairs. Specifically, this bill corrects a reference to the Board's name from "Board of Dental Examiners" to "Dental Board of California".

The Board currently uses "Dental Board of California" on all documents, forms, and its Web site. There are no implementation concerns.

Action Requested:

No action necessary.

Assembly Bill No. 258

CHAPTER 227

An act to add Section 11019.11 to the Government Code, relating to state agencies.

[Approved by Governor September 6, 2013. Filed with
Secretary of State September 6, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 258, Chávez. State agencies: veterans.

Existing law provides for the governance and regulation of state agencies, as defined. Existing law provides certain benefits and protections for members of the Armed Forces of the United States.

This bill would require, on or after July 1, 2014, every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran, to request that information in a specified manner.

The people of the State of California do enact as follows:

SECTION 1. Section 11019.11 is added to the Government Code, to read:

11019.11. (a) Every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran, shall request that information only in the following format: "Have you ever served in the United States military?"

(b) This section shall apply only to a written form or written publication that is newly printed on or after July 1, 2014.

Assembly Bill No. 512

CHAPTER 111

An act to amend Section 901 of the Business and Professions Code, relating to healing arts.

[Approved by Governor August 16, 2013. Filed with
Secretary of State August 16, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 512, Rendon. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.

This bill would delete the January 1, 2014, date of repeal, and instead allow the exemption to operate until January 1, 2018.

The people of the State of California do enact as follows:

SECTION 1. Section 901 of the Business and Professions Code is amended to read:

901. (a) For purposes of this section, the following provisions apply:

(1) “Board” means the applicable healing arts board, under this division or an initiative act referred to in this division, responsible for the licensure or regulation in this state of the respective health care practitioners.

(2) “Health care practitioner” means any person who engages in acts that are subject to licensure or regulation under this division or under any initiative act referred to in this division.

(3) “Sponsored event” means an event, not to exceed 10 calendar days, administered by either a sponsoring entity or a local government, or both, through which health care is provided to the public without compensation to the health care practitioner.

(4) “Sponsoring entity” means a nonprofit organization organized pursuant to Section 501(c)(3) of the Internal Revenue Code or a community-based organization.

(5) “Uninsured or underinsured person” means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.

(b) A health care practitioner licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified is exempt from the requirement for licensure if all of the following requirements are met:

(1) Prior to providing those services, he or she does all of the following:

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (d).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to comply with this section or for any act that would be grounds for denial of an application for licensure.

(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:

(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:

(A) The name of the sponsoring entity.

(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.

(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).

(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).

(E) Any additional information required by the board.

(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.

(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.

(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.

(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(l) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

Assembly Bill No. 836

CHAPTER 299

An act to amend Section 1645 of the Business and Professions Code, relating to dentists.

[Approved by Governor September 9, 2013. Filed with
Secretary of State September 9, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

AB 836, Skinner. Dentists: continuing education.

Existing law, the Dental Practice Act, provides for the licensure and regulation of dentists by the Dental Board of California until January 1, 2016, at which time the board shall be subject to review by the appropriate policy committees of the Legislature. Existing law authorizes the board to require licentiates to complete continuing education hours as a condition of license renewal. Existing law authorizes the board to, by regulation, reduce the renewal fee for a licensee who has practiced dentistry for 20 years or more in this state, has reached the age of retirement under the federal Social Security Act, and customarily provides his or her services free of charge to any person, organization, or agency.

This bill would prohibit the board from requiring a retired dentist who provides only uncompensated care to complete more than 60% of the hours of continuing education that are required of other licensed dentists. The bill would require all of those hours of continuing education to be gained through courses related to the actual delivery of dental services to the patient or the community, as determined by the board. The bill would require the board to report on the outcome of that provision, pursuant to, and at the time of, its regular sunset review process.

The people of the State of California do enact as follows:

SECTION 1. Section 1645 of the Business and Professions Code is amended to read:

1645. (a) Effective with the 1974 license renewal period, if the board determines that the public health and safety would be served by requiring all holders of licenses under this chapter to continue their education after receiving a license, it may require, as a condition to the renewal thereof, that they submit assurances satisfactory to the board that they will, during the succeeding two-year period, inform themselves of the developments in the practice of dentistry occurring since the original issuance of their licenses by pursuing one or more courses of study satisfactory to the board or by other means deemed equivalent by the board.

The board shall adopt regulations providing for the suspension of the licenses at the end of the two-year period until compliance with the assurances provided for in this section is accomplished.

(b) The board may also, as a condition of license renewal, require licentiates to successfully complete a portion of the required continuing education hours in specific areas adopted in regulations by the board. The board may prescribe this mandatory coursework within the general areas of patient care, health and safety, and law and ethics. The mandatory coursework prescribed by the board shall not exceed fifteen hours per renewal period for dentists, and seven and one-half hours per renewal period for dental auxiliaries. Any mandatory coursework required by the board shall be credited toward the continuing education requirements established by the board pursuant to subdivision (a).

(c) For a retired dentist who provides only uncompensated care, the board shall not require more than 60 percent of the hours of continuing education that are required of other licensed dentists. Notwithstanding subdivision (b), all of the hours of continuing education as described in this subdivision shall be gained through courses related to the actual delivery of dental services to the patient or the community, as determined by the board. Nothing in this subdivision shall be construed to reduce any requirements imposed by the board pursuant to subdivision (b).

(d) The board shall report on the outcome of subdivision (c) pursuant to, and at the time of, its regular sunset review process, as provided in Section 1601.1.

Senate Bill No. 562

CHAPTER 624

An act to amend Section 1657 of the Business and Professions Code, relating to dentists.

[Approved by Governor October 7, 2013. Filed with
Secretary of State October 7, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 562, Galgiani. Dentists: mobile or portable dental units.

Existing law, the Dental Practice Act, provides for the licensure and regulation by the Dental Board of California of those engaged in the practice of dentistry. Existing law provides that a person practices dentistry if the person, among other things, manages or conducts as manager, proprietor, conductor, lessor, or otherwise, in any place where dental operations are performed. Existing law authorizes a dentist to operate one mobile dental clinic or unit that is registered and operated in accordance with regulations adopted by the board. Existing law exempts specified mobile units from those requirements. Other provisions of existing law, the Mobile Health Care Services Act, require, subject to specified exemptions, licensure by the State Department of Health Care Services to operate a mobile service unit.

This bill would eliminate the one mobile dental clinic or unit limit and would require a mobile dental unit or a dental practice that routinely uses portable dental units, as defined, to be registered and operated in accordance with the regulations of the board. The bill would require any regulations adopted by the board pertaining to these matters to require the registrant to identify a licensed dentist responsible for the mobile dental unit or portable practice, and to include requirements for availability of followup and emergency care, maintenance and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties.

The people of the State of California do enact as follows:

SECTION 1. Section 1657 of the Business and Professions Code is amended to read:

1657. (a) For the purposes of this section, the following definitions shall apply:

(1) "Mobile dental unit" means a self-contained facility, which may include a trailer or van, in which dentistry is practiced that may be moved, towed, or transported from one location to another.

(2) “Portable dental unit” means a self-contained unit housing equipment used for providing dental treatment that is transported to, and used on a temporary basis at, nondental office locations.

(b) A mobile dental unit, or a dental practice that routinely uses portable dental units to provide treatment in nondental office locations, shall be registered and operated in accordance with regulations established by the board. These regulations shall not be designed to prevent or lessen competition in service areas. The regulations shall require the registrant to identify a licensed dentist responsible for the mobile dental unit or portable practice, and shall include, but shall not be limited to, requirements for availability of followup and emergency care, maintenance and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties. A mobile dental unit, or a dental practice using portable dental units, registered and operated in accordance with the board’s regulations and that has paid the fees established by the board, including a mobile dental unit registered for the purpose specified in subdivision (e), shall otherwise be exempt from this article and Article 3.5 (commencing with Section 1658).

(c) A mobile service unit, as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, and a mobile dental unit or portable dental unit operated by an entity that is exempt from licensure pursuant to subdivision (b), (c), or (h) of Section 1206 of the Health and Safety Code, are exempt from this article and Article 3.5 (commencing with Section 1658). Notwithstanding this exemption, the owner or operator of the mobile unit shall notify the board within 60 days of the date on which dental services are first delivered in the mobile unit, or the date on which the mobile unit’s application pursuant to Section 1765.130 of the Health and Safety Code is approved, whichever is earlier.

(d) A licensee practicing in a mobile unit described in subdivision (c) is not subject to subdivision (b) as to that mobile unit.

(e) Notwithstanding Section 1625, a licensed dentist shall be permitted to operate a mobile dental unit provided by his or her property and casualty insurer as a temporary substitute site for the practice registered by him or her pursuant to Section 1650 as long as both of the following apply:

(1) The licensed dentist’s registered place of practice has been rendered and remains unusable due to loss or calamity.

(2) The licensee’s insurer registers the mobile dental unit with the board in compliance with subdivision (b).

Senate Bill No. 809

CHAPTER 400

An act to add Sections 208, 209, and 2196.8 to the Business and Professions Code, and to amend Sections 11164.1, 11165, and 11165.1 of, and to add Section 11165.5 to, the Health and Safety Code, relating to controlled substances.

[Approved by Governor September 27, 2013. Filed with
Secretary of State September 27, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 809, DeSaulnier. Controlled substances: reporting.

(1) Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill would establish the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill would, beginning April 1, 2014, require an annual fee of \$6 to be assessed on specified licensees, including licensees authorized to prescribe, order, administer, furnish, or dispense controlled substances, and require the regulating agency of each of those licensees to bill and collect that fee at the time of license renewal. The bill would authorize the Department of Consumer Affairs to reduce, by regulation, that fee to the reasonable cost of operating and maintaining CURES for the purpose of regulating those licensees, if the reasonable regulatory cost is less than \$6 per licensee. The bill would require the proceeds of the fee to be deposited into the CURES Fund for the support of CURES, as specified. The bill would also permit specified insurers, health care service plans, qualified manufacturers, and other donors to voluntarily contribute to the CURES Fund, as described.

(2) Existing law requires the Medical Board of California to periodically develop and disseminate information and educational materials regarding various subjects, including pain management techniques, to each licensed physician and surgeon and to each general acute care hospital in California.

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

(3) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

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

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The Controlled Substance Utilization Review and Evaluation System (CURES) is a valuable preventive, investigative, and educational tool for health care providers, regulatory agencies, educational researchers, and law enforcement. Recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support CURES and its Prescription Drug Monitoring Program (PDMP). The CURES PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs. Without a dedicated funding source, the CURES PDMP is not sustainable.

(b) Each year CURES responds to more than 800,000 requests from practitioners and pharmacists regarding all of the following:

(1) Helping identify and deter drug abuse and diversion of prescription drugs through accurate and rapid tracking of Schedule II, Schedule III, and Schedule IV controlled substances.

(2) Helping practitioners make prescribing decisions.

(3) Helping reduce misuse, abuse, and trafficking of those drugs.

(c) Schedule II, Schedule III, and Schedule IV controlled substances have had deleterious effects on private and public interests, including the misuse, abuse, and trafficking in dangerous prescription medications resulting in injury and death. It is the intent of the Legislature to work with stakeholders to fully fund the operation of CURES which seeks to mitigate those deleterious effects and serve as a tool for ensuring safe patient care, and which has proven to be a cost-effective tool to help reduce the misuse, abuse, and trafficking of those drugs.

(d) The following goals are critical to increase the effectiveness and functionality of CURES:

(1) Upgrading the CURES PDMP so that it is capable of accepting real-time updates and is accessible in real-time, 24 hours a day, seven days a week.

(2) Upgrading the CURES PDMP in California so that it is capable of operating in conjunction with all national prescription drug monitoring programs.

(3) Providing subscribers to prescription drug monitoring programs access to information relating to controlled substances dispensed in California, including those dispensed through the United States Department of Veterans Affairs, the Indian Health Service, the Department of Defense, and any other entity with authority to dispense controlled substances in California.

(4) Upgrading the CURES PDMP so that it is capable of accepting the reporting of electronic prescription data, thereby enabling more reliable, complete, and timely prescription monitoring.

SEC. 2. Section 208 is added to the Business and Professions Code, to read:

208. (a) Beginning April 1, 2014, a CURES fee of six dollars (\$6) shall be assessed annually on each of the licensees specified in subdivision (b) to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees. The fee assessed pursuant to this subdivision shall be billed and collected by the regulating agency of each licensee at the time of the licensee's license renewal. If the reasonable regulatory cost of operating and maintaining CURES is less than six dollars (\$6) per licensee, the Department of Consumer Affairs may, by regulation, reduce the fee established by this section to the reasonable regulatory cost.

(b) (1) Licensees authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances or pharmacists licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2.

(2) Wholesalers and nonresident wholesalers of dangerous drugs licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2.

(3) Nongovernmental clinics licensed pursuant to Article 13 (commencing with Section 4180) and Article 14 (commencing with Section 4190) of Chapter 9 of Division 2.

(4) Nongovernmental pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2.

(c) The funds collected pursuant to subdivision (a) shall be deposited in the CURES Fund, which is hereby created within the State Treasury. Moneys in the CURES Fund shall, upon appropriation by the Legislature, be available to the Department of Consumer Affairs to reimburse the Department of Justice for costs to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(d) The Department of Consumer Affairs shall contract with the Department of Justice on behalf of the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Board of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board, the State Board of Optometry, and the California Board of Podiatric Medicine to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

SEC. 3. Section 209 is added to the Business and Professions Code, to read:

209. The Department of Justice, in conjunction with the Department of Consumer Affairs and the boards and committees identified in subdivision (d) of Section 208, shall do all of the following:

(a) Identify and implement a streamlined application and approval process to provide access to the CURES Prescription Drug Monitoring Program (PDMP) database for licensed health care practitioners eligible to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances and for pharmacists. Every reasonable effort shall be made to implement a streamlined application and approval process that a licensed health care practitioner or pharmacist can complete at the time that he or she is applying for licensure or renewing his or her license.

(b) Identify necessary procedures to enable licensed health care practitioners and pharmacists with access to the CURES PDMP to delegate their authority to order reports from the CURES PDMP.

(c) Develop a procedure to enable health care practitioners who do not have a federal Drug Enforcement Administration (DEA) number to opt out of applying for access to the CURES PDMP.

SEC. 4. Section 2196.8 is added to the Business and Professions Code, to read:

2196.8. The board shall periodically develop and disseminate information and educational material regarding assessing a patient's risk of abusing or diverting controlled substances and information relating to the Controlled Substance Utilization Review and Evaluation System (CURES), described in Section 11165 of the Health and Safety Code, to each licensed physician and surgeon and to each general acute care hospital in this state. The board shall consult with the State Department of Public Health, the boards and committees specified in subdivision (d) of Section 208, and the Department

of Justice in developing the materials to be distributed pursuant to this section.

SEC. 5. Section 11164.1 of the Health and Safety Code is amended to read:

11164.1. (a) (1) Notwithstanding any other provision of law, a prescription for a controlled substance issued by a prescriber in another state for delivery to a patient in another state may be dispensed by a California pharmacy, if the prescription conforms with the requirements for controlled substance prescriptions in the state in which the controlled substance was prescribed.

(2) All prescriptions for Schedule II, Schedule III, and Schedule IV controlled substances dispensed pursuant to this subdivision shall be reported by the dispensing pharmacy to the Department of Justice in the manner prescribed by subdivision (d) of Section 11165.

(b) Pharmacies may dispense prescriptions for Schedule III, Schedule IV, and Schedule V controlled substances from out-of-state prescribers pursuant to Section 4005 of the Business and Professions Code and Section 1717 of Title 16 of the California Code of Regulations.

SEC. 6. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that

may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section

208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

SEC. 7. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before January 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before January 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

- (i) Materially falsifying an application for a subscriber.
- (ii) Failure to maintain effective controls for access to the patient activity report.
- (iii) Suspended or revoked federal DEA registration.
- (iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.
- (v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the

process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

SEC. 8. Section 11165.5 is added to the Health and Safety Code, to read:

11165.5. (a) The Department of Justice may seek voluntarily contributed private funds from insurers, health care service plans, qualified manufacturers, and other donors for the purpose of supporting CURES. Insurers, health care service plans, qualified manufacturers, and other donors may contribute by submitting their payment to the Controller for deposit into the CURES Fund established pursuant to subdivision (c) of Section 208 of the Business and Professions Code. The department shall make information about the amount and the source of all private funds it receives for support of CURES available to the public. Contributions to the CURES Fund pursuant to this subdivision shall be nondeductible for state tax purposes.

(b) For purposes of this section, the following definitions apply:

(1) "Controlled substance" means a drug, substance, or immediate precursor listed in any schedule in Section 11055, 11056, or 11057 of the Health and Safety Code.

(2) "Health care service plan" means an entity licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(3) "Insurer" means an admitted insurer writing health insurance, as defined in Section 106 of the Insurance Code, and an admitted insurer writing workers' compensation insurance, as defined in Section 109 of the Insurance Code.

(4) "Qualified manufacturer" means a manufacturer of a controlled substance, but does not mean a wholesaler or nonresident wholesaler of

dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section 4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

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Senate Bill No. 821

CHAPTER 473

An act to amend Sections 1613, 1915, 1926.2, 3024, 3025, 3040, 3041.2, 3051, 3057.5, 3077, 3093, 3098, 3103, 3106, 3107, 3109, 3163, 4053, 4107, 4980.36, 4980.397, 4980.398, 4980.399, 4980.40, 4980.43, 4980.50, 4984.01, 4984.7, 4984.72, 4989.68, 4992.05, 4992.07, 4992.09, 4992.1, 4996.1, 4996.3, 4996.4, 4996.9, 4996.17, 4996.18, 4996.28, 4999.33, 4999.45, 4999.46, 4999.47, 4999.50, 4999.52, 4999.53, 4999.55, 4999.64, and 4999.100 of, and to add Section 4021.5 to, the Business and Professions Code, and to amend Section 14132 of the Welfare and Institutions Code, relating to healing arts.

[Approved by Governor October 1, 2013. Filed with
Secretary of State October 1, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 821, Committee on Business, Professions and Economic Development.
Healing arts.

(1) Existing law, the Dental Practice Act, establishes the Dental Board of California, which was formerly known as the Board of Dental Examiners of California. Existing law requires the board to have and use a seal bearing its name. Existing law creates, within the jurisdiction of the board, a Dental Hygiene Committee of California, that is responsible for regulation of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions.

This bill would amend those provisions to remove an obsolete reference to the former board and to make other technical changes.

(2) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. That act refers to the authorization to practice optometry issued by the board as a certificate of registration.

This bill would instead refer to that authorization issued by the board as an optometrist license and would make other technical and conforming changes.

(3) Existing law, the Pharmacy Law, governs the business and practice of pharmacy in this state and establishes the California State Board of Pharmacy. Existing law prohibits the board from issuing more than one site license to a single premises except to issue a veterinary food-animal drug retailer license to a wholesaler or to issue a license for compound sterile injectable drugs to a pharmacy.

This bill would additionally authorize the board to issue more than one site license to a single premises to issue a centralized hospital packaging

license. The bill would also establish a definition for the term “correctional pharmacy.”

Existing law authorizes the board to issue a license as a designated representative to provide supervision in a wholesaler or veterinary food-animal drug retailer. Existing law requires an individual to meet specified requirements to obtain and maintain a designated representative license, including a minimum of one year of paid work experience related to the distribution or dispensing of dangerous drugs or devices or meet certain prerequisites.

The bill would require the one year of paid work experience to obtain a designated representative license to be in a licensed pharmacy, or with a drug wholesaler, drug distributor, or drug manufacturer. The bill would also make related, technical changes.

(4) Existing law provides for the licensure and regulation of marriage and family therapists, licensed educational psychologists, licensed clinical social workers, and licensed professional clinical counselors by the Board of Behavioral Sciences. Existing law makes various changes to the licensing and associated eligibility and examination requirements for marriage and family therapists, licensed clinical social workers, and licensed professional clinical counselors, effective January 1, 2014.

This bill would delay the implementation of these and other related changes until January 1, 2016.

Existing law requires all persons applying for marriage and family therapist or licensed professional clinical counselor licensure examinations to have specified hours of experience, including experience gained by an intern or trainee as an employee or volunteer.

This bill would specify that experience shall be gained by an intern or trainee only as an employee or volunteer.

Existing law establishes a \$75 delinquent renewal fee for a licensed educational psychologist and for licensed clinical social workers.

This bill would instead specify that \$75 is the maximum delinquent renewal fee.

Existing law requires an applicant for registration as an associate clinical social worker to meet specified requirements. Existing law also defines the application of social work principles and methods.

This bill would additionally require that all applicants and registrants be at all times under the supervision of a supervisor responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who is responsible to the board for compliance with all laws, rules, and regulations governing the practice of clinical social work. The bill would also specify that the practice of clinical social work includes the use, application, and integration of the coursework and experience required.

Existing law requires a licensed professional clinical counselor, to qualify for a clinical examination for licensure, to complete clinical mental health experience, as specified, including no less than 1,750 hours of direct counseling with individuals or groups in specified settings and not more

than 250 hours of experience providing counseling or crisis counseling on the telephone.

This bill would specify that the hours of direct counseling may be with individuals, groups, couples or families and would instead require not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth.

(5) The bill would also make other technical, nonsubstantive changes.

The people of the State of California do enact as follows:

SECTION 1. Section 1613 of the Business and Professions Code is amended to read:

1613. The board shall have and use a seal bearing the name “Dental Board of California.”

SEC. 2. Section 1915 of the Business and Professions Code is amended to read:

1915. No person other than a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions or a licensed dentist may engage in the practice of dental hygiene or perform dental hygiene procedures on patients, including, but not limited to, supragingival and subgingival scaling, dental hygiene assessment, and treatment planning, except for the following persons:

(a) A student enrolled in a dental or a dental hygiene school who is performing procedures as part of the regular curriculum of that program under the supervision of the faculty of that program.

(b) A dental assistant acting in accordance with the rules of the dental board in performing the following procedures:

- (1) Applying nonaerosol and noncaustic topical agents.
- (2) Applying topical fluoride.
- (3) Taking impressions for bleaching trays.

(c) A registered dental assistant acting in accordance with the rules of the dental board in performing the following procedures:

- (1) Polishing the coronal surfaces of teeth.
- (2) Applying bleaching agents.
- (3) Activating bleaching agents with a nonlaser light-curing device.
- (4) Applying pit and fissure sealants.

(d) A registered dental assistant in extended functions acting in accordance with the rules of the dental board in applying pit and fissure sealants.

(e) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions licensed in another jurisdiction, performing a clinical demonstration for educational purposes.

SEC. 3. Section 1926.2 of the Business and Professions Code is amended to read:

1926.2. (a) Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate one mobile dental hygiene clinic registered as a dental hygiene office or facility. The owner or operator of the mobile dental hygiene clinic or unit shall be registered and operated in accordance with regulations established by the committee, which regulations shall not be designed to prevent or lessen competition in service areas, and shall pay the fees described in Section 1944.

(b) A mobile service unit, as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, and a mobile unit operated by an entity that is exempt from licensure pursuant to subdivision (b), (c), or (h) of Section 1206 of the Health and Safety Code, are exempt from this article. Notwithstanding this exemption, the owner or operator of the mobile unit shall notify the committee within 60 days of the date on which dental hygiene services are first delivered in the mobile unit, or the date on which the mobile unit's application pursuant to Section 1765.130 of the Health and Safety Code is approved, whichever is earlier.

(c) A licensee practicing in a mobile unit described in subdivision (b) is not subject to subdivision (a) as to that mobile unit.

SEC. 4. Section 3024 of the Business and Professions Code is amended to read:

3024. The board may grant or refuse to grant an optometrist license as provided in this chapter and may revoke or suspend the license of any optometrist for any of the causes specified in this chapter.

It shall have the power to administer oaths and to take testimony in the exercise of these functions.

SEC. 5. Section 3025 of the Business and Professions Code is amended to read:

3025. The board may make and promulgate rules and regulations governing procedure of the board, the admission of applicants for examination for a license as an optometrist, and the practice of optometry. All of those rules and regulations shall be in accordance with and not inconsistent with the provisions of this chapter. The rules and regulations shall be adopted, amended, or repealed in accordance with the provisions of the Administrative Procedure Act.

SEC. 6. Section 3040 of the Business and Professions Code is amended to read:

3040. It is unlawful for a person to engage in the practice of optometry or to display a sign or in any other way to advertise or hold himself or herself out as an optometrist without having first obtained an optometrist license from the board under the provisions of this chapter or under the provisions of any former act relating to the practice of optometry. The practice of optometry includes the performing or controlling of any acts set forth in Section 3041.

In any prosecution for a violation of this section, the use of test cards, test lenses, or of trial frames is prima facie evidence of the practice of optometry.

Senate Bill No. 821

CHAPTER 473

An act to amend Sections 1613, 1915, 1926.2, 3024, 3025, 3040, 3041.2, 3051, 3057.5, 3077, 3093, 3098, 3103, 3106, 3107, 3109, 3163, 4053, 4107, 4980.36, 4980.397, 4980.398, 4980.399, 4980.40, 4980.43, 4980.50, 4984.01, 4984.7, 4984.72, 4989.68, 4992.05, 4992.07, 4992.09, 4992.1, 4996.1, 4996.3, 4996.4, 4996.9, 4996.17, 4996.18, 4996.28, 4999.33, 4999.45, 4999.46, 4999.47, 4999.50, 4999.52, 4999.53, 4999.55, 4999.64, and 4999.100 of, and to add Section 4021.5 to, the Business and Professions Code, and to amend Section 14132 of the Welfare and Institutions Code, relating to healing arts.

[Approved by Governor October 1, 2013. Filed with
Secretary of State October 1, 2013.]

LEGISLATIVE COUNSEL'S DIGEST

SB 821, Committee on Business, Professions and Economic Development.
Healing arts.

(1) Existing law, the Dental Practice Act, establishes the Dental Board of California, which was formerly known as the Board of Dental Examiners of California. Existing law requires the board to have and use a seal bearing its name. Existing law creates, within the jurisdiction of the board, a Dental Hygiene Committee of California, that is responsible for regulation of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions.

This bill would amend those provisions to remove an obsolete reference to the former board and to make other technical changes.

(2) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. That act refers to the authorization to practice optometry issued by the board as a certificate of registration.

This bill would instead refer to that authorization issued by the board as an optometrist license and would make other technical and conforming changes.

(3) Existing law, the Pharmacy Law, governs the business and practice of pharmacy in this state and establishes the California State Board of Pharmacy. Existing law prohibits the board from issuing more than one site license to a single premises except to issue a veterinary food-animal drug retailer license to a wholesaler or to issue a license for compound sterile injectable drugs to a pharmacy.

This bill would additionally authorize the board to issue more than one site license to a single premises to issue a centralized hospital packaging

license. The bill would also establish a definition for the term “correctional pharmacy.”

Existing law authorizes the board to issue a license as a designated representative to provide supervision in a wholesaler or veterinary food-animal drug retailer. Existing law requires an individual to meet specified requirements to obtain and maintain a designated representative license, including a minimum of one year of paid work experience related to the distribution or dispensing of dangerous drugs or devices or meet certain prerequisites.

The bill would require the one year of paid work experience to obtain a designated representative license to be in a licensed pharmacy, or with a drug wholesaler, drug distributor, or drug manufacturer. The bill would also make related, technical changes.

(4) Existing law provides for the licensure and regulation of marriage and family therapists, licensed educational psychologists, licensed clinical social workers, and licensed professional clinical counselors by the Board of Behavioral Sciences. Existing law makes various changes to the licensing and associated eligibility and examination requirements for marriage and family therapists, licensed clinical social workers, and licensed professional clinical counselors, effective January 1, 2014.

This bill would delay the implementation of these and other related changes until January 1, 2016.

Existing law requires all persons applying for marriage and family therapist or licensed professional clinical counselor licensure examinations to have specified hours of experience, including experience gained by an intern or trainee as an employee or volunteer.

This bill would specify that experience shall be gained by an intern or trainee only as an employee or volunteer.

Existing law establishes a \$75 delinquent renewal fee for a licensed educational psychologist and for licensed clinical social workers.

This bill would instead specify that \$75 is the maximum delinquent renewal fee.

Existing law requires an applicant for registration as an associate clinical social worker to meet specified requirements. Existing law also defines the application of social work principles and methods.

This bill would additionally require that all applicants and registrants be at all times under the supervision of a supervisor responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who is responsible to the board for compliance with all laws, rules, and regulations governing the practice of clinical social work. The bill would also specify that the practice of clinical social work includes the use, application, and integration of the coursework and experience required.

Existing law requires a licensed professional clinical counselor, to qualify for a clinical examination for licensure, to complete clinical mental health experience, as specified, including no less than 1,750 hours of direct counseling with individuals or groups in specified settings and not more

than 250 hours of experience providing counseling or crisis counseling on the telephone.

This bill would specify that the hours of direct counseling may be with individuals, groups, couples or families and would instead require not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth.

(5) The bill would also make other technical, nonsubstantive changes.

The people of the State of California do enact as follows:

SECTION 1. Section 1613 of the Business and Professions Code is amended to read:

1613. The board shall have and use a seal bearing the name “Dental Board of California.”

SEC. 2. Section 1915 of the Business and Professions Code is amended to read:

1915. No person other than a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions or a licensed dentist may engage in the practice of dental hygiene or perform dental hygiene procedures on patients, including, but not limited to, supragingival and subgingival scaling, dental hygiene assessment, and treatment planning, except for the following persons:

(a) A student enrolled in a dental or a dental hygiene school who is performing procedures as part of the regular curriculum of that program under the supervision of the faculty of that program.

(b) A dental assistant acting in accordance with the rules of the dental board in performing the following procedures:

- (1) Applying nonaerosol and noncaustic topical agents.
- (2) Applying topical fluoride.
- (3) Taking impressions for bleaching trays.

(c) A registered dental assistant acting in accordance with the rules of the dental board in performing the following procedures:

- (1) Polishing the coronal surfaces of teeth.
- (2) Applying bleaching agents.
- (3) Activating bleaching agents with a nonlaser light-curing device.
- (4) Applying pit and fissure sealants.

(d) A registered dental assistant in extended functions acting in accordance with the rules of the dental board in applying pit and fissure sealants.

(e) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions licensed in another jurisdiction, performing a clinical demonstration for educational purposes.

SEC. 3. Section 1926.2 of the Business and Professions Code is amended to read:

1926.2. (a) Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate one mobile dental hygiene clinic registered as a dental hygiene office or facility. The owner or operator of the mobile dental hygiene clinic or unit shall be registered and operated in accordance with regulations established by the committee, which regulations shall not be designed to prevent or lessen competition in service areas, and shall pay the fees described in Section 1944.

(b) A mobile service unit, as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, and a mobile unit operated by an entity that is exempt from licensure pursuant to subdivision (b), (c), or (h) of Section 1206 of the Health and Safety Code, are exempt from this article. Notwithstanding this exemption, the owner or operator of the mobile unit shall notify the committee within 60 days of the date on which dental hygiene services are first delivered in the mobile unit, or the date on which the mobile unit's application pursuant to Section 1765.130 of the Health and Safety Code is approved, whichever is earlier.

(c) A licensee practicing in a mobile unit described in subdivision (b) is not subject to subdivision (a) as to that mobile unit.

SEC. 4. Section 3024 of the Business and Professions Code is amended to read:

3024. The board may grant or refuse to grant an optometrist license as provided in this chapter and may revoke or suspend the license of any optometrist for any of the causes specified in this chapter.

It shall have the power to administer oaths and to take testimony in the exercise of these functions.

SEC. 5. Section 3025 of the Business and Professions Code is amended to read:

3025. The board may make and promulgate rules and regulations governing procedure of the board, the admission of applicants for examination for a license as an optometrist, and the practice of optometry. All of those rules and regulations shall be in accordance with and not inconsistent with the provisions of this chapter. The rules and regulations shall be adopted, amended, or repealed in accordance with the provisions of the Administrative Procedure Act.

SEC. 6. Section 3040 of the Business and Professions Code is amended to read:

3040. It is unlawful for a person to engage in the practice of optometry or to display a sign or in any other way to advertise or hold himself or herself out as an optometrist without having first obtained an optometrist license from the board under the provisions of this chapter or under the provisions of any former act relating to the practice of optometry. The practice of optometry includes the performing or controlling of any acts set forth in Section 3041.

In any prosecution for a violation of this section, the use of test cards, test lenses, or of trial frames is prima facie evidence of the practice of optometry.



MEMORANDUM

DATE	November 6, 2013
TO	Dental Board of California Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17C: Update on Previously Approved Legislative Proposal Regarding Delegation of Authority to Accept the Findings of Any Commission or Accreditation Agency Approved by the Board and Adopt those Findings as its Own Relating to the Approval of Foreign Dental Schools

Background:

At its May 2012 meeting, the Board granted approval of the University De La Salle Bajio School of Dentistry's renewal application. At the meeting, Dr. Olinger, requested that the Board look at the possibility of having other qualified organizations conduct the evaluations of foreign dental schools and requested the issue be brought back to the Board as an agenda item.

Assembly Bill 1116 (Chapter 792, Statutes of 1997) established requirements for the approval, registration and renewal of foreign dental programs, stating that "the Legislature recognizes the need to ensure that graduates of foreign dental schools who have received an education that is equivalent to that of accredited institutions in the United States and that adequately prepares their students for the practice of dentistry shall be subject to the same licensure requirements as graduates of approved dental schools or colleges." Under the Board's authorization to approve foreign dental schools, Universidad De La Salle Bajio was approved in December 2004.

In 2004, no other entity had established policies, procedures or regulations that allowed for the approval of foreign dental programs. Since that time, the American Dental Association's Commission on Dental Accreditation (CODA) has developed and established an accreditation process for foreign dental programs. Currently, the Board accepts the findings of any commission or accreditation agency for graduates of dental programs in the United States, California Code of Regulations Section 1024(b). There is no current equivalent provision for the Board to accept the findings of any commission or accreditation agency for foreign dental schools.

At its February 25, 2011 meeting, the Board voted to seek statutory amendments to California Business and Professions Code Section 1636.4 to accept the findings of any

commission or accreditation agency and adopt those findings as its own for foreign dental schools. The Board proposed to add the following language to Section 1636.4:

The board may, in lieu of conducting its own independent investigation, accept the findings of any commission or accreditation agency approved by the board and adopt those findings as its own.

This language would allow the Board to defer to commissions or accreditation agencies that are equipped with the experience, education, and resources necessary to conduct evaluations of foreign dental schools.

Board staff delayed seeking an author to carry the proposed amendments until the review and approval process of University De La Salle Bajio School of Dentistry's renewal application had been completed. Now that the school has received Board approval, staff will move forward with seeking an author for the Board's proposed statutory amendments.

Action Requested:

No action necessary.



MEMORANDUM

DATE	November 14, 2013
TO	Dental Board of California Members
FROM	Jennifer Thornburg, Assistant Executive Officer Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17(D): Discussion and Possible Action Regarding Legislative Proposals for 2014

i. Amendment of Business and Professions Code §1724 Relating to Increasing the Statutorily Authorized Maximum for Dentistry Fees:

According to the State Dentistry Fund Condition for the Governor’s Budget 13-14, the Board is projecting a fund balance deficit in Budget Year (BY) 2014-15 as well as an ongoing fund balance deficit thereafter. The Board worked in consultation with the Department of Consumer Affairs’ Budget Office and determined it was necessary for the Board to increase the initial licensure and biennial renewal fees assessed to its dentist licensees via the regulatory process to \$450, the maximum amount allowed by statute, to reduce the fund balance deficit beginning BY 2014-15.

The current regulatory proposal will not eliminate the projected deficit in its entirety and it has become necessary for the Board to seek authorization via legislative amendment to increase the maximum fees it may assess in order to sustain a positive fund balance. The DCA Budget Office recommends a minimum of three to six months of revenue in the Board’s Contingent Fund to insure funding for existing programs and to offset increases in the cost of doing business. The Budget Office’s initial analysis estimates that initial license and renewal fees should be fixed at \$525. A conservative estimate based on both historical and projected inflation rates indicates the statutory fee ceiling should be set at \$700.

Additional documentation will be provided at the meeting for the Board’s consideration.

ii. Amendments to the Dental Practice Act (Business and Professions Code §1600 et seq.) for Inclusion in the Healing Arts Omnibus Bill:

Every year, the Senate Committee on Business, Professions, and Economic Development (BP&ED) introduce two omnibus bills; one bill is designated for healing arts board/bureau legislation, and the other for non-healing arts board/bureau legislation. The omnibus bills are lengthy and contain non-controversial, technical, or non-substantive amendments to various practice acts. This provides boards and bureaus with a relatively quick resource to “clean-up” statutory language.

Staff solicited recommendations for inclusion in the 2014 healing arts omnibus bill from Board Members, Board staff, and Legal Counsel. Staff has not received recommendations for inclusion in the omnibus bill and is not aware of any necessary amendments for the Board's consideration to include in 2014. Over the next year, staff will continue to monitor the Dental Practice Act for any amendments that may become necessary for the Board to consider for inclusion in the 2015 healing arts omnibus bill.

Action Requested:

No action necessary.



MEMORANDUM

DATE	November 4, 2013
TO	Dental Board of California Members
FROM	Bruce L. Witcher, DDS Chair, Licensing, Certification, and Permits Committee
SUBJECT	Agenda Item 17E: Discussion and Possible Action Regarding Future Proposal to Amend Business and Professions Code §§1646 to 1647.26 Relating to General Anesthesia, Conscious Sedation, and Oral Conscious Sedation

Background:

Under current law, general anesthesia, conscious sedation, oral conscious sedation for pediatric patients, and oral conscious sedation for adults may be administered by qualified dentists. The authorizing statutes for these techniques have not been revised since they were enacted. There have been advances in the practice of dental anesthesia and sedation that make it necessary for the board to consider updating these statutes.

Current statutory definitions describe the status of the patient undergoing general anesthesia and sedation in terms of level of consciousness, protective reflexes, and response to physical stimulation.

Contemporary definitions of general anesthesia and sedation published in the American Dental Association (ADA) Guidelines for the Use of Sedation and General Anesthesia by Dentists (attached) in 2007 and 2012 describe the states of general anesthesia, deep sedation, moderate sedation and minimal sedation in a way that includes the effects of various levels of anesthesia and sedation not only on level of consciousness, but also on ventilation and cardiovascular function. The ADA definitions are a more complete description of the effects of these treatment modalities. This improves the understanding of healthcare providers utilizing sedation and anesthesia and therefore enhances patient safety.

The states of Washington, Oregon, Idaho, Montana, Arizona, Florida, Texas, and Virginia have adopted the updated ADA definitions of general anesthesia, deep sedation, moderate and minimal sedation. The states of Utah and Nevada utilize definitions similar to those presently utilized in California law.

The definitions of general anesthesia and levels of sedation are important because they serve as the basis for classification of the permits issued to dentists by the Dental Board. For example a dentist must complete minimum of one year of training in an board approved residency to qualify for a general anesthesia permit, 60 hours of board approved training and completion of 20 supervised cases to qualify for a conscious sedation permit and 25 hours of board approved education to qualify for an adult or pediatric oral conscious sedation permit.

In 2010 Board President Dr. Bettinger appointed a board subcommittee to evaluate and make recommendations for an update of the sedation and anesthesia laws. This item was placed on the list of board priorities for future consideration.

This item is submitted for consideration by the Board as a proposal for future legislation.

Action Requested:

No action is requested at this time. This item is for information only.

**BUSINESS AND PROFESSIONS CODE
DIVISION 2. HEALING ARTS
CHAPTER 4. DENTISTRY**

**Proposed deletions are illustrated with strike-out.
Proposed additions are illustrated in blue *italic* font.**

ARTICLE 2.7. Use of General Anesthesia [§§1646 - 1646.9]

(Article 2.7 added by Stats. 1979, Ch. 886.)

§ 1646.

“General anesthesia,” as used in this article, means ~~a controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, produced by a pharmacologic or nonpharmacologic method, or a combination thereof.~~ *a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug induced depression of neuromuscular function. Cardiovascular function may be impaired.*

§ 1646.1.

(a) No dentist shall administer or order the administration of general anesthesia on an outpatient basis for dental patients unless the dentist either possesses a current license in good standing to practice dentistry in this state and holds a valid general anesthesia permit issued by the board or possesses a current permit under Section 1638 or 1640 and holds a valid general anesthesia permit issued by the board.

(b) No dentist shall order the administration of general anesthesia unless the dentist is physically within the dental office at the time of the administration.

(c) A general anesthesia permit shall expire on the date provided in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.

(d) This article does not apply to the administration of local anesthesia or to conscious-patient sedation.

§ 1646.2.

(a) A dentist who desires to administer or order the administration of general anesthesia shall apply to the board on an application form prescribed by the board. The dentist must submit an application fee and produce evidence showing that he or she has successfully completed ~~a minimum of one year of advanced training in anesthesiology and related academic subjects approved by the board,~~ *a minimum of one year of training in an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage general anesthesia,* or equivalent training or experience approved by the board, beyond the undergraduate school level.

(b) The application for a permit shall include documentation that equipment and drugs required by the board are on the premises.

§ 1646.3.

Any dentist holding a permit shall maintain medical history, physical evaluation, and general anesthesia records as required by board regulations.

§1646.4.

(a) Prior to the issuance or renewal of a permit for the use of general anesthesia, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure, unless within that time period the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once every five years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) The board may contract with public or private organizations or individuals expert in dental outpatient general anesthesia to perform onsite inspections and evaluations. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

§1646.5.

A permittee shall be required to complete 24 hours of approved courses of study related to general anesthesia as a condition of renewal of a permit. Those courses of study shall be credited toward any continuing education required by the board pursuant to Section 1645.

§ 1646.6.

(a) The application fee for a permit or renewal under this article shall not exceed two hundred fifty dollars (\$250).

(b) The fee for an onsite inspection shall not exceed three hundred fifty dollars (\$350).

(c) It is the intent of the Legislature that fees established pursuant to this section be equivalent to administration and enforcement costs incurred by the board in carrying out this article.

(d) At the discretion of the board, the fee for onsite inspection may be collected and retained by a contractor engaged pursuant to subdivision (b) of Section 1646.4.

§ 1646.7.

(a) A violation of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation.

(b) A violation of any provision of this article or Section 1682 is grounds for suspension or revocation of the physician's and surgeon's permit issued pursuant to this article by the Dental Board of California. The exclusive enforcement authority against a physician and surgeon by the Dental Board of California shall be to suspend or revoke the permit issued pursuant to this article. The Dental Board of California shall refer a violation of this article by a physician and surgeon to the Medical Board of California for its consideration as unprofessional conduct and further action, if deemed necessary by the Medical Board of California, pursuant to Chapter 5 (commencing with Section 2000). A suspension or revocation of a physician and surgeon's permit by the Dental Board of California pursuant to this article shall not constitute a disciplinary proceeding or action for any purpose except to permit the initiation of an investigation or disciplinary action by the Medical Board of California as authorized by Section 2220.5.

(c) The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the Dental Board of California shall have all the powers granted therein.

§ 1646.8.

Nothing in this chapter shall be construed to authorize a dentist to administer or directly supervise the administration of general anesthesia for reasons other than dental treatment, as defined in Section 1625.

§ 1646.9.

(a) Notwithstanding any other provision of law, including, but not limited to, Section 1646.1, a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) may administer general anesthesia in the office of a licensed dentist for dental patients, without regard to whether the dentist possesses a permit issued pursuant to this article, if both of the following conditions are met:

(1) The physician and surgeon possesses a current license in good standing to practice medicine in this state.

(2) The physician and surgeon holds a valid general anesthesia permit issued by the Dental Board of California pursuant to subdivision (b).

(b) (1) A physician and surgeon who desires to administer general anesthesia as set forth in subdivision (a) shall apply to the Dental Board of California on an application form prescribed by the board and shall submit all of the following:

(A) The payment of an application fee prescribed by this article.

(B) Evidence satisfactory to the Medical Board of California showing that the applicant has successfully completed a postgraduate residency training program in anesthesiology that is recognized by the American Council on Graduate Medical Education, as set forth in Section 2079.

(C) Documentation demonstrating that all equipment and drugs required by the Dental Board of California are possessed by the applicant and shall be available for use in any dental office in which he or she administers general anesthesia.

(D) Information relative to the current membership of the applicant on hospital medical staffs.

(2) Prior to issuance or renewal of a permit pursuant to this section, the Dental Board of California may, at its discretion, require an onsite inspection and evaluation of the facility, equipment, personnel, including, but not limited to, the physician and surgeon, and procedures utilized. At least one of the persons evaluating the procedures utilized by the physician and surgeon shall be a licensed physician and surgeon expert in outpatient general anesthesia who has been authorized or retained under contract by the Dental Board of California for this purpose.

(3) The permit of a physician and surgeon who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the physician and surgeon of the failure unless within that time period the physician and surgeon has retaken and passed an onsite inspection and evaluation. Every physician and surgeon issued a permit under this article shall have an onsite inspection and evaluation at least once every six years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

**ARTICLE 2.8. Use of ~~Conscious~~ Parenteral Moderate Sedation [§§ 1647 - 1647.9]
(Article 2.8 added by Stats. 1986, Ch. 1382, Sec. 3.)**

§ 1647.

(a) The Legislature finds and declares that a commendable patient safety record has been maintained in the past by dentists and those other qualified providers of anesthesia services who, pursuant to a dentist's authorization, administer patient sedation, and that the increasing number of pharmaceuticals and techniques used to administer them for patient sedation require additional regulation to maintain patient safety in the future.

(b) The Legislature further finds and declares all of the following:

(1) That previous laws enacted in 1980 contained separate and distinct definitions for general anesthesia and the state of consciousness.

(2) That in dental practice, there is a continuum of sedation used which cannot be adequately defined in terms of consciousness and general anesthesia.

(3) That the administration of sedation through this continuum results in different states of consciousness that may or may not be predictable in every instance.

(4) That in most instances, the level of sedation will result in a predictable level of consciousness during the entire time of sedation.

(c) The Legislature further finds and declares that the educational standards presently required for general anesthesia should be required when the degree of sedation in the continuum of sedation is such that there is a reasonable possibility that loss of consciousness may result, even if unintended. These degrees of sedation have been referred to as “deep sedation” and “light general anesthesia” in dental literature.

Parenteral moderate sedation is any technique of drug administration in which the drug bypasses the gastrointestinal (GI) tract. Parenteral administration includes intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), and intraosseous (IO) routes of drug administration.

However, achieving the degree of sedation commonly referred to as “~~light conscious~~ *parenteral moderate* sedation,” where a margin of safety exists wide enough to render unintended loss of consciousness unlikely, requires educational standards appropriate to the administration of the resulting predictable level of consciousness.

§ 1647.1.

(a) As used in this article, “~~conscious~~ *parenteral moderate* sedation” (*conscious sedation*) means a *drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained* ~~minimally depressed level of consciousness produced by a pharmacologic or nonpharmacologic method, or a combination thereof, that retains the patient’s ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command.~~

“~~Conscious~~ *Parenteral moderate* sedation” does not include the administration of oral medications or the administration of a mixture of nitrous oxide and oxygen, whether administered alone or in combination with each other.

(b) The drugs and techniques used in ~~conscious~~ *parenteral moderate* sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli shall not be considered to be in a state of conscious sedation.

(c) For the very young or handicapped individual, incapable of the usually expected verbal response, a minimally depressed level of consciousness for that individual should be maintained.

§ 1647.2.

(a) No dentist shall administer or order the administration of, ~~conscious~~ *parenteral moderate* sedation on an outpatient basis for dental patients unless one of the following conditions is met:

(1) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer ~~conscious~~ *parenteral moderate* sedation.

(2) The dentist possesses a current permit under Section 1638 or 1640 and either holds a valid anesthesia permit or obtains a permit issued by the board authorizing the dentist to administer ~~conscious~~ *parenteral moderate* sedation.

(b) A ~~conscious~~ *parenteral moderate* sedation permit shall expire on the date specified in Section 1715 which next occurs after its issuance, unless it is renewed as provided in this article.

(c) This article shall not apply to the administration of local anesthesia or to general anesthesia.

(d) A dentist who orders the administration of ~~conscious~~ *parenteral moderate* sedation shall be physically present in the treatment facility while the patient is sedated.

§ 1647.3.

(a) A dentist who desires to administer or order the administration of ~~conscious~~ *parenteral moderate* sedation, shall apply to the board on an application form prescribed by the board. The dentist shall submit an application fee and produce evidence showing that he or she has successfully completed a course of training in ~~conscious~~ *parenteral moderate* sedation that meets the requirements of subdivision (c).

(b) The application for a permit shall include documentation that equipment and drugs required by the board are on the premises.

(c) A course in the administration of ~~conscious~~ *parenteral moderate* sedation shall be acceptable if it meets all of the following as approved by the board:

(1) Consists of at least 60 hours of instruction.

(2) Requires satisfactory completion of at least 20 cases of administration of ~~conscious~~ *parenteral moderate* sedation for a variety of dental procedures.

(3) Complies with the requirements of the Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry of the American Dental Association.

§ 1647.5.

A permittee shall be required to complete 15 hours of approved courses of study related to conscious sedation as a condition of renewal of a permit. Those courses of study shall be credited toward any continuing education required by the board pursuant to Section 1645.

§ 1647.6.

A physical evaluation and medical history shall be taken before the administration of ~~conscious~~ *parenteral moderate* sedation. Any dentist holding a permit shall maintain records of the physical evaluation, medical history, and ~~conscious~~ *parenteral moderate* sedation procedures used as required by board regulations.

§ 1647.7.

(a) Prior to the issuance or renewal of a permit to administer ~~conscious~~ *parenteral moderate* sedation, the board may, at its discretion, require an onsite inspection and evaluation of the licentiate and the facility, equipment, personnel, and procedures utilized by the licentiate. The permit of any dentist who has failed an onsite inspection and evaluation shall be automatically suspended 30 days after the date on which the board notifies the dentist of the failure unless, within that time period, the dentist has retaken and passed an onsite inspection and evaluation. Every dentist issued a permit under this article shall have an onsite inspection and evaluation at least once in every six years. Refusal to submit to an inspection shall result in automatic denial or revocation of the permit.

(b) An applicant who has successfully completed the course required by Section 1647.3 may be granted a one-year temporary permit by the board prior to the onsite inspection and evaluation. Failure to pass the inspection and evaluation shall result in the immediate and automatic termination of the temporary permit.

(c) The board may contract with public or private organizations or individuals expert in dental outpatient ~~conscious~~ *parenteral moderate* sedation to perform onsite inspections and evaluations. The board may not, however, delegate its authority to issue permits or to determine the persons or facilities to be inspected.

§ 1647.8.

(a) The application fee for a permit or renewal under this article shall not exceed two hundred fifty dollars (\$250).

(b) The fee for an onsite inspection shall not exceed three hundred fifty dollars (\$350).

(c) It is the intent of the Legislature that the board hire sufficient staff to administer the program and that the fees established pursuant to this section be equivalent to administration and enforcement costs incurred by the board in carrying out this article.

§ 1647.9.

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, license, or both, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

ARTICLE 2.85. Use of ~~Oral Conscious~~ *Moderate Enteral* Sedation for Pediatric Patients

[§§ 1647.10 - 1647.17]

(Article 2.85 added by Stats. 1998, Ch. 513, Sec. 1.)

§ 1647.10.

As used in this article:

(a) ~~“Oral conscious sedation” means a minimally depressed level of consciousness produced by oral medication that retains the patient’s ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command.~~ *“Moderate Enteral Sedation” is a drug-induced depression of consciousness produced by administration of oral (enteral) medication during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.*

“Enteral” means any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

(1) The drugs and techniques used in ~~oral conscious~~ *moderate enteral* sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of ~~oral conscious~~ *moderate enteral* sedation.

(2) For very young or handicapped individuals, incapable of the usually expected verbal response, a minimally depressed level of consciousness should be maintained.

(b) “Minor patient” means a dental patient under the age of 13 years.

(c) “Certification” means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name, and the location where the administration of ~~oral conscious~~ *moderate enteral* sedation will occur, and fulfills the requirements specified in Sections 1647.12 and 1647.13.

§ 1647.11.

(a) Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer ~~oral conscious~~ *moderate enteral* sedation on an outpatient basis to a minor patient unless one of the following conditions is met:

(1) The dentist possesses a current license in good standing to practice dentistry in California and either holds a valid general anesthesia permit, ~~conscious~~ *a parenteral moderate* sedation permit, or has been certified by the board, pursuant to Section 1647.12, to administer ~~oral~~ *moderate enteral* sedation to minor patients.

(2) The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or ~~conscious~~ *parenteral moderate* sedation permit, or possesses a certificate as a provider of ~~oral-conscious~~ *moderate enteral* sedation to minor patients in compliance with, and pursuant to, this article.

(b) Certification as a provider of ~~oral-conscious~~ *moderate enteral* sedation to minor patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

(c) This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen or to the administration, dispensing, or prescription of postoperative medications.

§ 1647.12.

A dentist who desires to administer, or order the administration of, ~~oral-conscious~~ *moderate enteral* sedation for minor patients, who does not hold a general anesthesia permit, as provided in Sections 1646.1 and 1646.2, or a ~~conscious~~ *parenteral moderate* sedation permit, as provided in Sections 1647.2 and 1647.3, shall register his or her name with the board on a board-prescribed registration form. The dentist shall submit the registration fee and evidence showing that he or she satisfies any of the following requirements:

(a) Satisfactory completion of a postgraduate program in oral and maxillofacial surgery or pediatric dentistry approved by either the Commission on Dental Accreditation or a comparable organization approved by the board.

(b) Satisfactory completion of a periodontics or general practice residency or other advanced education in a general dentistry program *that includes training in enteral moderate sedation* approved by the board.

(c) Satisfactory completion of a board-approved educational program on oral medications and sedation.

§ 1647.13.

A certificate holder shall be required to complete a minimum of 7 hours of approved courses of study related to ~~oral-conscious~~ *moderate enteral* sedation of minor patients as a condition of certification renewal as an ~~oral-conscious~~ *moderate enteral* sedation provider. Those courses of study shall be accredited toward any continuing education required by the board pursuant to Section 1645.

§ 1647.14.

(a) A physical evaluation and medical history shall be taken before the administration of, ~~oral-conscious~~ *moderate enteral* sedation to a minor. Any dentist who administers, or orders the administration of, ~~oral-conscious~~ *moderate enteral* sedation to a minor shall maintain records of the physical evaluation, medical history, and ~~oral-conscious~~ *moderate enteral* sedation procedures used as required by the board regulations.

(b) A dentist who administers, or who orders the administration of, ~~oral-conscious~~ *moderate enteral* sedation for a minor patient shall be physically present in the treatment facility while the patient is sedated and shall be present until discharge of the patient from the facility.

(c) The drugs and techniques used in ~~oral-conscious~~ *moderate enteral* sedation to minors shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.

§ 1647.15.

The fee for an application for initial certification or renewal under this article shall not exceed the amount necessary to cover administration and enforcement costs incurred by the board in carrying out this article. The listed fee may be prorated based upon the date of the renewal of the dentist's license or permit.

§ 1647.16.

Any office in which ~~oral-conscious~~ *moderate enteral* sedation of minor patients is conducted pursuant to this article shall, unless otherwise provided by law, meet the facilities and equipment standards set forth by the board in regulation.

§ 1647.17.

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, certificate, license, or all three, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

ARTICLE 2.86. Use of Oral Conscious *Moderate Enteral* Sedation for Adult Patients

[§§ 1647.18 - 1647.26]

(Article 2.86 added by Stats. 2005, Ch. 539, Sec. 12.)

§ 1647.18.

As used in this article, the following terms have the following meanings:

(a) "Adult patient" means a dental patient 13 years of age or older.

(b) "Certification" means the issuance of a certificate to a dentist licensed by the board who provides the board with his or her name and the location at which the administration of oral-conscious *moderate enteral* sedation will occur, and fulfills the requirements specified in Sections 1647.12 and 1647.13.

(c) "~~Oral-conscious sedation~~" means ~~a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command.~~

"Moderate enteral sedation" means a drug-induced depression of consciousness produced by enteral administration of medication during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

For adults, administration of the FDA maximum recommended dose for home use shall not constitute moderate enteral sedation. A single supplemental dose of the initial drug that may be necessary for prolonged procedures may also be administered as long as the supplemental dose does not exceed one-half of the initial dose and is not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

Moderate enteral sedation ("Oral-conscious sedation") does not include dosages less than or equal to the single maximum recommended dose that can be prescribed for home use.

(1) The drugs and techniques used in oral-conscious *moderate enteral* sedation shall have a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from painful stimuli would not be considered to be in a state of oral-conscious *moderate enteral* sedation.

(2) For the handicapped individual, incapable of the usually expected verbal response, a minimally depressed level of consciousness for that individual should be maintained.

§ 1647.19.

(a) Notwithstanding subdivision (a) of Section 1647.2, a dentist may not administer ~~oral conscious~~ *moderate enteral* sedation on an outpatient basis to an adult patient unless the dentist possesses a current license in good standing to practice dentistry in California, and one of the following conditions is met:

(1) The dentist holds a valid general anesthesia permit, holds a ~~conscious—parenteral~~ *moderate* sedation permit, has been certified by the board, pursuant to Section 1647.20, to administer oral sedation to adult patients, or has been certified by the board, pursuant to Section 1647.12, to administer ~~oral-conscious~~ *moderate enteral* sedation to minor patients.

(2) The dentist possesses a current permit issued under Section 1638 or 1640 and either holds a valid general anesthesia permit, or ~~conscious—parenteral moderate~~ sedation permit, or possesses a certificate as a provider of ~~oral-conscious~~ *moderate enteral* sedation to adult patients in compliance with, and pursuant to, this article.

(b) Certification as a provider of ~~oral-conscious~~ *moderate enteral* sedation to adult patients expires at the same time the license or permit of the dentist expires unless renewed at the same time the dentist's license or permit is renewed after its issuance, unless certification is renewed as provided in this article.

(c) This article shall not apply to the administration of local anesthesia or a mixture of nitrous oxide and oxygen, or to the administration, dispensing, or prescription of postoperative medications.

§ 1647.20.

A dentist who desires to administer, or order the administration of, ~~oral-conscious~~ *moderate enteral* sedation for adult patients, who does not hold a general anesthesia permit, as provided in Sections 1646.1 and 1646.2, does not hold a ~~conscious~~ *parenteral moderate* sedation permit, as provided in Sections 1647.2 and 1647.3, and has not been certified by the board, pursuant to Section 1647.12, to administer ~~oral conscious~~ *moderate enteral* sedation to minor patients, shall register his or her name with the board on a registration form prescribed by the board. The dentist shall submit the registration fee and evidence showing that he or she satisfies any of the following requirements:

(a) Satisfactory completion of a postgraduate program in oral and maxillofacial surgery approved by either the Commission on Dental Accreditation or a comparable organization approved by the board.

(b) Satisfactory completion of a periodontics or general practice residency or other advanced education in a general dentistry program approved by the board.

(c) Satisfactory completion of a board-approved educational program on ~~oral~~*enteral* medications and sedation.

(d) For an applicant who has been using oral conscious sedation in connection with the treatment of adult patients, submission of documentation as required by the board of 10 cases of oral conscious sedation satisfactorily performed by the applicant on adult patients in any three-year period ending no later than December 31, 2005.

§ 1647.21.

A certificate holder shall be required to complete a minimum of seven hours of approved courses of study related to ~~oral-conscious~~ *moderate enteral* sedation of adult patients as a condition of certification renewal as an oral conscious sedation provider. Those courses of study shall be accredited toward any continuing education required by the board pursuant to Section 1645.

§ 1647.22.

(a) A physical evaluation and medical history shall be taken before the administration of ~~oral-conscious~~ *moderate enteral* sedation to an adult. Any dentist who administers, or orders the administration of, ~~oral-conscious~~ *moderate enteral* sedation to an adult shall maintain records of the physical evaluation, medical history, and ~~oral-conscious~~ *moderate enteral* sedation procedures used as required by the board regulations.

(b) A dentist who administers, or who orders the administration of, ~~oral-conscious~~ *moderate enteral* sedation for an adult patient shall be physically present in the treatment facility while the patient is sedated, and shall be present until discharge of the patient from the facility.

(c) The drugs and techniques used in ~~oral-conscious~~ *moderate enteral* sedation to adults shall have a margin of safety wide enough to render unintended loss of consciousness unlikely.

§ 1647.23.

The fee for an application for initial certification or renewal under this article shall not exceed the amount necessary to cover administration and enforcement costs incurred by the board in carrying out this article. The listed fee may be prorated based upon the date of the renewal of the dentist's license or permit.

§ 1647.24.

Any office in which ~~oral-conscious~~ *moderate enteral* sedation of adult patients is conducted pursuant to this article shall, unless otherwise provided by law, meet the facilities and equipment standards set forth by the board in regulation.

§ 1647.25.

A violation of any provision of this article constitutes unprofessional conduct and is grounds for the revocation or suspension of the dentist's permit, certificate, license, or

all three, or the dentist may be reprimanded or placed on probation. The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

§ 1647.26.

The sum of forty-seven thousand dollars (\$47,000) is hereby appropriated for the 2005–06 fiscal year from the State Dentistry Fund to the Department of Consumer Affairs for the purpose of processing applications for adult ~~conscious~~ *moderate enteral* sedation certificates pursuant to this article.



American Dental Association
www.ada.org



GUIDELINES

for the Use of Sedation and General Anesthesia by Dentists

As adopted by the October 2007 ADA House of Delegates

I. INTRODUCTION

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements*.

II. DEFINITIONS

Methods of Anxiety and Pain Control

analgesia – the diminution or elimination of pain.

local anesthesia – the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.

minimal sedation – a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.¹

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

The use of preoperative sedatives for children (aged 12 and under) except in extraordinary situations must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentists *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.



The following definitions apply to administration of minimal sedation:

maximum recommended (MRD) – maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing – administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing – during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

moderate sedation – a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.²

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration – administration of incremental doses of a drug until a desired effect is reached.

Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation – a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.²

general anesthesia – a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.²

For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral – any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral – a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal – a technique of administration in which the drug is administered by patch or iontophoresis through skin.

transmucosal – a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation – a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

qualified dentist – meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall – indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should – indicates the recommended manner to obtain the standard; highly desirable.

may – indicates freedom or liberty to follow a reasonable alternative.

continual – repeated regularly and frequently in a steady succession.

continuous – prolonged without any interruption at any time.

time-oriented anesthesia record – documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification³

ASA I – A normal healthy patient.

ASA II – A patient with mild systemic disease.

ASA III – A patient with severe systemic disease.

ASA IV – A patient with severe systemic disease that is a constant threat to life.

ASA V – A moribund patient who is not expected to survive without the operation.

ASA VI – A declared brain-dead patient whose organs are being removed for donor purposes.

E – Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

³ ASA Physical Status Classification System is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

III. EDUCATIONAL REQUIREMENTS**A. Minimal Sedation**

1. To administer minimal sedation the dentist must have successfully completed:
 - a. training to the level of competency in minimal sedation consistent with that prescribed in the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,
 - or
 - b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;and
 - c. a current certification in Basic Life Support for Healthcare Providers.
2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must have successfully completed:
 - a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,
 - or
 - b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;and
 - c. a current certification in 1) Basic Life Support for Healthcare Providers and 2) Advanced Cardiac Life Support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.
2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must have completed:
 - a. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines;and



- b. a current certification in 1) Basic Life Support for Healthcare Providers and 2) Advanced Cardiac Life Support (ACLS) or an appropriate dental sedation/anesthesia emergency management course.
2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.

For all levels of sedation and anesthesia, dentists, who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements.

IV. CLINICAL GUIDELINES

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.



- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include:

- Oxygenation:
 - Color of mucosa, skin or blood must be evaluated continually.
 - Oxygen saturation by pulse oximetry may be clinically useful and should be considered.
- Ventilation:
 - The dentist and/or appropriately trained individual must observe chest excursions continually.
 - The dentist and/or appropriately trained individual must verify respirations continually.
- Circulation:
 - Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intra-operatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.

The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentists *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device

that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operator room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Consciousness:
 - Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.
- Oxygenation:
 - Color of mucosa, skin or blood must be evaluated continually.
 - Oxygen saturation must be evaluated by pulse oximetry continuously.
- Ventilation:
 - The dentist must observe chest excursions continually.
 - The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO₂ or by verbal communication with the patient.
- Circulation:
 - The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).
 - Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs administered, including local anesthetics, dosages and monitored physiological parameters.
- Pulse oximetry, heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.



- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- If a reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured.

6. Emergency Management

If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.

The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentists *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.

- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- If volatile anesthetic agents are utilized, an inspired agent analysis monitor and capnograph should be considered.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

- Oxygenation:
 - Color of mucosa, skin or blood must be continually evaluated.
 - Oxygenation saturation must be evaluated continuously by pulse oximetry.

- Ventilation:
 - Intubated patient: End-tidal CO₂ must be continuously monitored and evaluated.
 - Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO₂ must be continually monitored and evaluated.
 - Respiration rate must be continually monitored and evaluated.
- Circulation:
 - The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
 - The dentist must continually evaluate blood pressure.
- Temperature:
 - A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
 - The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs administered, including local anesthetics, doses and monitored physiological parameters.
- Pulse oximetry and end-tidal CO₂ measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded at appropriate intervals.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Pediatric and Special Needs Patients

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very

brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

V. ADDITIONAL SOURCES OF INFORMATION

American Academy of Pediatric Dentists (AAPD). *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at <http://www.aapd.org/media/policies.asp>

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics*. Available at <http://www.perio.org/resources-products/posppr3-1.html>

American Dental Association Council on Scientific Affairs. *Acceptance Program Guidelines: Nitrous Oxide-Oxygen Conscious Sedation Systems, 2000*. Available at <http://www.ada.org/prof/resources/positions/standards/denmat.asp#ada>

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath 01) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Society of Anesthesiologist (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures*. Available at <http://www2.asahq.org/publications/p-178-practice-guidelines-for-preoperative-fasting.aspx>

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. Available at <http://www.asahq.org/publicationsAndServices/practiceparamhtm#sedation>

The ASA has other anesthesia resources that might be of interest to dentists.

For more information, go to <http://www.asahq.org/publicationsAndServices/sgstoc.htm>

Commission on Dental Accreditation (CODA). *Accreditation Standards for Predoctoral and Advanced Dental Education Programs*. Available at <http://www.ada.org/prof/ed/accred/standards/index.asp>

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at <http://www.cdc.gov/niosh/noxidair.html>

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. *JADA* 2006;137(4):502-13. ADA members can access this article online at <http://jada.ada.org/cgi/content/full/137/4/502>



Guidelines for the Use of Sedation and General Anesthesia by Dentists

As adopted by the October 2012 ADA House of Delegates

I. Introduction

The administration of local anesthesia, sedation and general anesthesia is an integral part of dental practice. The American Dental Association is committed to the safe and effective use of these modalities by appropriately educated and trained dentists. The purpose of these guidelines is to assist dentists in the delivery of safe and effective sedation and anesthesia.

Dentists providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document are not subject to *Section III. Educational Requirements*.

II. Definitions

Methods of Anxiety and Pain Control

analgesia - the diminution or elimination of pain.

conscious sedation¹ - a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation or verbal command and that is produced by a pharmacological or non-pharmacological method or a combination thereof.

In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of conscious sedation.

combination inhalation–enteral conscious sedation (combined conscious sedation) - conscious sedation using inhalation and enteral agents.

When the intent is anxiolysis only, and the appropriate dosage of agents is administered, then the definition of enteral and/or combination inhalation-enteral conscious sedation (combined conscious sedation) does not apply.

local anesthesia - the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

Note: Although the use of local anesthetics is the foundation of pain control in dentistry and has a long record of safety, dentists must be aware of the maximum, safe dosage limits for each patient. Large doses of local anesthetics in themselves may result in central nervous system depression, especially in combination with sedative agents.

minimal sedation - a minimally depressed level of consciousness, produced by a pharmacological method, that retains the patient's ability to independently and continuously maintain an airway and respond *normally* to

¹ Parenteral conscious sedation may be achieved with the administration of a single agent or by the administration of more than one agent.

tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected.²

Note: In accord with this particular definition, the drug(s) and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation.

When the intent is minimal sedation for adults, the appropriate initial dosing of a single enteral drug is no more than the maximum recommended dose (MRD) of a drug that can be prescribed for unmonitored home use.

The use of preoperative sedatives for children (aged 12 and under) prior to arrival in the dental office, except in extraordinary situations, must be avoided due to the risk of unobserved respiratory obstruction during transport by untrained individuals.

Children (aged 12 and under) can become moderately sedated despite the intended level of minimal sedation; should this occur, the guidelines for moderate sedation apply.

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.*

Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation.

Nitrous oxide/oxygen when used in combination with sedative agent(s) may produce minimal, moderate, deep sedation or general anesthesia.

The following definitions apply to administration of minimal sedation:

maximum recommended (MRD) - maximum FDA-recommended dose of a drug, as printed in FDA-approved labeling for unmonitored home use.

incremental dosing - administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

supplemental dosing - during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The total aggregate dose must not exceed 1.5x the MRD on the day of treatment.

² Portions excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004*, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

moderate sedation - a drug-induced depression of consciousness during which patients respond *purposefully* to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.³

Note: In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. Further, a patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

The following definition applies to the administration of moderate or greater sedation:

titration-administration of incremental doses of a drug until a desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over sedation. Although the concept of titration of a drug to effect is critical for patient safety, when the intent is moderate sedation one must know whether the previous dose has taken full effect before administering an additional drug increment.

deep sedation - a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.³

general anesthesia - a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Because sedation and general anesthesia are a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to diagnose and manage the physiologic consequences (rescue) for patients whose level of sedation becomes deeper than initially intended.³

For all levels of sedation, the practitioner must have the training, skills, drugs and equipment to identify and manage such an occurrence until either assistance arrives (emergency medical service) or the patient returns to the intended level of sedation without airway or cardiovascular complications.

Routes of Administration

enteral - any technique of administration in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa [i.e., oral, rectal, sublingual].

parenteral - a technique of administration in which the drug bypasses the gastrointestinal (GI) tract [i.e., intramuscular (IM), intravenous (IV), intranasal (IN), submucosal (SM), subcutaneous (SC), intraosseous (IO)].

transdermal - a technique of administration in which the drug is administered by patch or iontophoresis through skin.

³ Excerpted from *Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia, 2004*, of the American Society of Anesthesiologists (ASA). A copy of the full text can be obtained from ASA, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

transmucosal - a technique of administration in which the drug is administered across mucosa such as intranasal, sublingual, or rectal.

inhalation - a technique of administration in which a gaseous or volatile agent is introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.

Terms

qualified dentist - meets the educational requirements for the appropriate level of sedation in accordance with Section III of these *Guidelines*, or a dentist providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document.

must/shall - indicates an imperative need and/or duty; an essential or indispensable item; mandatory.

should - indicates the recommended manner to obtain the standard; highly desirable.

may - indicates freedom or liberty to follow a reasonable alternative.

continual - repeated regularly and frequently in a steady succession.

continuous - prolonged without any interruption at any time.

time-oriented anesthesia record - documentation at appropriate time intervals of drugs, doses and physiologic data obtained during patient monitoring.

immediately available – on site in the facility and available for immediate use.

American Society of Anesthesiologists (ASA) Patient Physical Status Classification⁴

ASA I - A normal healthy patient.

ASA II - A patient with mild systemic disease.

ASA III - A patient with severe systemic disease.

ASA IV - A patient with severe systemic disease that is a constant threat to life.

ASA V - A moribund patient who is not expected to survive without the operation.

ASA VI - A declared brain-dead patient whose organs are being removed for donor purposes.

E - Emergency operation of any variety (used to modify one of the above classifications, i.e., ASA III-E).

III. Educational Requirements

A. Minimal Sedation

1. To administer minimal sedation the dentist must have successfully completed:

a. training to the level of competency in minimal sedation consistent with that prescribed in the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students*, or a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage minimal sedation commensurate with these guidelines;

⁴ *ASA Physical Status Classification System* is reprinted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

and
c. a current certification in Basic Life Support for Healthcare Providers.

2. Administration of minimal sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

B. Moderate Sedation

1. To administer moderate sedation, the dentist must have successfully completed:

a. a comprehensive training program in moderate sedation that satisfies the requirements described in the Moderate Sedation section of the ADA *Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* at the time training was commenced,

or

b. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage moderate sedation commensurate with these guidelines;

and

c. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS) or completion of an appropriate dental sedation/anesthesia emergency management course on the same recertification cycle that is required for ACLS.

2. Administration of moderate sedation by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support for Healthcare Providers.

C. Deep Sedation or General Anesthesia

1. To administer deep sedation or general anesthesia, the dentist must have completed:

a. an advanced education program accredited by the ADA Commission on Dental Accreditation that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia, commensurate with Part IV.C of these guidelines;

and

b. 1) a current certification in Basic Life Support for Healthcare Providers and 2) either current certification in Advanced Cardiac Life Support (ACLS) or completion of an appropriate dental sedation/anesthesia emergency management course on the same re-certification cycle that is required for ACLS.

2. Administration of deep sedation or general anesthesia by another qualified dentist or independently practicing qualified anesthesia healthcare provider requires the operating dentist and his/her clinical staff to maintain current certification in Basic Life Support (BLS) Course for the Healthcare Provider.

For all levels of sedation and anesthesia, dentists, who are currently providing sedation and anesthesia in compliance with their state rules and/or regulations prior to adoption of this document, are not subject to these educational requirements. However, all dentists providing sedation and general anesthesia in their offices or the offices of other dentists should comply with the Clinical Guidelines in this document.

IV. Clinical Guidelines

A. Minimal sedation

1. Patient Evaluation

Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this may consist of a review of their

current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-Operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.

4. Monitoring and Documentation

Monitoring: A dentist, or at the dentist's direction, an appropriately trained individual, must remain in the operatory during active dental treatment to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The appropriately trained individual must be familiar with monitoring techniques and equipment. Monitoring must include

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.
- Oxygen saturation by pulse oximetry may be clinically useful and should be considered.

Ventilation:

- The dentist and/or appropriately trained individual must observe chest excursions continually.
- The dentist and/or appropriately trained individual must verify respirations continually.

Circulation:

- Blood pressure and heart rate should be evaluated pre-operatively, post-operatively and intraoperatively as necessary (unless the patient is unable to tolerate such monitoring).

Documentation: An appropriate sedative record must be maintained, including the names of all drugs administered, including local anesthetics, dosages, and monitored physiological parameters.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must monitor the patient during recovery until the patient is ready for discharge by the dentist.
- The qualified dentist must determine and document that level of consciousness, oxygenation, ventilation and circulation are satisfactory prior to discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation and providing the equipment and protocols for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

B. Moderate Sedation

1. Patient Evaluation

Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review of their current medical history and medication use. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative agents and informed consent for the proposed sedation must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative technique prescribed.
- Pre-operative verbal or written instructions must be given to the patient, parent, escort, guardian or care giver.

3. Personnel and Equipment Requirements

Personnel:

- At least one additional person trained in Basic Life Support for Healthcare Providers must be present in addition to the dentist.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering moderate sedation must remain in the operator room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level a qualified auxiliary may be directed by the dentist to remain with the patient and continue to monitor them as explained in the guidelines until they are discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Consciousness:

- Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.

Oxygenation:

- Color of mucosa, skin or blood must be evaluated continually.
- Oxygen saturation must be evaluated by pulse oximetry continuously.

Ventilation:

- The dentist must observe chest excursions continually.
- The dentist must monitor ventilation. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO₂ or by verbal communication with the patient.

Circulation:

- The dentist must continually evaluate blood pressure and heart rate (unless the patient is unable to tolerate and this is noted in the time-oriented anesthesia record).
- Continuous ECG monitoring of patients with significant cardiovascular disease should be considered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics, dosages and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record).
- Pulse oximetry, heart rate, respiratory rate, blood pressure and level of consciousness must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The qualified dentist or appropriately trained clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The qualified dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- If a pharmacological reversal agent is administered before discharge criteria have been met, the patient must be monitored for a longer period than usual before discharge, since re-sedation may occur once the effects of the reversal agent have waned.

6. Emergency Management

- If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation.
- The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation and providing the equipment, drugs and protocol for patient rescue.

7. Management of Children

For children 12 years of age and under, the American Dental Association supports the use of the American Academy of Pediatrics/American Academy of Pediatric Dentistry *Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures*.

C. Deep Sedation or General Anesthesia

1. Patient Evaluation

Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history and medication use and NPO status. However, patients with significant medical considerations (e.g., ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

2. Pre-operative Preparation

- The patient, parent, guardian or care giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and informed consent for the proposed sedation/anesthesia must be obtained.
- Determination of adequate oxygen supply and equipment necessary to deliver oxygen under positive pressure must be completed.
- Baseline vital signs must be obtained unless the patient's behavior prohibits such determination.
- A focused physical evaluation must be performed as deemed appropriate.
- Preoperative dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.
- Pre-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.
- An intravenous line, which is secured throughout the procedure, must be established except as provided in part IV. C.6. Pediatric and Special Needs Patients.

3. Personnel and Equipment Requirements

Personnel: A minimum of three (3) individuals must be present.

- A dentist qualified in accordance with part III. C. of these Guidelines to administer the deep sedation or general anesthesia.
- Two additional individuals who have current certification of successfully completing a Basic Life Support (BLS) Course for the Healthcare Provider.
- When the same individual administering the deep sedation or general anesthesia is performing the dental procedure, one of the additional appropriately trained team members must be designated for patient monitoring.

Equipment:

- A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.
- When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either (1) a functioning device that prohibits the delivery of less than 30% oxygen or (2) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.
- An appropriate scavenging system must be available if gases other than oxygen or air are used.
- The equipment necessary to establish intravenous access must be available.
- Equipment and drugs necessary to provide advanced airway management, and advanced cardiac life support must be immediately available.
- If volatile anesthetic agents are utilized, a capnograph must be utilized and an inspired agent analysis monitor should be considered.
- Resuscitation medications and an appropriate defibrillator must be immediately available.

4. Monitoring and Documentation

Monitoring: A qualified dentist administering deep sedation or general anesthesia must remain in the operator room to monitor the patient continuously until the patient meets the criteria for recovery. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

Oxygenation:

- Color of mucosa, skin or blood must be continually evaluated.
- Oxygenation saturation must be evaluated continuously by pulse oximetry.

Ventilation:

- Intubated patient: End-tidal CO₂ must be continuously monitored and evaluated.
- Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO₂ must be continually monitored and evaluated.
- Respiration rate must be continually monitored and evaluated.

Circulation:

- The dentist must continuously evaluate heart rate and rhythm via ECG throughout the procedure, as well as pulse rate via pulse oximetry.
- The dentist must continually evaluate blood pressure.

Temperature:

- A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.
- The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

Documentation:

- Appropriate time-oriented anesthetic record must be maintained, including the names of all drugs, dosages and their administration times, including local anesthetics and monitored physiological parameters. (See Additional Sources of Information for sample of a time-oriented anesthetic record)
- Pulse oximetry and end-tidal CO₂ measurements (if taken), heart rate, respiratory rate and blood pressure must be recorded continually.

5. Recovery and Discharge

- Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.
- The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation and level of consciousness.
- The dentist must determine and document that level of consciousness; oxygenation, ventilation and circulation are satisfactory for discharge.
- Post-operative verbal and written instructions must be given to the patient, parent, escort, guardian or care giver.

6. Pediatric Patients and Those with Special Needs

Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist responsible for administering the deep sedation or general anesthesia should document the reasons preventing the recommended preoperative management.

In selected circumstances, deep sedation or general anesthesia may be utilized without establishing an indwelling intravenous line. These selected circumstances may include very brief procedures or periods of time, which, for example, may occur in some pediatric patients; or the establishment of intravenous access after deep sedation or general anesthesia has been induced because of poor patient cooperation.

7. Emergency Management

The qualified dentist is responsible for sedative/anesthetic management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of deep sedation or general anesthesia and providing the equipment, drugs and protocols for patient rescue.

V. Additional Sources of Information

American Dental Association. Example of a time oriented anesthesia record at www.ada.org.

American Academy of Pediatric Dentistry (AAPD). *Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update*. Developed through a collaborative effort between the American Academy of Pediatrics and the AAPD. Available at <http://www.aapd.org/policies>.

American Academy of Periodontology (AAP). *Guidelines: In-Office Use of Conscious Sedation in Periodontics*. Available at http://www.perio.org/resources_products/posppr3-1.html—The AAP rescinded this policy in 2008.

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Parameters and Pathways: Clinical Practice Guidelines for Oral and Maxillofacial Surgery (AAOMS ParPath o1) Anesthesia in Outpatient Facilities*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Association of Oral and Maxillofacial Surgeons (AAOMS). *Office Anesthesia Evaluation Manual 7th Edition*. Contact AAOMS at 1-847-678-6200 or visit <http://www.aaoms.org/index.php>

American Society of Anesthesiologists (ASA). *Practice Guidelines for Preoperative Fasting and the Use of Pharmacological Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures*. Available at <https://ecommerce.asahq.org/p-178-practice-guidelines-for-preoperative-fasting.aspx>

American Society of Anesthesiologists (ASA). *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. Available at <http://www.asahq.org/publicationsAndServices/practiceparam.htm#sedation>. The ASA has other anesthesia resources that might be of interest to dentists. For more information, go to <http://www.asahq.org/publicationsAndServices/sgstoc.htm>

Commission on Dental Accreditation (CODA). *Accreditation Standards for Predoctoral and Advanced Dental Education Programs*. Available at <http://www.ada.org/115.aspx>.

National Institute for Occupational Safety and Health (NIOSH). *Controlling Exposures to Nitrous Oxide During Anesthetic Administration* (NIOSH Alert: 1994 Publication No. 94-100). Available at <http://www.cdc.gov/niosh/docs/94-100/>

Dionne, Raymond A.; Yagiela, John A., et al. Balancing efficacy and safety in the use of oral sedation in dental outpatients. *JADA* 2006;137(4):502-13. ADA members can access this article online at <http://jada.ada.org/cgi/content/full/137/4/502>



MEMORANDUM

DATE	October 21, 2013
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17F: 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.



MEMORANDUM

DATE	October 30, 2013
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17G: Update on Pending Regulatory Packages

i. Uniform Standards for Substance Abusing Licensees (California Code of Regulations, Title 16, §§ 1018 and 1018.01):

At its February 28, 2012 meeting, the Dental Board of California (Board) reconsidered approval of new proposed regulatory language relative to uniform standards for substance abusing licenses. At the meeting, the Board directed staff to initiate a rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on Tuesday, March 5th. The rulemaking was published in the California Regulatory Notice Register on Friday, March 15th and was noticed on the Board's web site and mailed to interested parties. The 45-day public comment period began on March 15th and ended on April 29th. The Board held a regulatory hearing in Sacramento on Monday, April 29th. The Board received one comment from the California Dental Association (CDA) seeking clarification. The Board responded to the comment from CDA at its May 2013 meeting. Since the comment was not considered adverse the Board adopted the proposed language and directed staff to finalize the rulemaking file.

Staff submitted the final rulemaking file to the Department of Consumer Affairs (Department) on June 28, 2013. To date, the final rulemaking file has been approved by the Director of the Department and the Secretary of the Business, Consumer Services and Housing Agency (Agency). The rulemaking file is currently pending approval from the Director of the Department of Finance (Finance).

Final rulemaking files are required to be approved by the Director of the Department, the Agency Secretary, and the Finance Director. Once approval signatures are obtained, the final rulemaking file will be submitted to the OAL. The OAL will have thirty (30) working days to review the file. Once approved, the rulemaking will be filed with the Secretary of State. Beginning January 1, 2013, new quarterly effective dates for regulations will be dependent upon the timeframe an OAL approved rulemaking is filed with the Secretary of State, as follows:

- The regulation would take effect on January 1 if the OAL approved rulemaking is filed with the Secretary of State on September 1 to November 30, inclusive.
- The regulation would take effect on April 1 if the OAL approved rulemaking is filed with the Secretary of State on December 1 to February 29, inclusive.
- The regulation would take effect on July 1 if the OAL approved rulemaking is filed with the Secretary of State on March 1 to May 31, inclusive.
- The regulation would take effect on October 1 if the OAL approved regulation is filed on June 1 to August 31, inclusive.

The deadline to submit this final rulemaking file to the Office of Administrative Law for review and determination of approval is March 15, 2014.

ii. Dentistry Fee Increase (California Code of Regulations, Title 16, § 1021):

At its March 1, 2013 meeting, the 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 OAL on Tuesday, 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. The Board held a regulatory hearing in Sacramento on Monday, September 23rd. The Board received one comment from the CDA. The Board responded to the comment at its October 9, 2013 Board teleconference meeting and directed staff to finalize the rulemaking.

Staff submitted the final rulemaking file to the Department on October 11, 2013 and it has been approved by the Director of the Department. The rulemaking file is currently pending approval from the Agency Secretary.

Final rulemaking files are required to be approved by the Director of the Department, the Agency Secretary, and the Finance Director. Once approval signatures are obtained, the final rulemaking file will be submitted to the OAL. The OAL will have thirty (30) working days to review the file. Once approved, the rulemaking will be filed with the Secretary of State. Beginning January 1, 2013, new quarterly effective dates for regulations will be dependent upon the timeframe an OAL approved rulemaking is filed with the Secretary of State, as follows:

- The regulation would take effect on January 1 if the OAL approved rulemaking is filed with the Secretary of State on September 1 to November 30, inclusive.
- The regulation would take effect on April 1 if the OAL approved rulemaking is filed with the Secretary of State on December 1 to February 29, inclusive.
- The regulation would take effect on July 1 if the OAL approved rulemaking is filed with the Secretary of State on March 1 to May 31, inclusive.
- The regulation would take effect on October 1 if the OAL approved regulation is filed on June 1 to August 31, inclusive.

The deadline to submit this final rulemaking file to the Office of Administrative Law for review and determination of approval is August 8, 2014.

iii. Portfolio Examination Requirements (California Code of Regulations, Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033, 1033.1, 1034, 1034.1, 1035, 1035.1, 1035.2, 1036, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039):

At its August 26, 2013 meeting, the Board approved proposed regulatory language relative to the portfolio examination requirements. At the meeting, the Board directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the OAL on Tuesday, October 29th. The rulemaking will be published in the California Regulatory Notice Register on Friday, November 8th. The 45-day public comment period will begin on November 8th and end on December 23rd; a regulatory hearing will be held in Sacramento on Monday, January 6, 2014. Any adverse comments received during the 45-day public comment period or at the regulatory hearing will be considered by the Board at its February meeting.

The deadline to submit this final rulemaking file to the Office of Administrative Law for review and determination of approval is November 7, 2014.

iv. Abandonment of Applications (California Code of Regulations, Title 16, §1004):

At its May 18, 2012 meeting, the Board discussed and approved proposed regulatory language relative to the abandonment of applications. The Board directed staff to initiate a rulemaking. At its December meeting, the Board deemed three other regulatory packages as top priority; those regulatory packages were relative to the fee increase, the Uniform Standards for Substance Abusing Licensees, and the Portfolio Examination Requirements. Staff will continue working on the initial rulemaking documents in priority order.

Action Requested:

No action necessary.



MEMORANDUM

DATE	October 30, 2013
TO	Dental Board of California Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 17H: Discussion and Possible Action Regarding Filing a Section 100 "Change without Regulatory Effect" with the Office of Administrative Law to Amend California Code of Regulations, Title 16, Section 1065 Relating to Notice to Consumers of Licensure by the Dental Board

Background:

As a result of Senate Bill 540 (Chapter 385, Statutes of 2011), the Dental Board of California (Board) adopted regulations requiring licensed dentists engaged in the practice of dentistry to provide a notice to patients in a conspicuous location accessible to public view that contains information that the Board is the entity that regulates dentists and provides a telephone number and Internet address of the Board. The Board adopted this requirement via the formal rulemaking process in which the proposal was mailed to interested parties and posted on the Board's Web site. Members of the public had the opportunity to comment on the proposal during the 45-day public comment period and during the regulatory hearing held in Sacramento, CA. The Board did not receive any comments in response to this regulatory proposal.

Specifically, California Code of Regulations, Title 16, Section 1065 requires licensed dentists to post the following notice:

NOTICE TO CONSUMERS
Dentists are licensed and regulated
by the Dental Board of California
(877) 729-7789
www.dbc.ca.gov

This notice is required to be prominently posted in a conspicuous location accessible to public view on the premises where the dentists provides licensed services, and is required to be in at least 48-point type font.

This regulation became effective on November 28, 2012. The Board mailed notification letters to all dentist licensees at the beginning of 2013.

Request from the Los Angeles Dental Society:

In March 2013, Dr. Kenneth Jacobs, DDS, President of the Los Angeles Dental Society, mailed a letter to the Board (Attachment 1) on the behalf of its Board of Directors requesting that the Board consider changing the notice's requirement to state "Notice to Patients" rather than "Notice to Consumers". The Los Angeles Dental Society objected to referring to patients as "consumers" rather than "patients", as it believes the relationship between a doctor and his or her patient is very different from the relationship between a barber or a contractor and his or her consumer of services.

Ms. Karen Fischer, Board Executive Officer, responded to the request in June 2013 (Attachment 2), informing the Los Angeles Dental Society's that its concerns would be addressed by the Board in the future, that the objection had been noted, and that any change to the language would require going through the regulatory process. Additionally, Ms. Fischer outlined the Board's process and timeline for the adoption of Section 1065 relating to notice to consumers.

CDA House of Delegates, November 2013:

Board staff is aware that the Los Angeles Dental Society has proposed a resolution to be brought before the California Dental Association's (CDA) House of Delegates in November 2013. The outcome of the resolution may be shared at the Board meeting.

Staff Recommendation:

If the Board considers amending Section 1065 in accordance with the Los Angeles Dental Society's request, staff would recommend changing "Notice to Consumers" to "Notice". By changing the language to "Notice", rather than "Notice to Patients", all individuals who may make contact with a licensed dentist over the course of treatment would be notified that dentists are licensed by the Board and would have access to the Board's contact information. Parents and guardians of minor patients, or those who provide assistance to elderly patients, may not be in receipt of dental services; however, they would have access to the Board's information in the event the patient experienced concerns over the course of treatment and it became necessary to act on their behalf. This change would not materially alter the requirement and responsibility for a licensed dentist to provide notification of licensure by the Board.

Staff recommends that this amendment may be achieved by filing a "Section 100" change. A "Section 100" is a reference to a change without regulatory effect. This stems from California Code of Regulations, Title 1, Section 100 (Attachment 3) relating to the review of proposed regulations by the Office of Administrative Law. To file a "Section 100", staff would need to file a STD. Form 400, the text of the changes without regulatory effect, and an explanatory statement. This filing is subject to the approval of the Office of Administrative Law (OAL). The OAL is required to determine whether a change submitted is a change without regulatory effect within 30 working days of its receipt; the OAL would then send written notification of the determination to the agency which submitted the changes. If the OAL determines that the submitted change is a change without regulatory effect, the OAL will file it with the Secretary of State and have

it published in the California Code of Regulations. The change would become effective upon its filing with the Secretary of State.

In accordance with the staff recommendation, proposed language (Attachment 4) has been included for the Board's consideration.

Action Requested:

The Board may take action to direct staff to file a "Section 100" to make a change without regulatory effect to amend California Code of Regulations, Title 16, Section 1065.



LOS ANGELES DENTAL SOCIETY

A Component of the California and American Dental Associations

Attachment 1

March 20, 2013

RECEIVED

MAR 25 2013

DENTAL BOARD OF CALIFORNIA

Huong N. Le, DDS
 President
 Dental Board of California
 345 9th Street, Suite 302
 Oakland, California 94607-6523

Dear Doctor Le:

I am writing on behalf of the Board of Directors of the Los Angeles Dental Society regarding the new requirement of Business and Professions Code Sections 138 and 1611.3 that dentists engaged in the practice of dentistry need to provide conspicuous notification to consumers that dentists in California are licensed and regulated by the Dental Board of California.

While the Los Angeles Dental Society does not object to informing our patients that we are governed and licensed by the Dental Board of California, we strongly object to the fact that our patients are referred to as "consumers" rather than "patients." Although the Dental Board of California is housed under the auspices of the Department of Consumer Affairs, the relationship between a doctor and his/her patient is very different than the relationship between a barber and his/her customer, or a contractor and his/her consumer of services. On the Dental Board of California website there is a FAQ section to provide guidance regarding this posting requirement to dentists and there you refer to our patients and not consumers.

We respectfully request that your Board consider changing the wording of the posting to "Notice to Patients" rather than "Notice to Consumers." If for some reason the power to make this change rests with another governmental agency, we request that you advise our dental society so we can send appropriate communications.

Thank you for your consideration of our request.

Sincerely,

Kenneth Jacobs, DDS
 President

C: Members, Dental Board of California
 Executive Director, Dental Board of California ✓

Attachment 2



STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.

Dental Board of California

2005 Evergreen Street, Suite 1550, Sacramento, California 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov



June 4, 2013

Kenneth Jacobs, DDS – President
Los Angeles Dental Society
3660 Wilshire Boulevard, #1152
Los Angeles, CA 90010

RE: **Notice to Consumers Regulations – California Code of Regulations (CCR),
Section 1065**

Dear Dr. Jacobs:

The Dental Board received your letter regarding your objection to the use of the term "consumers" in the notification to patients that dentists in California are licensed and regulated by the Dental Board of California (Board). The Board will make every effort to address your concerns when it reviews the regulatory priorities for the coming year. Your objection is noted, however any change to the language at this time would require going through the regulatory process.

The regulatory process is transparent and designed to encourage public participation. Prior to the adoption of the "notice to consumer" language, the Board discussed this item at two quarterly meetings (November 7, 2011 and May 18, 2012), where the public was able to comment. There was no public comment. In addition, the proposed text was noticed on the Board's website and mailed to interested parties on January 20, 2012. The 45-day public comment period began at that time and ended on March 5, 2012, culminating with a regulatory hearing in Sacramento, California. Again, the Board received no comments in response to the proposed regulations.

I would like to take this opportunity to encourage your members to subscribe to the Dental Board's e-mail notification list at www.dbc.ca.gov. There is no cost for this service. Subscribers are notified by e-mail of any updates to the Board's website such as meeting notices, agendas and materials, regulation and legislation updates, examination news, and other information.

If you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads 'Karen M. Fischer'.

Karen M. Fischer, MPA
Executive Officer
(916) 263-2188
Karen.Fischer@dca.ca.gov

cc: Dental Board Members

ATTACHMENT 3

**CALIFORNIA CODE OF REGULATIONS
TITLE 1. GENERAL PROVISIONS
DIVISION 1. OFFICE OF ADMINISTRATIVE LAW
CHAPTER 1. REVIEW OF PROPOSED REGULATIONS
ARTICLE 2. CRITERIA APPLIED IN THE REVIEW OF PROPOSED REGULATIONS**

§ 100. Publication of “Changes Without Regulatory Effect.”

(a) Subject to the approval of OAL as provided in subsections (c) and (d), an agency may add to, revise or delete text published in the California Code of Regulations without complying with the rulemaking procedure specified in Article 5 of the APA only if the change does not materially alter any requirement, right, responsibility, condition, prescription or other regulatory element of any California Code of Regulations provision. Subject to the approval of OAL, the Department of Social Services may add to, revise or delete text published in the department Manual of Policies and Procedures (MPP) without complying with the rulemaking procedure specified in Article 5 of the APA only if the change does not materially alter any requirement, right, responsibility, condition, prescription or other regulatory element of the MPP. The addition, revision or deletion is a “change without regulatory effect.” Changes without regulatory effect include, but are not limited to:

- (1) renumbering, reordering, or relocating a regulatory provision;
- (2) deleting a regulatory provision for which all statutory or constitutional authority has been repealed;
- (3) deleting a regulatory provision held invalid in a judgment that has become final, entered by a California court of competent jurisdiction, a United States District Court located in the State of California, the United States Court of Appeals for the Ninth Circuit, or the United States Supreme Court; however, OAL shall not approve any proposed change without regulatory effect if the change is based on a superior court decision which invalidated the regulatory provision solely on the grounds that the underlying statute was unconstitutional;
- (4) revising structure, syntax, cross-reference, grammar, or punctuation;
- (5) changing an “authority” or “reference” citation for a regulation; and,
- (6) making a regulatory provision consistent with a changed California statute if both of the following conditions are met:
 - (A) the regulatory provision is inconsistent with and superseded by the changed statute, and
 - (B) the adopting agency has no discretion to adopt a change which differs in substance from the one chosen.

(b) In submitting a change without regulatory effect to OAL for review the agency shall:

(1) submit seven copies of the regulations with an addition shown in underline or italics and a deletion shown in strike-out; and

(2) attach to each copy a completed Form 400, with at least one Form 400 bearing an original signature; and

(3) submit a written statement explaining why the change does not materially alter any requirement, right, responsibility, condition, prescription or other regulatory element of any California Code of Regulations provision.

(c) OAL shall determine whether a change submitted is a change without regulatory effect within 30 working days of its receipt. OAL shall send written notification of the determination to the agency which submitted the changes.

(d) If OAL determines that the submitted change is a change without regulatory effect, OAL shall file it with the Secretary of State and have it published in the California Code of Regulations. If the change without regulatory effect is a change to the MPP, OAL shall file the change with the Secretary of State and the Department of Social Services shall publish the change in the MPP.

Note: Authority cited: Sections 11342.4 and 11349.1(c), Government Code. Reference: Sections 11342.600, 11343.8, 11344.6 and 11346, Government Code; and Article III, Section 3.5, California Constitution.

ATTACHMENT 4

**TITLE 16. DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS**

**PROPOSED LANGUAGE
CHANGE WITHOUT REGULATORY EFFECT
(CAL. CODE OF REGS., TITLE 1, SECTION 100)**

Amend Section 1065 of Article 9 of Division 10 of Title 16 of the California Code of Regulations, to read as follows:

1065. Notice ~~to Consumers~~ of Licensure by the Dental Board.

(a) A licensed dentist engaged in the practice of dentistry shall provide notice to each patient of the fact that the dentist is licensed and regulated by the Board. The notice shall include the following statement and information:

~~NOTICE TO CONSUMERS~~
Dentists are licensed and regulated
by the Dental Board of California
(877) 729-7789
www.dbc.ca.gov

(b) The notice required by this section shall be provided by prominently posting the notice in a conspicuous location accessible to public view on the premises where the dentist provides the licensed services, in which case the notice shall be in at least 48-point type font.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 138 and 1611.3, Business and Professions Code.



MEMORANDUM

DATE	October 17, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	Agenda Item 18: Report from the Dental Assisting Council

The Chair of the Dental Assisting Council will provide a report from the Dental Assisting Council meeting.



MEMORANDUM

DATE	October 17, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	Agenda Item 19: Election of Board Officers for 2014

Business and Professions Code, Section 1606: Election of Officers

“The board shall elect a president, a vice president and a secretary from its membership. This section controls over the provisions of section 107 of this code with respect to the selection of officers.”

The Board Policy (adopted 2006) on election of officers reads:

“Election of Officers

It is board policy to elect officers at the final meeting of the calendar year for service during the next calendar year, unless otherwise decided by the board.”

Attached is a list of roles and responsibilities for Board Officers and Committee Chairs.

DENTAL BOARD OF CALIFORNIA

Roles and Responsibilities of Board Officers/Committee Chairs

President

- Acts as spokesperson for the Dental Board (attends legislative hearings and testifies on behalf of the Board, attends meetings with stakeholders and Legislators on behalf of Board, talks to the media on behalf of the Board, and signs letters on behalf of the Board).
- Meets and/or communicates with the Executive Officer (EO) on a regular basis.
- Provides oversight to the Executive Officer in performance of the EO duties.
- Approves leave requests, verifies accuracy and approves timesheets, approves travel and signs travel expense claims for the EO.
- Coordinates the EO annual evaluation process including contacting DCA Office of Human Resources to obtain a copy of the Executive Officer Performance Evaluation Form, distributes the evaluation form to members, and collates the ratings and comments for discussion.
- Communicates with other Board Members for Board business.
- Authors a president's message for every quarterly board meeting and published newsletters.
- Approves Board Meeting agendas.
- Chairs and facilitates Board Meetings.
- Chairs the Executive Committee.
- Signs specified full board enforcement approval orders.
- Establishes Committees and appoints Chairs and members.
- Establishes 2-Person subcommittees to research policy questions when necessary.

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee.
- Coordinates the revision of the Board's Strategic Plan.

Secretary

- Calls the roll at each Board meeting and reports that a quorum has been established.
- Is a member of Executive Committee.

Committee Chair

- Reviews agenda items with EO and Board President prior to Committee meetings.
- Approves the Committee agendas.
- Chairs and facilitates Committee meetings.
- Reports the activities of the Committee to the full Board.