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

# DENTAL BOARD OF CALIFORNIA

## NOTICE OF MEETING
## May 14-15, 2025

Board Members
Steven Chan, DDS, President
Alan Felsenfeld, MA, DDS, Vice President
Lilia Larin, DDS, Secretary
Kevin R. Cheng, JD, Public Member
Robert P. David, Public Member
Joni Forge, DDS
Angelita Medina, MHS, Public Member
Rosalinda Olague, PhD(c), RDA
Yogita Thakur, DDS, MS
James Yu, DDS, MS

**Action may be taken on any item listed on the agenda.**

**The Dental Board of California (Board) will meet in-person in accordance with Government Code section 11123, subdivision (a), approximately at, but no earlier than, 10:30 a.m., on Wednesday, May 14, 2025, and 8:30 a.m., on Thursday, May 15, 2025, at the following location:**

Hilton Anaheim
777 W. Convention Way (Fourth Floor, Huntington Room)
Anaheim, CA 92802
(714) 750-4321 (Hotel)
(916) 263-2300 or (877) 729-7789 (Board Office)

## AGENDA

**10:30 a.m., Wednesday, May 14, 2025**

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

2. Public Comment on Items Not on the Agenda **[6]**
   *Note: The Board may not discuss or take action on any matter raised during this Public Comment section, except to decide whether to place the matter on the agenda of a future meeting. (Government Code sections 11125 and 11125.7(a).)*

3. Discussion and Possible Action on February 6-7, 2025 Board Meeting Minutes **[7-38]**

4. Board President Report **[39]**

5. Assistant Executive Officer Report **[40]**
   a. Update on 2022-2025 Strategic Plan

6. Report on Department of Consumer Affairs (DCA) Activities, which may include updates on DCA's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters **[41]**

7. Budget Report **[42-48]**

8. Report on Dental Hygiene Board of California Activities **[49]**

9. Dental Assisting Council Meeting Report **[50]**

10. Update, Discussion, and Possible Action on Proposed Regulations
    a. Status Update on Pending Regulations **[51]**
       i. Update on Rulemaking to Amend California Code of Regulations (CCR), Title 16, Sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and Repeal Sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01 Regarding Applications for Dentist Licensure and Fees
    b. Discussion and Possible Action to Initiate a Rulemaking to Amend CCR, Title 16, Section 1005 Regarding Minimum Standards for Infection Control **[52-134]**

11. Licensing, Certifications, Permits, and Examinations
    a. Update on Dental Licensure and Permit Statistics **[135-146]**

12. Enforcement
    a. Review of Statistics and Trends **[147-154]**

13. Substance Use Awareness
    a. Diversion Program Report and Statistics **[155]**

14. Anesthesia and Sedation
    a. General Anesthesia and Sedation Permits: Inspections and Evaluations Statistics **[156-166]**
    b. Discussion and Possible Action on Recommendation from the Board's Anesthesia Committee Regarding Renewal of Moderate Sedation Permit Following Failure of Onsite Inspection and Evaluation **[167-170]**

15. Recess Open Session Until May 15, 2025, at 8:30 a.m.

**CLOSED SESSION (WILL NOT BE WEBCAST)**

16. Convene Closed Session

17. Pursuant to Government Code Section 11126(c)(3), the Board will Meet in Closed Session to Deliberate and Vote on Disciplinary Matters, Including Stipulations and Proposed Decisions

18. Adjourn Closed Session

**8:30 a.m., Thursday, May 15, 2025**

19. Reconvene Open Session – Call to Order/Roll Call/Establishment of a Quorum

20. Board President's Report on Closed Session Items **[171]**

21. Update, Discussion, and Possible Action on Legislative Proposals
    a. Legislative Proposal to Amend Business and Professions Code (BPC) Section 1724(a) to Remove Dentist Licensure Fee for Repealed Portfolio Pathway **[172-176]**
    b. Legislative Proposal to Add BPC Section 1778 Relating to Board Approval of Dental Assistant Educational Programs and Courses **[177-188]**
    c. Legislative Proposal to Amend BPC, Division 2, Chapter 4, Article 7 Title Regarding Dental Auxiliaries **[189]**
    d. Legislative Proposal to Amend BPC Sections 1753 and 1753.5 Regarding Authorized Duties and Procedures of Registered Dental Assistants in Extended Functions **[190-196]**

22. Update, Discussion, and Possible Action on Legislation Impacting the Board, DCA, and/or the Dental Profession
    a. 2025 Tentative Legislative Calendar – Information Only **[197-199]**
    b. Legislation of Interest **[200-226]**
        i. Assembly Bill (AB) 341 (Arambula, 2025) Oral Health for People with Disabilities Technical Assistance Center Program
        ii. AB 350 (Bonta, 2025) Health care coverage: fluoride treatments
        iii. AB 371 (Haney, 2025) Dental coverage
        iv. AB 479 (Tangipa, 2025) Criminal procedure: vacatur relief
        v. AB 485 (Ortega, 2025) Labor Commissioner: unsatisfied judgments: nonpayment of wages.
        vi. AB 489 (Bonta, 2025) Health care professions: deceptive terms or letters: artificial intelligence
        vii. AB 667 (Solache, 2025) Professions and vocations: license examinations: interpreters
        viii. AB 742 (Elhawary, 2025) Department of Consumer Affairs: licensing: applicants who are descendants of slaves
        ix. AB 837 (Davies, 2025) Ketamine
        x. AB 872 (Blanca Rubio, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances
        xi. AB 873 (Alanis, 2025) Dentistry: dental assistants: infection control course
        xii. AB 876 (Flora, 2025) Nurse anesthetists: scope of practice
        xiii. AB 966 (Carrillo, 2025) Dental Practice Act: foreign dental schools

xiv. AB 1107 (Flora, 2025) Cigarette and Tobacco Products Licensing Act of 2003: nitrous oxide: licensure
xv. AB 1215 (Flora, 2025) Hospitals: medical staff membership
xvi. AB 1298 (Harabedian, 2025) The Department of Consumer Affairs
xvii. AB 1307 (Ávila Farías, 2025) Licensed Dentists from Mexico Pilot Program
xviii. AB 1431 (Tangipa, 2025) Personal income taxes: credit: medical services: rural areas
xix. AB 1434 (Michelle Rodriguez, 2025) Health care boards: workforce data collection
xx. AB 1461 (Essayli, 2025) Department of Consumer Affairs: regulatory boards
xxi. Senate Bill (SB) 338 (Becker, 2025) Mobile Health for Rural Communities Pilot Program
xxii. SB 351 (Cabaldon, 2025) Health facilities
xxiii. SB 386 (Limón, 2025) Dental providers: fee-based payments
xxiv. SB 470 (Laird, 2025) Bagley-Keene Open Meeting Act: teleconferencing
xxv. SB 497 (Wiener, 2025) Legally protected health care activity
xxvi. SB 641 (Ashby, 2025) Department of Consumer Affairs and Department of Real Estate: states of emergency: waivers and exemptions
xxvii. SB 682 (Allen, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances
xxviii. SB 730 (Hurtado, 2025) Product safety: consumer products: perfluoroalkyl and polyfluoroalkyl substances
xxix. SB 806 (Dahle, 2025) Department of Consumer Affairs
xxx. SB 861 (Committee on Business, Professions and Economic Development, 2025) Consumer affairs

23. Public Comment on Future Agenda Items **[227]**
*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.*

24. Adjournment

Information regarding the meeting is available by contacting the Board at (916) 263-2300 or (877) 729-7789, email: DentalBoard@dca.ca.gov, or send a written request to the Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815. This agenda can be found on the Dental Board of California website at dbc.ca.gov. The time and order of agenda items are subject to change at the discretion of the Board President and may be taken out of order. Items scheduled for a particular day may be moved to an earlier or later day to facilitate the effective transaction of business. In accordance with the Bagley-Keene Open Meeting Act, all meetings of the Board are open to the public.

The meeting will be webcast, provided there are no unforeseen technical difficulties or limitations. To view the webcast, please visit **thedcapage.wordpress.com/webcasts/**. The meeting will not be cancelled if webcast is not available. Meeting adjournment may not be webcast if it is the only item that occurs after a closed session. Members of the

public may, but are not obligated to, provide their names or personal information as a condition of observing or participating in the meeting. (Government Code section 11124.)

Government Code section 11125.7 provides the opportunity for the public to address each agenda item during discussion or consideration by the Board prior to the Board taking any action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Board, but the Board President may, at their discretion, apportion available time among those who wish to speak. Individuals may appear before the Board to discuss items not on the agenda; however, the Board can neither discuss nor take official action on these items at the time of the same meeting (Government Code sections 11125, 11125.7(a)).

This meeting location is accessible to the physically disabled. A person who needs disability-related accommodations or modifications to participate in the meeting may make a request by contacting Christy Bell, Assistant Executive Officer, at Dental Board of California, 2005 Evergreen Street, Suite 1550, Sacramento, CA 95815, or by phone at (916) 263-2300. Providing your request at least five (5) business days prior to the meeting will help ensure availability of the requested accommodations. TDD Line: (877) 729-7789

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 2.:** Public Comment on Items Not on the Agenda |

**Notes**

# DENTAL BOARD OF CALIFORNIA
# MEETING MINUTES
# February 6-7, 2025

Pursuant to Government Code section 11123.2, the Dental Board of California (Board) met by teleconference/WebEx Events on February 6-7, 2025, with the following location available for Board and public member participation:

Department of Consumer Affairs
1625 N. Market Blvd., Hearing Room #102
Sacramento, CA 95834

**Board Members Present:**
Steven Chan, DDS, President
Alan Felsenfeld, MA, DDS, Vice President
Lilia Larin, DDS, Secretary
Kevin R. Cheng, JD, Public Member
Robert P. David, Public Member (February 6 only)
Joni Forge, DDS (remote participant)
Angelita Medina, MHS, Public Member
Rosalinda Olague, PhD(c), RDA
Yogita Thakur, DDS, MS (remote participant)
James Yu, DDS, MS

**Staff Present:**
Tracy A. Montez, Ph.D., Executive Officer
Christy Bell, Assistant Executive Officer
Ryan Blonien, Enforcement Chief (North)
Jodi Ortiz, Chief of Licensing and Examination Division
Paige Ragali, Chief of Administration and Compliance
Jessica Olney, Anesthesia Unit Manager
Wilbert Rumbaoa, Administrative Services Unit Manager
Jerry Fuhrman, Investigator
Brant Nelson, Legislative and Regulatory Specialist
Mirela Taran, Administrative Analyst
Joseph Tippins, Investigator
Catherine Bachiller, Appointments and Recruitment Specialist, Office of Human Resources (OHR), Department of Consumer Affairs (DCA) (February 6 only)
Melissa Gear, Deputy Director, Board and Bureau Relations, DCA
Sarah Irani, Facilitator and Strategic Planner, SOLID, DCA
Stephanie Louie, Section Chief, OHR, DCA (February 6 only)

Bryce Penney, Television Specialist, Office of Public Affairs, DCA
Kristy Schieldge, Regulations Counsel, Attorney IV, Legal Affairs Division, DCA (February 6 only)
Tara Welch, Board Counsel, Attorney IV, Legal Affairs Division, DCA

## 10:00 a.m., Thursday, February 6, 2025

Agenda Item 1: Call to Order/Roll Call/Establishment of a Quorum
The Board President, Dr. Steven Chan, called the meeting to order at 10:50 a.m. Board Members Joni Forge, DDS, and Yogita Thakur, DDS, MS, participated remotely and confirmed there were no individuals 18 years of age or older present in the room at their remote locations in compliance with Government Code section 11123.2, subdivision (j)(4).

The Board Secretary, Dr. Lilia Larin, called the roll; 10 Board Members were present, and a quorum was established.

Agenda Item 2: Public Comment on Items Not on the Agenda
There were no public comments made on items not on the agenda.

Agenda Item 3: Discussion and Possible Action on November 7-8, 2024 Board Meeting Minutes
(M/S/C) (David/Yu) to approve the November 7-8, 2024 meeting minutes.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Olague, Thakur, Yu.
Nays: None.
Abstentions: Medina.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 4: Board President Report
President Chan, on behalf of the Board Members and the entire working crew of the Board, extended condolences and sympathies for the survivors of the catastrophic events of the firestorms in Southern California. He voiced that he has had the benefit of weekly briefings since November 2024 with Executive Officer Dr. Tracy Montez and Assistant Executive Officer Christy Bell, as well as Vice President Dr. Alan Felsenfeld. He thanked the Board Members for accepting their committee assignments for 2025

and applauded Secretary Larin for accepting the appointment to the vacancy on the Dental Assisting Council (DAC). He extended his thanks to past Board Members Joanne Pacheco, Meredith McKenzie, and Dr. Sonia Molina who have completed their terms of appointment to the Board for their service. On behalf of the Board, he recognized Dr. Montez's service and leadership as Executive Officer of the Board.

President Chan requested public comment on this item. The Board received public comment.

Shari Becker, Tooka Zokaie, Dr. Bruce Whitcher, Gary Cooper, Leslie Canham, Susan McLearan, Joanne Pacheco, and Anthony Lum congratulated Dr. Montez on her retirement and expressed their appreciation.

Agenda Item 5: Assistant Executive Officer Report
Christy Bell shared that she first joined the Board in December of 2022 but has been with DCA for over 10 years holding various positions. She noted that the Board's 2022-2025 Strategic Plan is concluding, and strategic planning will be discussed further at the May Board meeting. Additionally, she stated the 2025 Dental Practice Act (DPA) will be available to order soon; there will be additional information on the Board's webpage on how to order it.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 6: Report on Department of Consumer Affairs Activities, which may include updates on the Department's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters
Melissa Gear provided a departmental update, which included the following.

Ms. Gear congratulated President Yu on his reappointment to the Board and his continued commitment to protecting the consumers of California and thanked Dr. Molina, Ms. McKenzie, and Ms. Pacheco for their service and commitment to the Board and California's consumers. Additionally, she thanked Dr. Montez for her service to the Board and the consumers of California. Ms. Gear noted that on January 29, 2025, Governor Newsom issued Executive Order N-15-25 to provide quick recovery relief for local businesses by deferring renewal fees and waiving other fees for DCA licensees in the Los Angeles wildfire areas. She noted that specific DCA provisions include DCA licensees whose licenses expire between January 1 and July 1, 2025, will be granted a one-year extension to pay their renewal fee if their business or residence address is in certain zip codes impacted by the fires. Licensees will still need to renew their licenses, but their fees will be postponed for one year. In addition, duplicate or replacement licenses or wall certificates will be provided free of charge until January 7, 2026, and delinquency fees are suspended until July 1, 2025, for those in the impacted areas. Ms. Gear stated that after the Governor's Executive Order was issued, DCA met with board

and bureau leadership on January 29 to discuss the Executive Order and its implementation. DCA is providing messaging to the boards and bureaus for dissemination to the impacted licensees, as well as consistent messaging for use on all board and bureau websites. In addition, DCA has a specific disaster help center webpage accessible at www.dca.ca.gov that includes information on the Executive Order, frequently asked questions, and other important resources that may be helpful as licensees and survivors navigate the rebuilding process. DCA also has a dedicated tollfree number 1-800-799-8314 and email cafires@dca.ca.gov available for fire survivors needing assistance.

Ms. Gear reported that Governor Newsom released his proposed 2025-26 state budget on January 10, which included eight budget change proposals for DCA's boards and bureaus. Additionally, DCA's vacancy reduction and government efficiency plans were approved by the Department of Finance and may be made official in the spring revisions. She conveyed that the Governor remains committed to funding resources to address California's housing and homelessness crisis. Included in the Governor's proposed budget is the creation of a dedicated California Housing and Homeless Agency. DCA and their regulators currently under the Business, Consumer Services and Housing Agency would form a consumer protection agency. Ms. Gear voiced that this is an extraordinary opportunity for DCA to better align with other consumer protection entities as one consumer protection agency. With a consumer protection agency secretary within the Governor's cabinet, this is an exciting opportunity that will only strengthen the mission, momentum, and delivery of services to California. She added that the Governor's reorganization proposal will be reviewed by the nonpartisan Little Hoover Commission and the Legislature in the spring.

Ms. Gear provided updates on the new Form 700 filing with the Fair Political Practices Commission (FPPC) and addressed upcoming trainings for Board members, which include the annual President's Training and Board Member Orientation Training (BMOT).

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 7: Budget Report

Wilbert Rumbaoa provided a report on the Board's budget for fiscal year (FY) 2024-2025. Mr. Rumbaoa conveyed that on January 10, the Governor's Budget was released, and the new appropriation for the Board is $20,272,000, and revenue is reported at $23,883,000. He added that in the finalization for the budget letters for the control section 4.12 and 4.05, the Board will be losing approximately two positions, and the reduction from the Board has been identified as $147,000, which should be finalized by spring. Mr. Rumbaoa stated that the Board is projected to revert roughly $1.5 million; from that will be $4 million in personnel services that are projected and $5 million in Operating Expense & Equipment (OE&E). Additionally, the projected revenues for the year are $20.3 million to the end of the FY.

Board Member Robert David inquired what the funds would be reverted to. Mr. Rumbaoa responded they would be reverted to the Dental Board's State Dentistry Fund. He added that the Board has a set amount that it can spend each year and if it does not spend the entirety of that amount, it goes back into the Board's funds.

Regarding the statement "the $5 million repayment will be coordinated as part of any future regulatory and/or statutory fee increase proposals," Secretary Larin inquired whether that is renewal fees for dentists. Mr. Rumbaoa responded that it would be the fee increase for any licensing fees. Secretary Larin noticed in the meeting materials there are increases for other items not related to licensure renewal and inquired whether that includes all of the fees or just the licensure renewal. Ms. Bell responded that the fees in that legislative proposal are not new but existing fees and merely being moved into statute so that the information is captured.

Secretary Larin asked whether that means the repayment has to be coordinated only when there is an increase in renewal fees. Mr. Rumbaoa responded that in regard to fees, they are typically set via statute, and regulations clarify how much those fees are going to be. He added that the Board is not at the statutory cap on all of its fees; for those that have been identified, Board staff is clarifying what those fees are going to be set at. He expressed that the keyword here is existing fees versus new fees and noted the $5 million would not come into play unless there are any new fees for the Board and dental assistants being pursued.

Board Member Robert David noted there was a loan made from the Board's fund to the General Fund and before any fee increases are anticipated, that money has to be repaid to the Board. Mr. Rumbaoa responded that is correct.

Tara Welch conveyed there are fee changes submitted to the Board under agenda item 11.c. Applications for Dentist Licensure; there is the dental assisting program and course fees that is a legislative proposal, but that is not actually any increase in fees and is merely reflective of what the Board has been charging under regulation. Separately, there is a regulatory package that would change the dentist licensure fees.

President Chan requested public comment on this item. There were no public comments made on this item.

*Agenda Item 8: Presentation from DCA, Strategic Organizational Leadership and Individual Development (SOLID) on Strategic Planning

Sarah Irani provided a verbal presentation on initiating the new strategic planning process.

Dr. Montez added it is anticipated this will come back at the May Board meeting for the next phase; there will be an update on the current Strategic Plan, and many of those goals and objectives have been achieved.

Vice President Felsenfeld asked if there is a financial implication for the Board or whether this is being supplied through DCA. Ms. Irani responded that as far as she is aware, this is covered by pro rata, so there is no additional cost to this.

Ms. Welch asked when it is anticipated for the environmental scan to be completed for presentation to the Board. Ms. Irani responded that when she spoke with Dr. Montez and Ms. Bell, the strategic planning would begin around June or July. Typically, that means the survey will go live and will be open for about four weeks. Depending on the number of responses received on that survey, SOLID would need another four to six weeks to analyze and compile that information.

Ms. Welch noted the next Board meetings are scheduled for May, August, and November. She stated if the process does not begin until June or July, it did not appear [the environmental scan] would be ready for the August meeting, so the Board would either need to hold a meeting scheduled outside of the quarterly meetings or have a third day of the November meeting.

Dr. Montez stated that for the May Board meeting, the Board will have an update on the current Strategic Plan. She encouraged the Board to have a third day of the November meeting.

Vice President Felsenfeld asked how much of the work is going to be done by the Board's Members versus through DCA. Ms. Irani responded that the Board Members are included for providing feedback, and during the actual strategic planning process, they will be given that report ahead of time to read and write down their thoughts. During that session, SOLID will go through each goal area, highlighting the weaknesses, and the Board Members would have the opportunity to divulge what they believe are important issues from that feedback. Ms. Irani stated that after that meeting, she will do the refinement offline, and the Board Members will receive a draft copy. Then, at the next Board meeting, the Board Members will have a chance to review, approve, and make edits.

Ms. Bell added for the Board Members' awareness, if a third day is added to the November Board meeting, it would be November 5.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 9: Report on Dental Hygiene Board of California Activities
Ms. Bell provided the report, which is available in the meeting materials.

President Chan requested public comment on this item. The Board received public comment.

Leslie Canham, a certified and registered dental assistant (RDA), certified in dental infection prevention and control, and authorized by the federal government as an Occupational Safety and Health Administration (OSHA) outreach trainer, is a provider of continuing education for the Board and the Academy of General Dentistry (AGD), and authorized to provide the infection control two-hour course for license renewal and the eight-hour infection control course for unlicensed dental assistants. Ms. Canham raised concern with the draft regulation for the minimum standards for infection control. She stated there are a variety of flaws and inconsistencies with OSHA regulations and with Center for Disease Control (CDC) recommendations, both the 2003 recommendations for infection control and dental healthcare settings and the 2016 update, as well as other discussion for future changes to CDC guidelines for dental settings. She is extremely concerned with the lack of information or requirements on the infection control regulations for dental unit water lines and inconsistencies with CDC's recommendations for treatment, testing, and monitoring and strategies to improve water quality, purging, and flushing. She stated the document has been identified in the infection control minimum standards as it was in 2011, which CDC states that purging and flushing dental unit water lines does not address monitoring of water quality and can be a safety issue for patient care. Ms. Canham offered her assistance to the Board or the working committees on the infection control regulation guidelines to provide her insight and input.

Agenda Item 10: Dental Assisting Council Meeting Report
DAC Chair, De'Andra Epps-Robbins, provided a verbal report on the February 6, 2025 DAC meeting. Ms. Epps-Robbins advised the Board regarding DAC discussion of DAC meeting agenda items.

Ms. Welch clarified the motion that came out of the DAC meeting for agenda item 9.b. was a motion to amend Business and Professions Code (BPC) sections 1725, 1753.52, 1754.5, and 1755.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 11: Update, Discussion, and Possible Action on Proposed Regulations
Agenda Item 11.a.: Status Update on Pending Regulations
Brant Nelson provided the report, which is available in the meeting materials.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 11.b.: Discussion and Possible Action to Initiate a Rulemaking to Amend California Code of Regulations (CCR), Title 16, Section 1005 Regarding Minimum Standards for Infection Control
Mr. Nelson provided the report, which is available in the meeting materials.

Kristy Schieldge conveyed that during the DAC meeting, they received about eight adverse comments about the proposed text, which Board staff had recommended the Board adopt in Attachment 2 of the meeting materials and includes the issue the California Dental Association (CDA) had flagged at the Dental Hygiene Board of California (DHBC) meeting. The CDA issue had been addressed, but there were about eight additional adverse comments, one of which the Board heard in public comment under a prior agenda item. She added that the DAC is recommending this text be brought back to the working group for consideration. She noted the Board lost Ms. Pacheco, who was on the initial working group, and Board Member Rosalinda Olague agreed to replace her and help staff work through consideration of all the comments that have been received. Ms. Schieldge stated Board staff are recommending no Board action on the item at this time. Ms. Schieldge requested Board or public comment on Attachment 2 for additional consideration by the working group, so they can get as much input as possible on this proposal and avoid bringing the item back over and over again.

Board Member Olague encouraged stakeholders to submit, in writing, any thoughts, comments, or feedback to Mr. Nelson so the working group can have those on hand.

Secretary Larin stated she would like to follow the recommendations of the DAC, especially where it says that certain things have to be done immediately, which is not feasible, and to provide feedback on the motor comment and whether it should be sterilized.

President Chan requested public comment on this item. The Board received public comment.

Ms. Canham, RDA and certified in dental infection prevention and control, volunteered her services on the working group for the draft regulations and submission of information for the infection control minimum standards. She has a great deal of access to information, on top of her resources, that she can provide. Ms. Canham is particularly concerned about the dental unit waterline issues and how that would affect the safety of the California consumer.

Vice President Felsenfeld sought clarification on the DAC actions on this proposal. He heard during the DAC meeting there was agreement that the “top shield” requirement was removed, and that was the motion to have been passed through. The problem was there were at least half a dozen other concerns with the proposal. Then the DAC made a motion to refer the proposal back to the working group. Vice President Felsenfeld discussed parliamentary procedure and noted the DAC sent the rulemaking back to the working group to work through everything. He noted there is nothing before the Board for action. He moved to accept the DAC recommendation and refer the comments and original motion for motion work by the working group. Ms. Schieldge clarified the prior Board motion to send the rulemaking to the working group is still in play. Ms. Welch said the Board does not have anything to act on; the rulemaking was referred by the Board

to the DAC, which referred the rulemaking to the working group. So there is nothing for the Board to do at this time. Vice President Felsenfeld noted there was no second to his motion, so the motion died.

Board Member Olague commented that the word “immediately” came up in two situations. She wants the working group to look at that language. In her mindset, if [personal protective equipment (PPE)] becomes soiled or saturated, for example, during a pediatric OS procedure, that is an immediate need for the PPE to be changed. Board Member Olague requested the working group to look at the history of that language and use of the word before going to a different pathway. She wants the working group and stakeholders to discuss the word and come to some collaboration with the word, as that was how she always understood the term in the history of knowing this language. She also echoed the importance of the working group looking at the dental water unit lines.

Agenda Item 11.c.: Discussion and Possible Action to Initiate a Rulemaking to Amend CCR, Title 16, Sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and Repeal Sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01 Regarding Applications for Dentist Licensure and Fees

Jodi Ortiz provided the report, which is available in the meeting materials.

Regarding the initial license fee proposal to move from $400 to $490, Board Member David asked when it was last raised. Ms. Schieldge responded that it has been more than a decade since the Board has raised any of the license application fees. She added the Board is required by the Department of Finance, which also reviews the Board’s regulatory proposals, to do either a fee study or a desk audit to justify any increase. She noted that was done by staff back in 2023 with rate calculators that were projections. She stated that now that Board staff have the actual numbers, Board staff revisited that calculator they used and used actual numbers. Use of the revised, updated staff hourly rate calculators are based upon the budget year in which these fees would probably be adopted, if approved at this meeting, and are therefore a more accurate calculation of the Board’s costs. Ms. Schieldge noted that number is actually $10 lower than originally projected based on actual hourly rate calculators.

Secretary Larin inquired whether this fee increase is tied into the loan repayment. Ms. Schieldge was not sure if a license application fee increase would trigger repayment or if it would be the renewal fee that would trigger it; Board staff would need to get back to Secretary Larin on that. Ms. Schieldge added the Board is required by state policy and the State Administrative Manual to recover the actual costs for any service provided by the Board, which is why Board staff had to re-evaluate whether the application being updated would cause services to be more costly. She confirmed it is more expensive to process an application, and currently, the Board is absorbing this cost. The Board has the authority to increase the fee to recover those costs that the Board has been losing money on. The proposal would be to increase it to $490 to recover the cost that the Board has been losing on the application.

Secretary Larin asked that when they say the loan has to be repaid when you have a fee increase like this, would it be because this fee is under the statutory fee cap authority. Ms. Schieldge responded that is something Board staff would have to work with the Budget Office to find out.

(M/S/C) (Larin/Medina) to rescind the Board's prior November 9, 2023 motion approving prior text for this item, and instead approve the proposed regulatory text in Attachment 1, including the repeal of the forms incorporated by reference in Attachments 2 through 6. I further direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, for amendments to sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and for the repeal of sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

At 12:11 p.m., the Board recessed for a break.

At 1:15 p.m., the Board reconvened.

Agenda Item 12: Licensing, Certifications, Permits, and Examinations
Agenda Item 12.a.: Update on Dental Licensure and Permit Statistics
Ms. Ortiz provided the report, which is available in the meeting materials.

Ms. Ortiz noted that moderate sedation permit holders who apply for an under seven pediatric endorsement are also approved for an under 13 pediatric endorsement.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 12.b.: Report on Commission on Dental Competency Assessment, Western Regional Examining Board, and Council of Interstate Testing Agencies (CDCA-WREB-CITA)
Dr. Guy Shampaine, Senior Advisor to CDCA-WREB-CITA, provided a verbal report on their activities.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 13: Anesthesia and Sedation
Agenda Item 13.a.: General Anesthesia and Sedation Permits: Inspections and Evaluations Statistics
Jessica Olney provided the report, which is available in the meeting materials.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 13.b.: Discussion and Possible Action Regarding Appointment of General Anesthesia, Medical General Anesthesia, and Moderate Sedation Permit Evaluators
Ms. Olney provided the report, which is available in the meeting materials.

(M/S/C) (Felsenfeld/Yu) to appoint Dr. Karen Baghdasaryan as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/David) to appoint Dr. Amandeep Bhullar as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Medina) to appoint Dr. Devan Dalla as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: David.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Cheng) to appoint Dr. Eric Driver as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Olague) to appoint Dr. Mario Flores as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Chan) to appoint Dr. Hamed Javadi as an evaluator for the moderate sedation onsite inspection and evaluation program.

Yogita Thakur noted that Dr. Javadi's type of practice is dental public health and asked whether that is specialty training he has and how that qualifies him as an evaluator for general anesthesia. Vice President Felsenfeld responded that dental public health is a recognized specialty, and individuals can become board certified in it and be a dental public health dentist by training. He added it is not impossible that part of the training would include moderate sedation.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Yu) to appoint Dr. Anthony Lizano as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Cheng) to appoint Dr. Joseph Miller as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Olague) to appoint Dr. Omonlegho Briana Ovbude as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.

Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/David) to appoint Dr. Sireesha Penumetcha as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Yu) to appoint Dr. Aarti Puri as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Medina) to appoint Dr. Jose David Sanchez as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Cheng) to appoint Dr. Krikor Simonian as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Medina) to appoint Dr. Harjinder Singh as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Olague) to appoint Dr. James C. Standring as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Yu) to appoint Dr. Yusuke Suzuki as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Felsenfeld/Cheng) to appoint Dr. Ann Wei as an evaluator for the moderate sedation onsite inspection and evaluation program.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.

Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 14: Enforcement
Agenda Item 14.a.: Presentation of "Attorney General's Annual Report on Accusations Prosecuted for Department of Consumer Affairs Client Agencies, Business and Professions Code Section 312.2, January 1, 2025"
Carl Sonne, Senior Assistant Attorney General, Office of the Attorney General (OAG), Department of Justice, provided a verbal update and presentation on the Attorney General's Annual Report.

Board Member David asked what the Board can do to help drive continuous improvement in the measures that Mr. Sonne went over. Mr. Sonne responded that staffing is always an issue that he knows their clients are seeking, which is to have the adequate number of personnel to evaluate and investigate cases. He added that is not unique to the Board and is true for all agencies. Mr. Sonne stated that getting the very best can sometimes be a lot of effort. When the OAG hires and interact with client agency personnel, they are high quality people. When there is a retirement, it can take time to fill those positions. He noted all of the evaluators the Board approved in the prior agenda item and stated it is that type of work to make sure staffing is complete as best as you can do. He stated that really helps their work, seeing the client has all the resources it needs to send their cases to the OAG for evaluation.

Ms. Welch conveyed that the Board's Deputy Attorney General (DAG) Liaison, Daniel McGee, is outstanding. She noted that Mr. McGee's institutional knowledge of OAG and Board procedures is extremely helpful, especially when the Board goes through Executive Officer transitions. She added that his willingness to assist the client is also outstanding. She noted recent instances where Mr. McGee had to quickly pivot to represent the Board on an expeditious manner, and she appreciated his abilities and the assistance he provides to the Board.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 14.b.: Review of Statistics and Trends
Ryan Blonien provided the report, which is available in the meeting materials. Mr. Blonien expressed that Board staff is currently in the process of hiring two sworn peace officers and two special investigators.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 15: Substance Use Awareness
Agenda Item 15.a.: Diversion Program Report and Statistics
Ms. Bell provided the report, which is available in the meeting materials. Ms. Bell noted a correction to the table from the November 2024 Board meeting memorandum. The number of participants was incorrect, and this has been corrected in the current table. She added that as of January 1, 2025, the Board has a new program administrator, Premier Health Group.

President Chan requested public comment on this item. There were no public comments made on this item.

At 2:45 p.m., the Board recessed for a break.

At 3:01 p.m., the Board reconvened.

Agenda Item 16: Executive Officer Recruitment and Selection Process
Agenda Item 16.a.: Presentation from DCA, Office of Human Resources on Executive Officer Recruitment and Selection Process
Catherine Bachiller provided a verbal report on the EO recruitment and selection process.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 16.b.: Discussion and Possible Action on Process for Recruitment and Selection of an Executive Officer
Ms. Bachiller provided the report, which is available in the meeting materials.

Ms. Bachiller reported that Dr. Montez has reviewed the duty statement and recruitment announcement, and her edits have been incorporated. She added that the OHR has also reviewed the documents to bring standard language current.

Board Member David asked whether this is similar to how other health licensing boards do recruitments for executive officers. Ms. Bachiller responded that the process is essentially the same.

(M/S/C) (Chan/Felsenfeld) to delegate to the DCA Office of Human Resources the authority to advertise the position of Executive Officer and coordinate and set interviews of candidates for the position.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

Agenda Item 16.c.: Review and Possible Action on Revised Executive Officer Duty Statement and Recruitment Announcement
Ms. Bachiller provided the report, which is available in the meeting materials.

(M/S/C) (Felsenfeld/Medina) to adopt the Executive Officer Duty Statement, as shown in the meeting packet.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.
Recusals: None.

The motion passed.

(M/S/C) (Chan/Yu) to approve the Recruitment Announcement, as shown in the meeting packet.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, David, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: None.

Recusals: None.

The motion passed.

Agenda Item 16.d.: Discussion and Possible Action on Appointment of an Executive Officer Selection Committee
President Chan recommended that he and Vice President Felsenfeld populate the Executive Officer Selection Committee.

Agenda Item 17: Recess Open Session Until February 7, 2025, at 8:30 a.m.
President Chan recessed Open Session at 3:17 p.m.

Agenda Item 18: Convene Closed Session
At 3:25 p.m., the Board convened Closed Session

Agenda Item 19: Pursuant to Government Code Section 11126(a)(1), the Board will Meet in Closed Session to Discuss and Take Possible Action on Appointment of an "Acting" or "Interim" Executive Officer
The Board convened in Closed Session to discuss and take possible action on the appointment of an Acting or Interim EO.

Agenda Item 20: Pursuant to Government Code Section 11126(c)(3), the Board will Meet in Closed Session to Deliberate and Vote on Disciplinary Matters, Including Stipulations and Proposed Decisions
The Board convened in Closed Session to discuss disciplinary matters.

Agenda Item 21: Adjourn Closed Session
President Chan adjourned Closed Session at 4:35 p.m.

## 8:30 a.m., Friday, February 7, 2025

Agenda Item 22: Reconvene Open Session – Call to Order/Roll Call/Establishment of a Quorum
President Chan called the meeting to order at 8:35 a.m. Board Members Joni Forge, DDS, and Yogita Thakur, DDS, MS, participated remotely and confirmed there were no individuals 18 years of age or older present in the room at their remote locations in compliance with Government Code section 11123.2, subdivision (j)(4).

Secretary Larin called the roll; nine Board Members were present, and a quorum was established. Board Member David was absent.

Agenda Item 23: Board President's Report on Closed Session Items
President Chan provided a verbal report regarding Closed Session items. He reported that the Board voted to appoint an Interim Executive Officer effective on the retirement

date of the current Executive Officer. An announcement regarding who the appointed person is will be made after the confirmation of the satisfaction of all Executive Officer appointment requirements. Additionally, the Board voted to reject and submit a counteroffer to a stipulated settlement. The Board also voted to adopt a proposed decision, adopt a proposed decision with a reduced penalty, reject and remand a proposed decision, and grant a motion to vacate a default decision.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 24: Presentation from California Northstate University, College of Dental Medicine

Dr. Kevin Keating, Dean and Professor at California Northstate University (CNU), College of Dental Medicine (CDM), provided a verbal presentation on the status of accreditation and development of CNU CDM.

Vice President Felsenfeld noted the school has 180 chairs and 150 students and asked whether all of the clinical experiences are going on at the school or whether they are going out into the community into underserved areas to help fulfill some of their needs with the students getting that experience. Dr. Keating responded that to be able to go out into the community, you have to have a level of competence. Therefore, before they are there, they had to get to that phase before being released. CNU has its D4 cohort do eight weeks of community rotation, which is nonacademic and experiential learning where they do get frequency. Additionally, they are also doing volunteer programs and have been working with Adventist Health and going out to their church communities to provide free clinics, going around with Adventist Health using their D3s, D4s, and then D2s that can then come in and have reached a certain level of safety as they now are sharps trained.

Vice President Felsenfeld asked how many faculty members CNU has for its 150 students. Dr. Keating responded they have 68 faculty at the moment. Of the 12 specialties that exist, Vice President Felsenfeld asked how many of them are being taught by those specialists within the school. Dr. Keating responded that the Commission on Dental Accreditation (CODA) expectation is to have the expertise in order to do that. As CNU is a general dental program with no residencies, that does mean they have specialists teaching along with general dentists. He added that it is a challenge at all the colleges around the United States with shortages in the specialty category. However, they do have faculty that cover all the areas of expertise.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 25: Update, Discussion, and Possible Action on Legislative Proposals

Agenda Item 25.a.: Legislative Proposal to Amend Business and Professions Code (BPC) Section 1638.1 Regarding Elective Facial Cosmetic Surgery Permits

Ms. Ortiz provided the report, which is available in the meeting materials.

(M/S/C) (Felsenfeld/Yu) to approve for submission to the California State Legislature the legislative proposal to amend BPC section 1638.1 regarding elective facial cosmetic surgery permits.

President Chan requested public comment before the Board acted on the motion. There were no public comments made on the motion.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: David.
Recusals: None.

The motion passed.

Agenda Item 25.b.: Legislative Proposal to Amend BPC Sections 1725, 1750, and 1753.52, and Repeal BPC Sections 1754.5 and 1755 Regarding Dental Assisting Courses

Mr. Nelson provided the report, which is available in the meeting materials.

Ms. Welch reviewed the new legislative proposal handout and stated that regarding page 2, the proposed amendments to BPC section 1725 would insert a new subdivision (l), this new provision establishes Board approval application fees in the amount of $300 for the interim therapeutic restoration (ITR) course. She added that at the moment, the ITR statute refers to the application fees established in regulation, but there is no such regulation establishing that fee. So that this ITR course can be quickly provided and approved by the Board, the fee would be set at $300, which is consistent with all other application fees for these types of courses. She stated the fee was already contemplated in the new ITR statute, and Board staff is merely changing the citation to the statute instead of the regulation. This provision would also establish the approval application fee for the radiation safety and infection control courses added by Senate Bill (SB) 1453 and similarly set those fees at $300. The radiation safety course and regulatory infection control course [application fees] are already established at $300 in the regulation, and Board staff is merely establishing those fees in statute as these are effectively new courses. Ms. Welch stated that for the radiation safety course, Board staff is proposing amendments to that statute [BPC section 1754.5] with the intent of repealing the existing radiation safety course regulations, [CCR, title 16, sections] 1014 and 1014.1. If those regulations are ultimately repealed because the Board has done a good job of incorporating consumer protection measures into the statute, the regulation setting the $300 fee for the existing radiation safety course would need to be in statute.

That is what this legislative proposal does. As far as the infection control course fee, that is going to be added here. Ms. Welch noted the infection control course in new BPC section 1755 applies only to certain individuals; it does not apply to certain RDA license applicants. Otherwise, those folks have to refer to the infection control course established in regulation. Because these are two different courses, the Board is going to establish a $300 application fee for that BPC section 1755 infection control course. Regarding the amendments to BPC section 1753.52 on page 2, Ms. Welch conveyed that this is where the change would be made to no longer cite to a fee established in regulation for the ITR course as it currently does not exist in regulation. Instead, it would refer to BPC section 1725, so the ITR course approval application fee is in statute not regulation.

Regarding amendments to BPC section 1754.5 on page 7, Ms. Welch noted that Board staff is adding some additional clarifying language so that the Board, in lieu of conducting its own investigation regarding an application to offer a radiation safety course, could accept the findings of any commission or accreditation agency approved by the Board and adopt those findings as its own. She added that a lot of the changes contemplated in this statute were previously reviewed and approved by the Board in the dental assisting course rulemaking She believed those materials are posted on the Board's August 2023 Board meeting. She voiced that this reflects the changes the Board previously reviewed and approved with the understanding that the dental assisting education program and course rulemaking is currently on hold pending revisions by the Board's Regulations Counsel. Ms. Welch stated the amendments are intended to reflect the modernization of those regulations previously requested by the Board. Ms. Welch noted the proposed amendments also establish laboratory and clinical instruction facility requirements, which are also modeled on the language previously approved by the Board for that dental assisting education program and course rulemaking. She stated that on page eight of the handout, the proposed amendments clarify what laboratory instruction is, and this language reflects what is currently the definition for laboratory instruction in regulation. Similarly, amendments would be made to clarify the meaning of clinical instruction based on the Board's existing regulatory definition for clinical instruction. On page nine, the amendments would establish some protocol for offering the didactic instruction portion of the course through electronic distance learning. This is intended to protect prospective students of the course so they are aware of the computer technology requirements to successfully complete the didactic instruction through electronic distance learning modalities and also provide them with technological assistance if they are having trouble connecting to the course. Ms. Welch noted this language would be inserted into the statute for student protection with the understanding that the Board is not an educational oversight entity; the Board is primarily a licensing and regulatory body. The language attempts to provide some protection for students taking these courses through electronic distance modalities.

Ms. Welch stated Board staff is also proposing to make some additional clarifying amendments in that section based upon existing regulation and/or the Board's

previously approved amendments to the regulatory provisions. On page 10 of the new proposal, the amendments to BPC section 1755 would better clarify this new infection control course statute made effective through SB 1453. The proposed amendments to subdivision (b) are intended to allow a dental assistant, who previously took or wants to take a Board-approved education program's infection control course currently authorized in regulation or an eight-hour infection control course currently authorized in regulation, to be able to use any of those infection control courses to satisfy this requirement under BPC section 1755, in effect grandfathering in those individuals who have already completed the infection control course. She noted that as it stands, BPC section 1755 sets up a new requirement for dental assistants to take a six-hour didactic and two-hour laboratory instruction course; courses taken through an education program or regulatory infection control course would not satisfy the new statutory requirement. The language is intended to accommodate dental assistants who have already completed the infection control course, so they are not waiting, trying to get access to the new eight-hour course of six hours of didactic instruction and two hours of laboratory instruction.

Additionally, the amendments on page 10 establish clarifying amendments for how to apply to offer the infection control course. Ms. Welch stated page 11 continues those clarifying amendments to establish the information that needs to be provided in the application. As these provisions related to the course director requirements are based on existing regulation, this would establish requirements for course documentation modeled on the regulations. Similar to the radiation safety control course protections for electronic delivery of instruction, the proposed amendments would add the same student protections for delivery of the infection control course electronically. She stated that page 12 better clarifies the didactic instruction requirements and establishes laboratory instruction requirements. On page 13, the amendments would require the student to pass a written examination reflecting the infection control course curriculum. In subdivision (d), the amendments would add an additional requirement for infection control course certificates of completion to state the statutory authority for which the course has been approved. This would assist Board staff in understanding how the individual satisfied the requirement for the infection control course under BPC section 1755, whether they satisfied the requirement by taking a course through an educational program, regulatory infection control course, or electronic course as established in BPC section 1755. The amendments in subdivision (e) would establish a process for Board approval, denial, or withdrawal. These amendments would also better direct the infection control course to what Board staff understands is the real need to get unlicensed dental assistants access to infection control courses now that SB 1453 amended BPC section 1750 to require an unlicensed dental assistant to take an infection control course before providing any dental services that involve infection control. She stated what Board staff has heard is dental offices in rural areas have limited access to the infection control courses provided by an education program and infection control courses offered under regulation. The purpose of BPC section 1755 was to provide better access to those rural communities through electronic delivery of the infection control course. Board staff have done what they can [in this proposal] to

maintain that electronic delivery for unlicensed dental assistants to assist dental offices in hiring individuals. For consumer protection purposes, the proposed amendments would remove the ability for only some RDA license pathway applicants to take the electronic infection control course while other RDA license pathway applicants are unable to fulfil the infection control course requirement utilizing the electronic course. She noted that RDAs have expanded duties above what unlicensed dental assistants can do. Board staff understand the real issue is electronic access for unlicensed dental assistants. The statute [BPC section 1755] unfortunately set up a situation where some RDA license applicants can take the electronic course but other license applicants have to take the course that includes clinical instruction. Board staff heard from stakeholders that clinical instruction better protects consumers because the students are receiving better information on exactly how to protect patients from infection. The amendments would direct the electronic courses solely to unlicensed dental assistants, so that all RDA license, orthodontic assistant, and dental sedation permit applicants would continue to take the eight-hour infection control course offered by an education program or infection control course provider under regulation, and all RDA license and permit applicants are better prepared, have better knowledge, and practical experience to protect dental patients from infection. It does not make sense to have some RDA license pathway applicants receive clinical instruction, while other RDA license pathway applicants can do it electronically [without clinical instruction]. Because of the information received from stakeholders that the real issue is improving access for unlicensed dental assistants to infection control courses, the amendments would direct the new electronic course to those individuals who have fewer duties involving infection.

Secretary Larin stated the [University of California, San Diego (UCSD)] Pre-Dental program is the biggest dental program in the country run by the pre-dental students offering four or five clinics around San Diego. She stated the UCSD Pre-Dental program students are worried about the eight-hour infection control [course], because these pre-dental students volunteer at those clinics and the students are not full-time [employees] but volunteer. The students are prepared for infection control; they get two hours of infection control training, OSHA training, and basic dental assisting training. The pre-dental students want to know if the eight-hour infection control [course requirement] applies to them. Secretary Larin told them the requirement would apply to the pre-dental students. The pre-dental students think the course requirement would be a burden for them because of the cost. Secretary Larin wondered if the Board could at some point create an online course or something that would not cost as much. The pre-dental students said the course requirement would be prohibitive and they would not be able to volunteer. Secretary Larin noted this issue probably applies in other volunteer situations, such as CDA Cares.

Tina Vallery responded that the hard part is that in those situations, it is unclear to Board staff if they are working in their capacity as a student under a dental program or if they are working as just strictly a volunteer and what duties they are performing. She voiced that this infection control course is required strictly for those working as an unlicensed dental assistant, and therefore they would be performing the duties of an

unlicensed dental assistant. Ms. Vallery indicated that she is unsure where these students or volunteers fall under. If they are performing the duties of an unlicensed dental assistant and working just strictly as a volunteer, then this course technically would apply to them. She suggested that if those organizations reach out, she can provide some guidance.

Ms. Welch believed it was important to discuss the legislative proposal in the meeting materials. She said initially Board staff were talking with stakeholders, after the November meeting presentation on the practical and implementation problems with BPC section 1755. After the stakeholder conversations, Board staff tried to figure out how to amend the radiation safety and infection control course statutes [BPC sections 1754.5 and 1755]. Board staff thought about the limitations of the Board in coming up appropriate educational course requirements. She acknowledged the urgent issue with BPC section 1755, which is in effect, and noted that as explained during the November meeting, Board staff is unable to implement BPC section 1755 because there are no implementing regulations for that statute. That process is going to take years and involves the dental assisting education program and course rulemaking that the Board has been working on for years and continues to be on hold. Ms. Welch noted the Board is receiving a lot of communication from practitioners on how to comply with the new law. To quickly resolve the issues, it seemed best to repeal the radiation safety and infection control course statutes; that way, existing regulations [for those courses] would continue to control while Board staff worked with stakeholders to flesh out the issues with the understanding that unlicensed dental assistants need access to the courses. Following additional conversations the week of this Board meeting, Board staff understood the Legislature has just created these two new statutes, so it would be better to flesh out the existing statutes with appropriate revisions to resolve the Board's concerns and maintain electronic delivery of the infection control course. These are the reasons why Board staff is recommending the Board approve the legislative proposal distributed on Wednesday [handout].

President Chan clarified the issue for the Board is whether to repeal the statutes or amend them. Ms. Welch noted that Option 1 in the meeting materials does not reflect the new legislative proposal distributed on Wednesday. She stated if the Board desires to move the new legislative proposal with amendments to BPC sections 1754.5 and 1755, but no amendments to BPC section 1750, Ms. Welch could provide that motion language. But if the Board desires to move the legislative proposal in the meeting materials to repeal BPC sections 1754.5 and 1755, that motion is reflect on page 353 of the meeting materials [Option 1].

Ms. Welch also clarified the amendments in the first legislative proposal to BPC section 1750 would have delayed the requirement for unlicensed dental assistants to complete the infection control course within 60 days of hiring. Board staff offered that amendment because stakeholders said if the Board tried to resolve the implementation issues with the radiation safety and infection control course statutes by repealing the statutes, and then work on better fixes to the statutes, then practitioners needed a way to access the

courses and would need a delay of implementation. So, Board staff initially recommended changes to BPC section 1750 to respond to that concern, but since the new recommendation from Board staff is to amend the radiation safety and infection control statutes [BPC sections 1754.5 and 1755], so that process would be completed this year rather than in a year or two, Board staff believe changes to BPC section 1750 are no longer necessary to respond to the [delayed implementation] concern. She also noted the Legislature has already determined that unlicensed dental assistants need to take the infection control course prior to performing basic supportive services on patients involving infectious material.

Dr. Forge requested information on delay for implementation for clinicians and unlicensed dental assistants, and since some of the provisions moot each other, is it better to work on amending or repealing the statutes. Ms. Welch responded Board staff received information that the preference is to amend the existing statutes rather than repealing the statutes that were just made effective and confirmed that amending the statutes would mean the Board moving the new legislative proposal to the Legislature.

Dr. Felsenfeld inquired which of the two proposals would be more facilitating of getting people doing things appropriately. He noted Ms. Welch said one of the proposals would be faster than the other, but he needed clarification on the proposals. Ms. Welch responded that in terms of success and efficiency, the new legislative proposal likely will have better success at the Legislature. She understood there may be some additional things to work out; the Board could authorize its Executive Committee to work with stakeholders and the Legislature to resolve any issues that come up on the legislative proposal. She stated that for efficiency and to resolve the concerns quickly, but also move something that likely will have a greater success, that would be the new proposal. Mr. Nelson also noted the new legislative proposal was recommended by the DAC to the Board.

(M/S/C) (Cheng/Felsenfeld) to approve the recommendation for submission to the California State Legislature the legislative proposal to amend Business and Professions Code sections 1725, 1753.52, 1754.5, and 1755 regarding dental assisting courses, and authorize the Executive Committee to work with the Legislature and stakeholders to resolve any concerns with the legislative proposal.

Secretary Larin inquired whether the legislative proposal would include the amendment for the extension of the period for implementation. Ms. Welch responded no and explained that if [the implementation] is still a problem, stakeholders who raised that concern can work with the Legislature to make that change. She did not recommend that change because it is existing law and Board staff was only trying to accommodate the concern raised in response to the initial recommendation to repeal [BPC sections 1754.5 and 1755]. The new direction is to better resolve the issues by amending [BPC sections 1754.5 and 1755]. At this point, she did not know what would be the Board's justification for proposing the [delayed implementation] amendment to BPC section 1750.

President Chan requested public comment before the Board acted on the motion. The Board received public comment.

Melodi Randolph, representing the Alliance, stated that overall, with the compromises that have gone back and forth with CDA, the Alliance believes the new recommendation is the best compromise and achieves the best of what needs to be achieved. She communicated they are encouraged by the changes in [the new legislative proposal] and the delineation between the virtual being only for unlicensed dental assistants and the existing eight-hour infection control for anyone seeking licensure. She stated that was a great improvement. She pointed out that BPC section 1754.5 on the radiation safety courses is not addressing any information on who the qualifications for the director or the faculty and is in the infection control course [statute amendments]. She believes that needs to be added, and vice versa, BPC section 1754.5(c) regarding the re-evaluation process is in the X-ray [statute] but not in the infection control [course amendments]. She noted that if the Board is trying to make these courses reflective and include the same information, then that needs to be reviewed. Ms. Randolph added that the tone of BPC section 1754.5(e), on page 8 of the handout, where it says “supervised experience performing procedures using study models “and then again in the last sentence “supervised experience in performing procedures,” suggests that the student is doing this on their own with supervision. She noted there is general supervision for X-rays, so the doctor does not even have to be in the building. Ms. Randolph suggested that the word “experience” should be changed to “instruction” as this is a class, and it should be instruction. Additionally, Ms. Randolph voiced they agree with not including the allowance for 60 days to get the virtual course done. She reiterated that if an eight-hour virtual course is approved, the person could be hired on Monday, complete the virtual course on Tuesday, and begin working on Wednesday.

Ms. Zokaie, representing CDA, stated she is thankful for diving into this significant concern for CDA members. As she shared at the DAC meeting the day before, CDA is seeing a 25% increase in concerns related just to this issue. While there are no proposed amendments in the legislative proposal to BPC section 1750(c), it is part of the agenda item, and that is where it talks about the course needing to be taken before exposure to blood and saliva. CDA strongly recommends amending that language to 90 days. One of the reasons for this is that they heard from their members that when they hire someone to be an unlicensed dental assistant, there is not a course available, and while there is language about an online course being acceptable, currently one does not exist. The reality at this time is the language is inaccessible because before exposure to blood and saliva, especially in rural areas which is the most necessary area to have these unlicensed dental assistants working and helping support patients and the dental offices. If [the dental assistants] are not able to take the course, they cannot start. CDA asks the Board to consider amending BPC section 1750(c) to 90 days and provide guidance to dentist employers who are unable to get new unlicensed dental assistants enrolled in a course in a timely manner. She explained if there is not a course available, if they have looked and are in an area where an in-person course is not available, how can they

document that they are not able to take a course and there is not a course close enough to the practice or where the employee lives to take the course. CDA would appreciate guidance on what to tell their dentists who are hiring unlicensed dental assistants and want them to work and protect patient safety.

Dr. Whitcher echoed Ms. Zokaie's comments and added that everyone who has been in clinical practice understand there has to be an onboarding interval where new hires are brought on; they are not just turned loose, or at least they should not be. They are paired up with an experienced assistant who shows them around. At the end of the point where they have reached some degree of competency, then they get sent off for training at that point, because this represents a significant investment, both in their time and the employer's time and money. Dr. Whitcher voiced there needs to be this delayed implementation. From a practical standpoint, to have an abrupt entry point where you are not eligible to do anything until you take this course, he believes is going to cause problems.

William Kushner, representing California AGD as well as Academy General Dentistry as a Regional Director, conveyed they support properly trained staff, including dental assistants and non-licensed dental assistants, for their safety. However, he believes for their members this is a challenge with getting enough of those staff members trained properly to meet the criteria of the legislation timely. He agreed with CDA with respect to extending that time frame to 90 days. Speaking as an individual, regarding the legislation of BPC section 1755, he would like to see some changes with respect to the American Society for Testing and Materials (ASTM) mask levels and use of respiratory protection as part of a respiratory protection plan included in that training.

Ms. Becker, representing the Alliance, concurred with Ms. Randolph's previous comments and reminded everyone that the DAC brought this forward at their meeting, and that was proposed and brought forward. She added the unlicensed dental assistant has needed to be trained in an infection control course since January 1, 2010, and that that allowed 120 days of employment and gave the employer 12 months to get their dental assistants in compliance. Ms. Becker expressed they see a lot of unlicensed dental assistants, who have been currently practicing and have not been compliant with [the infection control course requirement, come through and take their courses.

Ms. Canham concurred with Ms. Randolph and Ms. Becker with regard to the availability of the courses and the fact that dentists have known since 2010 that their unlicensed dental assistants need to take this eight-hour infection control course. When dentists take their DPA course biannually to renew their license, their memory is refreshed of this requirement. She added there has been knowledge out there, and it has been in existing law since 2010. Ms. Canham noted the other thing that would make it more easily accessible to dentists is the list of 170 providers of the eight-hour infection control course, and the PDF on the Board's website does not delineate between the standalone programs and the dental assisting programs that only offer this eight-hour infection control course to their own students. She recommended that when the new provider list is made

available, there is some information that helps to direct dental assistants to which is a standalone program and which is not.

Dr. Montez reminded the Board this legislative proposal is an alternative being brought to the Board in response to stakeholder comment and is in addition to what was seen in the Board meeting packet. The intent of this proposal is to clarify certain sections that would allow the Board to implement this provision of its Sunset bill that the Board clearly stated at its November meeting it could not do. She conveyed Board staff recognize that all of the details may still need some regulatory work. She reiterated in response to stakeholder concerns, this was the most immediate and best approach to take at this time, and the intent here is not to vet it and change it but rather to do that as this proposal goes through the legislative process and/or through the regulatory process. Dr. Montez added Board staff is trying to recognize the intent here was for a virtual option of this course, as well as it being taken immediately for unlicensed dental assistants; those were the key public or consumer patient protections. She stated comments can continue to be included as the proposal works through the process, but the goal at this meeting was not to pick apart each section or element of that to stay true to what the Legislature approved in SB 1453, which was echoed by Ms. Randolph and Ms. Welch. She encouraged the Board to consider that the DAC recommended the Board approve the proposal as presented.

President Chan called for the vote on the motion. Secretary Larin took a roll call vote on the motion.

Ayes: Chan, Cheng, Felsenfeld, Forge, Larin, Medina, Olague, Thakur, Yu.
Nays: None.
Abstentions: None.
Absent: David.
Recusals: None.

The motion passed.

Agenda Item 26: Update, Discussion, and Possible Action on Legislation Impacting the Board, DCA, and/or the Dental Profession
Agenda Item 26.a.: 2025 Tentative Legislative Calendar – Information Only
Mr. Nelson provided an overview of the 2025 Tentative Legislative Calendar, which is available in the meeting materials.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 26.b.: Legislation of Interest
Mr. Nelson provided the report, which is available in the meeting materials.

President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 27: Public Comment on Future Agenda Items
President Chan requested public comment on this item. There were no public comments made on this item.

Agenda Item 28: Adjournment
President Chan adjourned the meeting at 10:12 a.m.

*Agenda item heard out of order; the meeting minutes reflect the order of business as noticed in the Board meeting Agenda

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

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|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 4.:** Board President Report |

## Background

Dr. Steven Chan, President of the Dental Board of California, will provide a verbal report.

## Action Requested

No action is requested.

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# MEMORANDUM

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|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 5.:** Assistant Executive Officer Report |

## Background

Christy Bell, Assistant Executive Officer of the Dental Board of California, will provide a verbal report.

## Action Requested

No action requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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# MEMORANDUM

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|---|---|
| **DATE** | April 9, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 6.:** Report on Department of Consumer Affairs (DCA) Activities, which may include updates on DCA's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters |

## Background

The Department of Consumer Affairs Board and Bureau Relations will provide a verbal report.

## Action Requested

No action requested.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

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|---|---|
| **DATE** | April 14, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Yvette Ramirez, Budget and Contract Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 7.:** Budget Report |

## Background

The Dental Board of California (Board) administers the State Dentistry Fund (Fund), which derives revenues (primarily) through licensing-related fees to fund the Board's administrative, licensing, and enforcement activities.

The Board receives the legislated annual budget appropriation upon the chaptering of the Budget Act. The Board is statutorily required to remain within its appropriation spending limit and to ensure the Fund's ongoing solvency.

## 2025-26 Governor's Budget

The following chart provides an overview of the Governor's Budget for the 2024-25 fiscal year for the Dental Board of California.

| 2025-26 Governor's Budget: Fiscal Year 2024-25 | | |
|---|---|---|
| **Fund** | **Revenue** | **Expenditures*** |
| **State Dentistry Fund** | $23,883,000 | $20,272,000** |

*$283,000 (net) reimbursements – probation monitoring and fingerprints

**Projected expenditures reduced $355,000 from the 2024-25 Budget Act to the 2025-26 Governor's Budget due to Section 3.60 Pension Contribution Adjustment of -$722,000. This reduction was partially offset by the $237,000 Allocation for Employee Compensation and $131,000 Allocation for Staff Benefits.

## Analysis of Fund Condition Statement (see Attachment 3):

The attached fund condition statement (FCS) is based on the 2025-26 Governor's Budget. It has been updated with 2024-25 expenditure and revenue projections, which

resulted in a fund balance reserve of $25.3 million (14.0 months). Other adjustments have also been included.

**Revenues (See Attachments 2&3)** – The Board began 2024-25 with a fund balance of $19.2 million and is projected to collect approximately $20.4 million in revenues with $3.5 million from initial license fees and $15.1 million from license renewals.

The Board notes, SB 501, Dentistry: anesthesia and sedation: report (Chapter 929, Statutes of 2018), created additional anesthesia permit and certificate types and fees. The Office of Administrative Law approved this regulatory action in August of 2022. The first two years of implementation earned $172,000 and $284,000 of permit applicant revenue. Revenue fluctuates the first two years of implementation as existing permit holders transition to the new permit types but permit applicant revenues are estimated at $234,000 per year.

**Expenditures (see Attachment 1&3)** – The Board's 2024-25 appropriation is $19.8 million. This includes an estimated $432,000 net adjustment tied to the 2024 Budget Act funding reductions. See Control Sections 4.12 and 4.05 below for more information. Meanwhile, expenditures are projected to be $18.4 million. The FCS projects ongoing expenditures in the future with a three percent (growth factor) increase per year. The FCS also shows the Board fully expending its appropriation ongoing which has not been the trend in recent years. To the extent the Board does not fully expend its appropriation, any savings remains in the Fund for future use.

Overall expenditures are projected to rise in future years. Personnel services, investigation costs, and statewide contributions make up the largest portion of the increases in out years.

The Board notes, future legislation or other events could require the Board to request additional resources through the annual budget process, which would increase cost pressure on the Fund.

**2024 Budget Act** – The 2024 Budget Act puts the state, including the Board, on a long-term plan of budgetary reductions in 2024-25 and beyond. According to Budget Letter (BL) 24-10, the Department of Finance (DOF) will work with all state agencies in the coming months, to implement the two required budgetary reductions described below:

- **Control Section 4.12:** Vacant Positions Funding reduction and Elimination of Positions – Beginning in 2024-25 and continuing in 2025-26, agency budgets will be reduced by $1.5 billion ($762.5 million General Fund [GF]) for savings associated with vacant positions. Participation by all agencies and departments is encouraged. In 2025-26, Finance will also adjust the position authority to eliminate approximately 6,500 positions statewide.

Per the Business, Consumer Services, and Housing Agency and the DOF, the Board was tasked with identifying 4.0 authorized positions for elimination. However, after working with the Department of Consumer Affairs (DCA) Budget Office to address concerns with the elimination of mission critical positions, the Board selected only two positions for elimination. Accordingly, the Board's budget will be reduced $285,000 beginning in 2024-25, and its position authority will be reduced by two positions beginning in 2025-26.

- **Control Section 4.05: Ongoing Reduction to State Operations** – Beginning in 2024-25 and ongoing, agency budgets will be reduced by 7.95 percent, which includes, personal services, operating expenses and equipment, and consulting and professional services funded through General Fund and/or Other Funds.

  The Board's budget reduction will be a $147,000 permanent budget cut beginning in 2024-25. This cut would come from expenditure categories with historically significant savings in the past three fiscal years including: travel, communications, exam proctor, expert examiner, and interdepartmental services.

**General Fund Loan** – Item 1111-011-0741, Budget Act of 2020, authorizes a $5 million loan transfer from the Fund to the GF. The loan is required to be repaid with interest in the event the Board needs the funds, or if the GF no longer needs the funds.

The interest rate for the Budget Act of 2020 loan will be .67% and is scheduled to be repaid on June 30, 2025.

Board staff notes, the $5 million repayment will be coordinated as part of any future regulatory and/or statutory fee increase proposals.

**Fund Balance Months in Reserve** – The fund balance reserve reports the dollar amount remaining in the Fund at the end of any given fiscal year. This is used to calculate the Months in Reserve balance based on projected expenditures for the next fiscal year. Typically, a healthy fund has about 3 to 6 months in reserve.

The fund balance reserve is currently stable but does show a declining balance in future years due to a structural imbalance caused by the fund's revenues projected to stay stationary, and the fund's expenditures to increase by 3%. The fund should remain healthy through 2027-28, although, unforeseen expenditures can cause this to change.

**Structural Imbalance** – A structural imbalance occurs when projected revenues are less than anticipated expenditures.

**Action Required (future)** – The Board will continue to monitor the Fund and work with DCA Budget Office to ensure solvency.

The Board had significant 2022-23 prior-year savings of approximately $2.7 million related to vacant positions. However, the Board is actively recruiting to fill these positions and any savings will likely be reduced in the future as the positions are filled. As of April 2025, the Board has a 9% vacancy rate.

The Board further notes, most existing license fee types currently being assessed are set below their statutory maximums and will be increased through regulations, which could eliminate the existing structural imbalance. Proposals for regulatory fee changes typically take 18 to 24 months to promulgate.

Board staff will be working with the DCA Budget Office to identify possible actions to reduce or eliminate the structural imbalance to ensure the Board remains solvent and able to fully meet its licensing and enforcement mandates.

Board staff will present the findings and recommendations at future board meetings to allow for public input and Board Member consideration.

## Action Requested

This item is informational only. No action requested.

# Attachment 1

**Department of Consumer Affairs**

**Expenditure Projection Report**

**Dental Board of California**
**Reporting**
**Structure(s):**
**Fiscal Month: 8**
**Fiscal Year: 2024 - 2025**
Run Date: 03/20/2025

**PERSONAL SERVICES**

| Fiscal Code | Line Item | PY Budget | PY FM13 | Budget | Current Month | YTD | Encumbrance | YTD + Encumbrance | Projections to Year End | Balance |
|---|---|---|---|---|---|---|---|---|---|---|
| 5100 | PERMANENT POSITIONS | $7,333,000 | $6,202,335 | $7,263,000 | $546,011 | $4,429,610 | $0 | $4,429,610 | $6,612,849 | $650,151 |
| 5100 | TEMPORARY POSITIONS | $284,000 | $13,362 | $284,000 | $3,919 | $100,491 | $0 | $40,996 | $125,675 | $158,325 |
| 5105-5108 | PER DIEM, OVERTIME, & LUMP SUM | $130,000 | $19,561 | $130,000 | $500 | $11,832 | $0 | $11,832 | $77,770 | $52,230 |
| 5150 | STAFF BENEFITS | $4,405,000 | $3,753,409 | $3,944,000 | $286,638 | $2,309,483 | $0 | $2,309,483 | $3,481,073 | $462,927 |
| PERSONAL SERVICES | | $12,152,000 | $9,988,668 | $11,621,000 | $837,067 | $6,851,415 | $0 | $6,851,415 | $10,297,368 | $1,323,632 |

**OPERATING EXPENSES & EQUIPMENT**

| Fiscal Code | Line Item | PY Budget | PY FM13 | Budget | Current Month | YTD | Encumbrance | YTD + Encumbrance | Projections to Year End | Balance |
|---|---|---|---|---|---|---|---|---|---|---|
| 5301 | GENERAL EXPENSE | $167,000 | $150,827 | $375,000 | $3,584 | $40,943 | $11,524 | $52,467 | $150,141 | $224,859 |
| 5302 | PRINTING | $85,000 | $156,201 | $75,000 | $9,320 | $22,937 | $124,859 | $147,797 | $156,912 | -$81,912 |
| 5304 | COMMUNICATIONS | $47,000 | $33,343 | $47,000 | $828 | $12,474 | $0 | $12,474 | $51,841 | -$4,841 |
| 5306 | POSTAGE | $54,000 | $60,464 | $54,000 | $19,602 | $45,523 | $194 | $45,717 | $63,642 | -$9,642 |
| 5308 | INSURANCE | $2,000 | $19,301 | $2,000 | $0 | $18,850 | $0 | $18,850 | $19,011 | -$17,011 |
| 53202-204 | IN STATE TRAVEL | $170,000 | $59,207 | $152,000 | $6,199 | $39,717 | $0 | $39,717 | $96,200 | $55,800 |
| 53206-208 | OUT OF STATE TRAVEL | $0 | $0 | $0 | $0 | $1,000 | $0 | $1,000 | $6,072 | -$6,072 |
| 5322 | TRAINING | $12,000 | $7,822 | $12,000 | $0 | $2,200 | $264 | $2,464 | $14,300 | -$2,300 |
| 5324 | FACILITIES | $855,000 | $728,517 | $716,000 | $60,776 | $476,040 | $236,300 | $712,340 | $748,155 | -$32,155 |
| 5326 | UTILITIES | $1,000 | $0 | $1,000 | $0 | $0 | $0 | $0 | $0 | $1,000 |
| 53402-53403 | C/P SERVICES (INTERNAL) | $2,564,000 | $1,812,856 | $2,487,000 | $246,775 | $1,278,300 | $7,569 | $1,285,869 | $2,105,562 | $381,438 |
| 53404-53405 | C/P SERVICES (EXTERNAL) | $1,024,000 | $1,573,826 | $1,275,000 | $50,920 | $583,361 | $167,695 | $751,056 | $1,047,982 | $227,018 |
| 5342 | DEPARTMENT PRORATA | $3,405,000 | $2,965,277 | $3,384,000 | $0 | $2,555,250 | $0 | $2,555,250 | $3,288,000 | $96,000 |
| 5342 | DEPARTMENTAL SERVICES | $36,000 | $229,837 | $186,000 | $11,310 | $99,027 | $0 | $99,027 | $224,968 | -$38,968 |
| 5344 | CONSOLIDATED DATA CENTERS | $42,000 | $54,226 | $42,000 | $0 | $0 | $0 | $0 | $40,997 | $1,003 |
| 5346 | INFORMATION TECHNOLOGY | $304,000 | $32,934 | $32,000 | $1,955 | $19,732 | $18,056 | $37,788 | $52,401 | -$20,401 |
| 5362-5368 | EQUIPMENT | $112,000 | $24,572 | $89,000 | $1,013 | $3,271 | $190,810 | $194,081 | $217,719 | -$128,719 |
| 5390 | OTHER ITEMS OF EXPENSE | $5,000 | $50,186 | $5,000 | $5,230 | $34,325 | $10,021 | $44,345 | $72,031 | -$67,031 |
| 54 | SPECIAL ITEMS OF EXPENSE | $0 | $9,504 | $0 | $0 | $2,735 | $0 | $2,735 | $9,504 | -$9,504 |
| OPERATING EXPENSES & EQUIPMENT | | $8,885,000 | $7,968,902 | $8,934,000 | $417,511 | $5,235,685 | $767,292 | $6,002,977 | $8,365,438 | $568,562 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| OVERALL TOTALS | | $21,037,000 | $17,957,569 | $20,555,000 | $1,254,578 | $12,087,100 | $767,292 | $12,854,392 | $18,662,806 | $1,892,194 |
| FINGERPRINT REPORTS | | -$66,000 | -$66,000 | -$66,000 | | | | | -$66,000 | |
| EXTERNAL/PRIVATE/GRANT | | -$217,000 | -$217,000 | -$217,000 | | | | | -$217,000 | |
| OVERALL NET TOTALS | | $20,820,000 | $17,740,569 | $20,272,000 | $1,254,578 | $12,087,100 | $767,292 | $12,854,392 | $18,379,806 | $1,892,194 |
| ESTIMATED TOTAL NET ADJUSTMENTS | | | | -$432,000 | | | | | | |
| OVERALL NET TOTALS | | $20,820,000 | $17,740,569 | $19,840,000 | $0 | $0 | $0 | $0 | $18,379,806 | $1,460,194 |
| | | | | | | | | | | 7.36% |

# Attachment 2

**Department of Consumer Affairs**

**Revenue Projection Report**

**Reporting Structure(s):**
**Fiscal Month: 8**
**Fiscal Year: 2024 - 2025**
Run Date: 03/20/2025

**Revenue**

| Fiscal Code | Line Item | Budget | July | August | September | October | November | December | January | February | Year to Date | Projection To Year End |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Delinquent Fees | | $359,000 | $32,452 | $27,841 | $29,888 | $30,218 | $31,934 | $28,847 | $30,847 | $31,560 | $243,586 | $361,364 |
| Other Regulatory Fees | | $275,000 | $34,724 | $38,412 | $25,778 | $46,859 | $34,299 | $34,298 | $18,284 | $41,824 | $274,478 | $391,720 |
| Other Regulatory License and Permits | | $3,352,000 | $339,449 | $362,049 | $307,394 | $295,090 | $247,232 | $240,076 | $285,183 | $284,043 | $2,360,517 | $3,511,370 |
| Other Revenue | | $205,000 | $2,735 | $132,203 | $963 | $290,469 | $580 | $593 | $318,424 | $1,875 | $747,841 | $1,062,709 |
| Renewal Fees | | $14,692,000 | $1,625,395 | $1,856,542 | $2,206,118 | $1,295,110 | $1,224,870 | $1,197,483 | $1,367,779 | $1,173,173 | $11,946,470 | $15,055,540 |
| Revenue | | $18,883,000 | $2,034,755 | $2,417,046 | $2,570,142 | $1,957,746 | $1,538,915 | $1,501,296 | $2,020,517 | $1,532,474 | $15,572,891 | $20,382,703 |

**Reimbursements**

| Fiscal Code | Line Item | Budget | July | August | September | October | November | December | January | February | Year to Date | Projection To Year End |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Scheduled Reimbursements | | $0 | $2,597 | $2,254 | $1,862 | $2,124 | $1,813 | $2,107 | $2,303 | $2,614 | $17,674 | $232,037 |
| Unscheduled Reimbursements | | $0 | $49,431 | $31,255 | $12,298 | $40,496 | $70,874 | $65,268 | $16,886 | $40,558 | $327,066 | $554,235 |
| Reimbursements | | $0 | $52,028 | $33,509 | $14,160 | $42,620 | $72,687 | $67,375 | $19,189 | $43,172 | $344,740 | $786,272 |

# Attachment 3

**0741 - Dental Board of California Fund Analysis of Fund Condition**
**(Dollars in Thousands)**
**2025-26 Governor's Budget With FM 8 Projections**

**Prepared 4.21.25**

| | Actuals 2023-24 | CY 2024-25 | BY 2025-26 | BY +1 2026-27 |
|---|---|---|---|---|
| **BEGINNING BALANCE** | $ 17,639 | $ 19,224 | $ 25,259 | $ 23,346 |
| Prior Year Adjustment | $ 402 | $ - | $ - | $ - |
| Adjusted Beginning Balance | $ 18,041 | $ 19,224 | $ 25,259 | $ 23,346 |
| **REVENUES, TRANSFERS AND OTHER ADJUSTMENTS** | | | | |
| Revenues | | | | |
| 4121200 - Delinquent fees | $ 361 | $ 361 | $ 364 | $ 364 |
| 4127400 - Renewal fees | $ 14,741 | $ 15,056 | $ 14,791 | $ 14,791 |
| 4129200 - Other regulatory fees | $ 310 | $ 392 | $ 291 | $ 291 |
| 4129400 - Other regulatory licenses and permits | $ 3,474 | $ 3,511 | $ 3,431 | $ 3,431 |
| 4143500 - Miscellaneous Services to the Public | $ - | $ 1 | $ 15 | $ 15 |
| 4150500 - Interest Income from Interfund Loans | $ - | $ 131 | $ - | $ - |
| 4163000 - Income from surplus money investments | $ 859 | $ 903 | $ 789 | $ 710 |
| 4170400 - Capital Asset Sales Proceeds | $ 8 | $ - | $ - | $ - |
| 4171400 - Escheat of unclaimed checks and warrants | $ 19 | $ 14 | $ 12 | $ 12 |
| 4172500 - Miscellaneous revenues | $ 14 | $ 14 | $ 2 | $ 2 |
| Totals, Revenues | $ 19,786 | $ 20,383 | $ 19,695 | $ 19,616 |
| Transfers to/from Other Funds | | | | |
| Loan repayment from the General Fund (0001) to the State Dentistry Fund (0741) per Item 1111-011-0741, Budget Act of 2020 | $ - | $ 5,000 | $ - | $ - |
| Totals, Transfers and Other Adjustments | $ - | $ 5,000 | $ - | $ - |
| **TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS** | $ 19,786 | $ 25,383 | $ 19,695 | $ 19,616 |
| **TOTAL RESOURCES** | $ 37,827 | $ 44,607 | $ 44,954 | $ 42,962 |
| Expenditures: | | | | |
| 1111 Department of Consumer Affairs Regulatory Boards, Bureaus, Divisions (State Operations) | $ 17,201 | $ 17,877 | $ 20,296 | $ 20,905 |
| Reductions | $ 0 | $ 0 | $ -432 | $ -432 |
| 9892 Supplemental Pension Payments (State Operations) | $ 351 | $ 241 | $ 241 | $ - |
| 9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations) | $ 1,051 | $ 1,230 | $ 1,503 | $ 1,503 |
| **TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS** | $ 18,603 | $ 19,348 | $ 21,608 | $ 21,976 |
| **FUND BALANCE** | | | | |
| Reserve for economic uncertainties | $ 19,224 | $ 25,259 | $ 23,346 | $ 20,986 |
| Months in Reserve | 11.9 | 14.0 | 12.7 | 11.1 |

**NOTES:**
1. Assumes workload and revenue projections are realized in BY+1 and ongoing.
2. Expenditure growth projected at 3% beginning BY+1.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 8.:** Report on Dental Hygiene Board of California Activities |

## Background

Mr. Anthony Lum, Executive Officer of the Dental Hygiene Board of California, will provide a verbal report.

## Action Requested

No action requested.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 9.:** Dental Assisting Council Meeting Report |

## Background

Ms. De'Andra Epps-Robbins, Chair of the Dental Assisting Council, will provide a verbal report on the May 14, 2025 meeting.

## Action Requested

No action requested.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 16, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Brant Nelson, Legislative and Regulatory Specialist<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 10.a.:** Status Update on Pending Regulations |

## Background

This memo addresses rulemaking packages that have moved forward in the rulemaking process since the last Dental of California Board (Board) meeting. Rulemaking packages that require Board action will be presented as separate agenda items or will be presented at a future Board meeting.

**Rulemaking to Amend California Code of Regulations (CCR), Title 16, Sections 1021, 1028, 1028.4, 1028.5, 1030, and 1035, and Repeal Sections 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033.1, 1034, and 1036.01 Regarding Applications for Dentist Licensure and Fees**

**Summary of Proposed Changes:**
A summary of the proposed changes can be found within the February 6-7, 2025 Board meeting materials.

**Update:**
The proposed text was approved by the Board at its February 6-7, 2025 Board meeting. Since that time, Board staff have drafted an initial rulemaking package, which includes the proposed text, and Initial Statement of Reasons (ISOR) explaining the regulation's purpose and impact. This package is now undergoing internal review by the DCA regulatory counsel and budget staff as a standard part of the regulatory process.

## Action Requested

This item is informational only. No action is requested.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 28, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Brant Nelson, Legislative and Regulatory Specialist<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 10.b.:** Discussion and Possible Action to Initiate a Rulemaking to Amend CCR, Title 16, Section 1005 Regarding Minimum Standards for Infection Control |

## Background

Business and Professions Code (BPC) section 1680, subdivision (ad), requires the Dental Board of California (Board) to review infection control guidelines (Guidelines), if necessary, on an annual basis. Proposed changes to the Guidelines must be reviewed by the Dental Hygiene Board of California (DHBC) by law. Section 1680, subdivision (ad), requires the DHBC to submit any recommended changes to the Guidelines to the Board for review "to establish a consensus." The Board has adopted its Guidelines at CCR, title 16, section 1005, which were last revised in 2011. Beginning on April 15, 2024, DBC and DHBC working groups met to discuss possible updates to the Guidelines and further develop specific recommendations for discussion and possible action at future Dental Assisting Council (Council), DHBC, and Board meetings.

To begin the process of establishing a "consensus" on the Guidelines, the Board's and DHBC's working groups' original final draft at **Attachment 1** was brought to the DHBC's Legislation and Regulatory Committee on November 15, 2024, for review and action, and thereafter brought to the DHBC at its November 16, 2024 Board meeting. However, at these DHBC meetings, the California Dental Association (CDA) raised concerns about two issues in the proposed regulatory amendments. After the DHBC's meetings, Board staff, in consultation with the Board's and DHBC's working groups, revised the text.

The revised text was presented at the Council's February 6, 2025 meeting (Agenda Item 8.b. found here: February 6, 2025 Meeting Materials). However, at the meeting, stakeholders provided public comments about additional concerns with the proposed text. In response to those concerns, the Council voted to take back public comment and

any discussion that the Council had to the working groups and have this proposal come back to a future Council meeting for consideration. Commenters who provided comments on the proposed text at either the Board or Council meetings on February 6 and 7, 2025, were asked to provide their comments in writing to the Board's Regulatory Specialist to facilitate review by the Board's and DHBC's respective working groups. These comments were submitted as provided in **Attachments 3 through 6** ("public comments").

**Update**

Following the Board and Council meetings in February, Board staff requested input from the Board's and DHBC's working groups, which are comprised of subject matter experts, on the public comments received and advice on any possible further revisions. **Attachment** 2 reflects the working groups' revisions to the regulatory text to resolve the public concerns. In addition, Board staff have provided in **Attachment 7** explanations for changes made and the rationales for accepting or rejecting prior public comments submitted at the February 6 and 7, 2025, Council and Board meetings and/or in writing, and any additional recommendations for revisions to the Guidelines from the working groups.

Considering the subject matter experts' recommendations from both the Board's and DHBC's working groups, Board staff recommends that the Board consider approval of the text as set forth in **Attachment 2**.

**Action Requested**

The Board members should review the proposed regulatory text and related attachments and consider whether they would support the staff's recommendation to adopt **Attachment 2** or if there are suggested changes to the proposed text. After review, the staff requests that the Board consider one of the following motions:

**Option 1** (if the Board agrees with the staff recommendation and has no changes)
I move to approve the proposed regulatory text in **Attachment 2**, and request that staff provide **Attachment 2** to the Dental Hygiene Board of California for their review and reconsideration of their prior action on this item, and to obtain a consensus with this Board on the Guidelines. Upon receiving notice that the Dental Hygiene Board of California has approved **Attachment 2** and thereby reached consensus with this Board, the Board further directs staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, section 1005.

**Option 2** (The Board has suggested changes for the proposed regulatory text in **Attachment 2**.)

I move to approve the proposed regulatory text in **Attachment 2** with the following changes (Describe the proposed changes to the proposed text here), and request that staff provide **Attachment 2** as amended to the Dental Hygiene Board of California for their review and reconsideration of their prior action on this item, and to obtain a consensus with this Board on the Guidelines. Upon receiving notice that the Dental Hygiene Board of California has approved **Attachment 2** as amended and thereby reached consensus with this Board, the Board further directs staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review. If no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the text and the package, and set the matter for a hearing if requested. If after the 45-day public comment period, no adverse comments are received, and no public hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking, and adopt the proposed regulations as noticed for CCR, title 16, section 1005.

**Attachments**:

1. Proposed Regulatory Text to Amend CCR, Title 16, Section 1005 Approved by DHBC and dated 11/5/24
2. Proposed Regulatory Text to Amend CCR, Title 16, Section 1005, dated 5/14/25
3. Letter from the California Dental Assisting Alliance, dated February 7, 2025
4. Email from Leslie Canham, dated February 11, 2025, with seven attachments (eighth attachment C.V./BIO not provided and CE provider advertising redacted from email)
5. Email from Amy Condrin, dated March 1, 2025, with attachment from CDC's Morbidity and Mortality Weekly Report entitled "Guidelines for Infection Control in Dental Health-Care Settings — 2003," dated December 19, 2003
6. Email from Amy Condrin, dated March 2, 2025
7. 16 CCR 1005 Summary of Stakeholder Comments with the Board's Working Group's Responses and Other Recommendations

**DENTAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**

**PROPOSED REGULATORY LANGUAGE**

Proposed amendments to the regulatory language are shown in single underline for new text and single ~~strikethrough~~ for deleted text. Where the Board proposes to re-number existing paragraphs to a new paragraph within this section, the Board has ~~struck through~~ the existing number of the paragraph and underlined the new proposed paragraph number to show the proposed re-ordering of paragraphs within this section.

**Amend Section 1005 of Division 10 of Title 16 of the California Code of Regulations to read as follows:**

**§ 1005. Minimum Standards for Infection Control.**

(a) Definitions of terms used in this section:

(1) "Standard precautions" are ~~a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status,~~ infection prevention protocols and procedures established for use in any setting in which dental healthcare is delivered. These include: hand hygiene protocols and hand care, ~~use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure,~~ use of personal protective equipment, procedures for patient care items, ~~and~~ safe handling of sharps~~.~~, safe handling and disposal of contaminated medical waste, respiratory hygiene or cough etiquette, and use of disinfectant agents in accordance with this section. Standard precautions shall be used for care of all patients regardless of ~~their diagnoses or personal infectious status.~~ the procedure performed or the health history of the patient.

(4) "Instrument/device classifications" are categories used to identify patient care items ("items") as critical, semi-critical, or non-critical depending on the potential risk for infection associated with their intended use and their required level of sterilization or disinfection for safe practice, as follows:

~~(2)~~(A) "Critical items" ~~confer a high risk for infection if they are contaminated with any microorganism.~~ carry the highest risk of transmitting infection. These include all instruments, devices, and other items used to penetrate soft tissue or bone~~.~~, such as surgical instruments, periodontal instruments, hygiene scalers, and burs.

~~(3)~~ (B) "Semi-critical items" are instruments, devices, and other items that ~~are not used to penetrate soft tissue or bone, but contact oral mucous membranes, non-~~

~~intact skin or other potentially infectious materials (OPIM).~~ come into contact with oral tissue, blood, or OPIM without penetration, such as those items used for intraoral examination, and dental procedures including dental mouth mirrors, amalgam condensers, reusable dental impression trays, and orthodontic pliers with plastic parts.

~~(4)~~ (C) "Non-critical items" are instruments, devices, equipment, and surfaces ("clinical contact surfaces") that come in contact with soil (e.g., organic and inorganic material), debris, blood, OPIM and intact skin, but not oral mucous membranes, and are utilized extraorally or are indirectly contaminated with debris, blood, or OPIM during clinical procedures, such as dental X-ray machines, assistant cart attachments, dental material delivery systems, patient safety eyewear, plastic dental syringes, and countertops.

~~(5)~~ "Disinfect" or "Disinfection" means the use of a chemical solution to reduce or lower the number of microorganisms on inanimate objects using a Cal/EPA-registered product.

~~(6)~~ "Disinfection classifications" are categories used to determine the effectiveness of a disinfectant agent to inactivate mycobacterium during surface disinfection procedures and are as follows:

(5) (A) "Low-level disinfection" is the least effective disinfection process. It kills some bacteria, some viruses and fungi, but does not kill bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.

(6) (B) "Intermediate-level disinfection" kills mycobacterium tuberculosis var bovis indicating that many human pathogens are also killed. This process does not necessarily kill spores.

(7) (C) "High-level disinfection" ~~kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.~~ inactivates all vegetative bacteria, mycobacteria, viruses, fungi, and some bacterial spores.

(7) "Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Environmental Protection Agency (Cal EPA) that has demonstrated bactericidal, fungicidal, and virucidal activity. The product used shall include a label from the manufacturer that indicates the level of disinfection (low, intermediate, or high) and both the EPA registration number and the California Department of Pesticide Regulation (Cal DPR) registration number.

(8) ~~"Germicide" is a chemical agent that can be used to disinfect items and surfaces based on the level of contamination.~~

~~(9)~~(8) "Sterilization" is a ~~validated process used to render a product free of all forms of viable microorganisms.~~ mechanical process used to eliminate all forms of microbial life using acceptable methods of sterilization set forth in this section with a device approved by the U.S. Food and Drug Administration (FDA) for sterilization.

~~(10)~~(9) "Cleaning" is the removal of visible soil ~~(e.g., organic and inorganic material),~~ debris, blood, and OPIM from objects and surfaces and shall be accomplished manually or mechanically using water with detergents or enzymatic products. prior to the use of a sterilization device or disinfectant for surface disinfection, using one of the following applicable methods:

(A) Cleaning of clinical contact surfaces and non-critical items means hand scrubbing using water and a detergent, or a surface disinfectant, either of which is registered with Cal/EPA as a disinfectant to clean surfaces or items according to manufacturer's instructions.

(B) Cleaning of semi-critical or critical items means hand scrubbing with a long-handled brush or using an FDA-approved mechanical device to remove visible soil from contaminated items using detergents or enzymatic products. Acceptable mechanical cleaning devices shall include ultrasonic cleaners using enzymatic products or detergents that require manual drying, or devices manufactured specifically for washing and mechanical drying of dental instruments, cassettes, and devices prior to preparing for sterilization. All mechanical cleaning devices shall be used in accordance with the manufacturer's instructions for the device or item type and quantity being cleaned.

~~(11)~~(2) "Personal Protective Equipment" (PPE) is specialized clothing or equipment worn or used for protection against a hazard. PPE items may include, but are not limited to, gloves, masks, respiratory devices, protective eyewear, and protective attire which are intended to prevent exposure to blood, ~~body fluids, OPIM~~other potentially infectious materials, and chemicals used for infection control. General work attire such as uniforms, scrubs, pants, and shirts, are not considered to be PPE.

~~(12)~~(3) "Other Potentially Infectious Materials" (OPIM) means any ~~one~~ of the following:

(A) Human body fluids such as saliva in dental procedures and any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

(B) Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

(C) Any of the following, if known or reasonably likely to contain or be infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV):

1. Cell, tissue, or organ cultures from humans or experimental animals;

2. Blood, organs, or other tissues from experimental animals; or

3. Culture medium or other solutions.

~~(13)~~(10) "Dental Healthcare Personnel" (DHCP)~~,~~ are all paid and non-paid personnel in the ~~dental healthcare setting~~ treatment facility who might be occupationally exposed to infectious materials, including ~~body substances~~blood, OPIM, and contaminated supplies, equipment, environmental surfaces, water, or air. DHCP includes dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).

(11) "Contaminated medical waste" shall include "medical waste" as defined in Section 117690 of the Health and Safety Code occurring in the dental healthcare setting and shall not include those applicable items set forth in Section 117700 of the Health and Safety Code.

(b) All DHCP shall comply with all applicable infection control standard precautions and enforce the following applicable minimum standard precautions in the treatment facility to protect patients and DHCP and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA).

(1) Standard precautions shall be ~~practiced~~used in the care of all patients.

(2) A written ~~protocol shall be developed, maintained, and periodically updated for proper instrument processing, operatory cleanliness, and management of injuries. The protocol shall be made available to all DHCP at the dental office.~~ infection control plan detailing the protocols and procedures that shall be developed, maintained, and periodically updated for all standard precautions in accordance with the requirements of this section. The written infection control plan shall be made readily available to all DHCP at the treatment facility and reviewed and updated at least annually by the DHCP employer or employer-designated representative

responsible for infection control compliance, and as needed to maintain compliance with this section.

(3) A copy of this regulation shall be conspicuously posted in each ~~dental office.~~ treatment facility and included in the written infection control plan described in paragraph (2).

(4) Personal Protective Equipment~~:~~ (PPE):

~~(4)~~(A) All DHCP shall wear single-use, disposable surgical facemasks in combination with either chin length plastic face shields or protective eyewear during patient treatment or whenever there is potential for aerosol spray, splashing, or spattering of the following: droplet nuclei, blood, chemical or ~~germicidal~~disinfectant agents, or OPIM. For the purposes of this section, "protective eyewear" includes safety glasses with top and side shields bearing evidence of compliance with American National Standard for Occupational and Education Personal Eye and Face Protection Devices ANSI/ISEA Z87.1-2020 (the "Z87" marking).

(B) A new, single-use, disposable surgical facemask shall be used for each patient at the beginning of their treatment session. Surgical facemask replacement shall occur at any point during a procedure where the mask becomes moist or soiled. ~~Chemical-resistant utility gloves and appropriate, task specific PPE shall be worn when handling hazardous chemicals.~~ After each patient treatment, surgical facemasks shall be changed and disposed when leaving laboratories or areas of patient care activities.

(C) Chin-length face shields and face visors are acceptable replacements for protective eyewear when worn in combination with a surgical facemask. Face shields and face visors shall not be used as a replacement for a surgical facemask. After each patient treatment, face shields and protective eyewear shall be cleaned, disinfected, or disposed when leaving laboratories or areas of patient care activities.

(D) Chemical and puncture-resistant utility gloves and chemical-resistant PPE shall be worn when handling hazardous chemicals and shall be worn in accordance with paragraph (6).

(E) Reusable protective eyewear, face shields and visors shall be washed with soap and water, or if visibly soiled, cleaned and disinfected between patients.

~~(5)~~(F) Protective attire shall be worn for disinfection, sterilization, and housekeeping procedures involving the use of ~~germicides~~ disinfectants or when handling contaminated items. All DHCP shall wear reusable or disposable

protective attire during patient treatment, or whenever there is a potential for aerosol spray, splashing, or spattering of blood, OPIM, or chemicals and ~~germicidal~~ disinfectant agents. Protective attire ~~must~~shall be changed daily, or ~~between patients~~immediately if they should become moist or visibly soiled. All PPE used during patient care shall be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal/OSHA Bloodborne Pathogens Standards (Title 8, Cal. Code Regs., section 5193).

(5) Hand Hygiene~~:~~ Protocols and Hand Care:

~~(6)~~(A) All DHCP shall thoroughly wash their hands with soap and water (covering all surfaces of hands and fingers) for no less than 20 seconds at the start and end of each workday. DHCP shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated, an alcohol-~~-~~based hand rub, with an alcohol concentration between 60-95%, may be used as an alternative to soap and water. An alcohol-based hand rub shall be used according to the manufacturer's instructions. Hands shall be ~~thoroughly dried~~completely dry before donning gloves in order to prevent promotion of ~~bacterial~~ microbial growth and washed again immediately after glove removal.

(B) A DHCP shall refrain from providing direct patient care and from handling patient care equipment if hand conditions such as the presence of lesions, rash, or weeping dermatitis are present that may render DHCP or patients more susceptible to opportunistic infection or exposure.

~~(7) All DHCP who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves~~.

(6) Gloves:

~~(8)~~(A) Medical examination gloves shall be worn by DHCP whenever there is contact with mucous membranes, blood, OPIM, and during all pre-clinical, clinical, post-clinical, and laboratory procedures. Medical examination gloves are disposable, synthetic single-use only items. Gloves shall be replaced when torn or punctured, upon completion of dental treatment, and before leaving laboratories or areas of patient care activities.

(B) Chemical and puncture-resistant utility gloves shall be available at the point of use and worn by DHCP for clinical care break-down (setting up or breaking down a treatment room), cleaning, and disinfectant procedures. Chemical and

puncture-resistant utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(C) When processing contaminated sharp instruments, needles, and devices, DHCP shall wear ~~heavy-duty~~chemical and puncture-resistant utility gloves ~~to prevent puncture wounds~~. Utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(D) Gloves ~~must~~shall be discarded under any of the following circumstances:

(i) when torn or punctured~~,~~;

(ii) upon completion of dental treatment when using medical examination gloves;~~,~~ and,

(iii) before leaving laboratories or areas of patient care activities when using medical examination gloves.

(E) All DHCP shall perform hand hygiene protocols and hand care procedures specified in paragraph (5) before donning gloves and after removing and discarding medical examination gloves. Medical examination ~~G~~gloves shall not be washed before or after use, or reused.

(7) Needle and Sharps Safety:

~~(9)~~(A) Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal.

(B) Disposable needles, syringes, scalpel blades, or other sharp items and instruments shall be placed into sharps containers for disposal as close as possible to the point of use according to all applicable local, state, and federal regulations.

(8) Sterilization and Disinfection:

~~(10)~~(A) All ~~germicides must~~ products used to clean or disinfect items or surfaces shall be used in accordance with intended use and label instructions.

~~(11)~~(B) Standard precautions for disinfection and sterilization shall be performed in the following order:

(i) first, use appropriate hand hygiene protocols and hand care in accordance with paragraph (5);

(ii) second, ~~C~~clean~~ing must precede~~ items or surfaces prior to any disinfection or sterilization process; and,

(iii) third, use the disinfection or sterilization standards required by this section. ~~Products used to clean items or surfaces prior to disinfection procedures shall be used according to all label instructions~~ Disinfection procedures shall include use of a Cal/EPA-registered product with an applicable disinfection classification in accordance with paragraph (6) of subsection (a) to disinfect items.

~~(12)~~(C) Critical instruments, items, and devices shall be ~~discarded or~~ pre-cleaned, packaged or wrapped, and sterilized immediately after each use. Methods of sterilization shall include steam under pressure (autoclaving), chemical vapor, and dry heat. If a critical item is heat-sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process. These instruments, items, and devices~~,~~ shall remain sealed and stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(13)~~(D) Semi-critical instruments, items, and devices shall be pre-cleaned, packaged or wrapped, and sterilized immediately after each use. Methods of sterilization include steam under pressure (autoclaving), chemical vapor and dry heat. If a semi-critical item is heat sensitive, it shall, at minimum, be processed with high level disinfection and packaged or wrapped upon completion of the disinfection process. These packages or containers shall remain sealed and shall be stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(14)~~(E) Non-critical surfaces and patient care items shall be cleaned and disinfected after every use with a ~~California Environmental Protection Agency (~~Cal/EPA~~)~~-registered hospital disinfectant (low-level disinfectant) spray or wipe ~~labeled effective against HBV and HIV~~. When the item is visibly contaminated with blood or OPIM, a Cal/EPA-registered hospital intermediate-level disinfectant with a tuberculocidal claim shall be used.

~~(15)~~(F) All high-speed dental hand pieces, low-speed hand pieces, rotary components, and dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be packaged, labeled, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item.

~~(16)~~(G) Single use critical, semi-critical, and non-critical disposable items such as scalpel blades, prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips, and gloves shall be used for one patient only and discarded.

~~(17)~~(H) Proper functioning of the sterilization cycle of all sterilization devices shall be verified at least weekly through the use of a biological indicator (such as a spore test) with results confirmed by either authorized DHCP or an independent laboratory. Test results shall be documented and maintained for 12 months.

(I)(i) A chemical indicator shall be used inside every sterilization package to verify that the sterilizing agent has penetrated the package and reached the instruments inside. If the internal chemical indicator is not visible from the outside of the package, an external chemical indicator shall also be used.

(ii) The chemical indicator shall be inspected immediately when removing packages from the sterilizer; if the chemical indicator did not register that the sterilizing agent has penetrated the package, the instruments shall be repackaged and sterilized again.

(9) Irrigation:

~~(18)~~(A) Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone.

(B) When performing procedures on exposed dental pulp, water or other irrigation solutions shall be sterile or contain disinfecting or antibacterial properties.

(C) Sterile coolants/irrigants ~~must~~shall be delivered using a sterile delivery system.

(10) Treatment Facilities:

~~(19)~~(A) If non-critical items or clinical contact surfaces likely to be contaminated ~~are~~ or manufactured in a manner preventing cleaning and disinfection, they shall be ~~protected~~physically covered with disposable impervious barriers approved by the FDA and designed by the manufacturer for that purpose. Disposable barriers shall be changed when visibly soiled or damaged and between patients.

~~(20)~~(B) Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a ~~California Environmental Protection Agency~~ ~~(~~Cal/EPA~~)~~ ~~-~~ registered, hospital grade low- to intermediate-level ~~germicide~~disinfectant after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use an intermediate-level disinfectant if visibly contaminated with blood. Use disinfectants in accordance with the manufacturer's instructions.

(C) Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal/EPA~~-~~ ~~-~~registered, hospital grade disinfectant. Products used to clean items or surfaces prior to disinfection procedures shall be clearly labeled, and DHCP shall follow all ~~material~~ safety data sheet (~~M~~SDS) handling and storage instructions.

~~(21)~~(D) Dental unit water lines shall be anti-retractive. At the beginning of each workday, dental unit lines and devices shall be ~~purged with air or~~ flushed with water for at least two (2) minutes prior to attaching handpieces, scalers, air water syringe tips, or other devices. The dental unit lines and devices shall be flushed between each patient and after the final patient of the day for a minimum of twenty (20) seconds.

~~(22)~~(E) Contaminated solid waste shall be disposed of according to applicable local, state, and federal environmental standards.

(11) Lab Areas:

~~(23)~~(A) Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a sterilized or new, disposable rag-wheel shall be used for each patient. ~~Devices~~

(B) Laboratory equipment, including handpieces, polishing (rag) wheels, grinding wheels, and laboratory burs, used to polish, trim, or adjust contaminated appliances and ~~intraoral~~ prosthetic devices shall be cleaned, disinfected ~~or sterilized~~, properly packaged or wrapped, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item as specified in subparagraph (D) of paragraph (8), or if a single-use item, disposed of in accordance with subparagraph (G) of paragraph (8).

(C) Laboratory equipment shall be stored in a manner consistent with the same storage practices as a semi-critical item as specified in subparagraph (D) of paragraph (8).

~~(24)~~(D) All intraoral items such as impressions, bite registrations, and prosthetic and orthodontic appliances shall be cleaned and disinfected with ~~an~~ Cal/EPA-registered intermediate-level disinfectant before and after manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

(12) Respiratory Hygiene/Cough Etiquette: Measures shall be implemented to contain respiratory secretions and to prevent droplet and fomites transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory infections such as influenza, RSV, adenovirus, parainfluenza virus, or SARS-CoV-2 (COVID-19) virus, as follows.

(A) Prominently posting at least one sign at every point of entrance and reception or registration desk of the treatment facility, accessible to public view, in which case the signs shall be in at least 12-point type font. The signs shall contain instructions to patients who cough or sneeze at the treatment facility to do at least all of the following: (i) cover their mouths or noses when coughing or sneezing; (ii) use and dispose of tissues in waste receptables; and, (iii) wash hands with soap and water or use alcohol hand rub after coughing or sneezing.

(B) Provide tissues and no-touch receptacles (e.g. foot-pedal operated lid or open plastic-lined waste basket) for disposal of tissues.

(C) Have soap, warm running water, and paper towels, or alcohol hand rub available for use in or immediately adjacent to waiting areas.

(D) Offer masks to coughing or sneezing patients or other persons when they enter the treatment facility.

(E) Provide distance between patients who cough or sneeze in common waiting areas. If available, facilities shall place these patients in a separate area while waiting for care.

(c) DHCP who are employers of other DHCP shall provide those personnel with a training program on the minimum standards required by this section and the infection control plan specified in paragraph (2) of subsection (b). Such training program shall be provided at no cost to the DHCP and during working hours in accordance with all of the following.

(1) The training program shall be provided as follows:

(A) Prior to assignment to tasks where OPIM exposure may take place; and,

(B) Within one year of the date of the DHCP's previous training thereafter.

(2) DHCP employers shall provide additional training prior to or by the effective date of any change to the minimum standards in this section or to the written infection control plan specified in paragraph (2) of subsection (b). The additional training may be limited to addressing the changes in the standards required by this section or the written infection control plan.

~~(c) The Dental Board of California and Dental Hygiene Committee of California shall review this regulation annually and establish a consensus.~~

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~~[1] Cal/EPA contacts: WEBSITE www.cdpr.ca.gov or Main Information Center (916) 324-0419.~~

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1680, Business and Professions Code.

**DENTAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**

**PROPOSED REGULATORY LANGUAGE**

Proposed amendments to the regulatory language are shown in single underline for new text and single ~~strikethrough~~ for deleted text.

Where the Board proposes to re-number existing paragraphs to a new paragraph within this section, the Board has ~~struck through~~ the existing number of the paragraph and underlined the new proposed paragraph number to show the proposed re-ordering of paragraphs within this section.

**Amend Section 1005 of Division 10 of Title 16 of the California Code of Regulations to read as follows:**

**§ 1005. Minimum Standards for Infection Control.**

(a) Definitions of terms used in this section:

(1) "Standard precautions" are ~~a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status,~~ infection prevention protocols and procedures established for use in any setting in which dental healthcare is delivered. These include: hand hygiene protocols and hand care, ~~use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure,~~ use of personal protective equipment, procedures for patient care items, ~~and~~ safe handling of sharps~~.~~, safe handling and disposal of contaminated medical waste, respiratory hygiene or cough etiquette, and use of disinfectant agents in accordance with this section. Standard precautions shall be used for care of all patients regardless of ~~their diagnoses or personal infectious status.~~ the procedure performed or the health history of the patient.

(4) "Instrument/device classifications" are categories used to identify patient care items ("items") as critical, semi-critical, or non-critical depending on the potential risk for infection associated with their intended use and their required level of sterilization or disinfection for safe practice, as follows:

~~(2)~~(A) "Critical items" ~~confer a high risk for infection if they are contaminated with any microorganism.~~ carry the highest risk of transmitting infection. These include all instruments, devices, and other items used to penetrate soft tissue or bone~~.~~, such as surgical instruments, periodontal instruments, hygiene scalers, and burs.

(3) (B) "Semi-critical items" are instruments, devices, and other items that ~~are not used to penetrate soft tissue or bone, but contact oral mucous membranes, non-intact skin or other potentially infectious materials (OPIM).~~ come into contact with oral tissue, blood, or OPIM without penetration, such as those items used for intraoral examination, and dental procedures including dental mouth mirrors, amalgam condensers, reusable dental impression trays, and orthodontic pliers with plastic parts.

(4) (C) "Non-critical items" are instruments, devices, equipment, and surfaces ("clinical contact surfaces") that come in contact with soil (e.g., organic and inorganic material), debris, blood, OPIM and intact skin, but not oral mucous membranes, and are utilized extraorally or are indirectly contaminated with debris, blood, or OPIM during clinical procedures, such as dental X-ray machines, assistant cart attachments, dental material delivery systems, patient safety eyewear, plastic dental syringes, and countertops.

(5) "Disinfect" or "disinfection" means the use of a chemical solution to reduce or lower the number of microorganisms on inanimate objects using a Cal/EPA-registered product.

(6) "Disinfection classifications" are categories used to determine the effectiveness of a disinfectant agent to inactivate mycobacterium during surface disinfection procedures and are as follows:

(5) (A) "Low-level disinfection" is the least effective disinfection process. It ~~kills~~inactivates some bacteria, ~~some~~ viruses, and fungi, but does not ~~kill~~inactivate bacterial spores or mycobacterium tuberculosis var bovis, a laboratory test organism used to classify the strength of disinfectant chemicals.

(6) (B) "Intermediate-level disinfection" ~~kills~~inactivates mycobacterium tuberculosis var bovis indicating that many human pathogens are also ~~killed~~inactivated. This process does not necessarily ~~kill~~inactivate spores.

(7) (C) "High-level disinfection" ~~kills some, but not necessarily all bacterial spores. This process kills mycobacterium tuberculosis var bovis, bacteria, fungi, and viruses.~~ inactivates all vegetative bacteria, mycobacterium, viruses, fungi, and some bacterial spores.

(7) "Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Department of Pesticide Regulation for sale and use in California as a pesticide.

(8) ~~"Germicide" is a chemical agent that can be used to disinfect items and surfaces based on the level of contamination.~~

~~(9)~~(8) "Sterilization" is a validated process used to ~~render a product free of all forms of viable microorganisms.~~ eliminate all forms of microbial life using acceptable methods of sterilization set forth in this section.

~~(10)~~(9) "Cleaning" is the removal of visible soil ~~(e.g., organic and inorganic material)~~, debris, blood, and OPIM from objects and surfaces and shall be accomplished manually or mechanically using water with detergents or enzymatic products~~.~~ prior to the use of a sterilization device or disinfectant for surface disinfection, using one of the following applicable methods:

(A) Cleaning of clinical contact surfaces and non-critical items means scrubbing using water and a detergent, or a surface disinfectant, either of which is registered with Cal/EPA as a disinfectant to clean surfaces or items according to manufacturer's instructions.

(B) Cleaning of semi-critical or critical items means scrubbing with a long-handled brush or using an FDA-approved mechanical device to remove visible soil from contaminated items using detergents or enzymatic products. Acceptable mechanical cleaning devices shall include ultrasonic cleaners using enzymatic products or detergents that require manual drying, or devices manufactured specifically for washing and mechanical drying of dental instruments, cassettes, and devices prior to preparing for sterilization. All mechanical cleaning devices shall be used in accordance with the manufacturer's instructions for the device or item type and quantity being cleaned.

~~(11)~~(2) "Personal Protective Equipment" (PPE) is specialized clothing or equipment worn or used for protection against a hazard. PPE items may include, but are not limited to, gloves, masks, respiratory devices, protective eyewear, and protective attire which are intended to prevent exposure to blood, ~~body fluids, OPIM~~other potentially infectious materials, and chemicals used for infection control. General work attire such as uniforms, scrubs, pants, and shirts, are not considered to be PPE.

~~(12)~~(3) "Other Potentially Infectious Materials" (OPIM) means any ~~one~~ of the following:

(A) Human body fluids such as saliva in dental procedures and any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

(B) Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

(C) Any of the following, if known or reasonably likely to contain or be infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), or hepatitis C virus (HCV):

1. Cell, tissue, or organ cultures from humans or experimental animals;

2. Blood, organs, or other tissues from experimental animals; or

3. Culture medium or other solutions.

~~(13)~~(10) "Dental Healthcare Personnel" (DHCP)~~,~~ are all paid and non-paid personnel in the ~~dental healthcare setting~~ treatment facility who might be occupationally exposed to infectious materials, including ~~body substances~~blood and OPIM, and contaminated supplies, equipment, environmental surfaces, water, or air. DHCP includes dentists, dental hygienists, dental assistants, dental laboratory technicians (in-office and commercial), students and trainees, contractual personnel, and other persons not directly involved in patient care but potentially exposed to infectious agents (e.g., administrative, clerical, housekeeping, maintenance, or volunteer personnel).

(11) "Contaminated medical waste" shall include "medical waste" as defined in Section 117690 of the Health and Safety Code occurring in the dental healthcare setting and shall not include those applicable items set forth in Section 117700 of the Health and Safety Code.

(b) All DHCP shall comply with all applicable infection control standard precautions and enforce the following applicable minimum standard precautions in the treatment facility to protect patients and DHCP and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA).

(1) Standard precautions shall be ~~practiced~~used in the care of all patients.

(2) A written ~~protocol shall be developed, maintained, and periodically updated for proper instrument processing, operatory cleanliness, and management of injuries. The protocol shall be made available to all DHCP at the dental office.~~ infection control plan detailing the protocols and procedures that shall be developed, maintained, and periodically updated for all standard precautions in accordance with the requirements of this section. The written infection control plan shall be made readily available to all DHCP at the treatment facility and reviewed and updated at least annually by the DHCP employer or employer-designated representative

responsible for infection control compliance, and as needed to maintain compliance with this section.

(3) A copy of this regulation shall be conspicuously posted in each ~~dental office.~~ treatment facility and included in the written infection control plan described in paragraph (2).

(4) Personal Protective Equipment~~:~~ (PPE):

~~(4)(A)~~ All DHCP shall wear single-use, disposable surgical facemasks in combination with either chin length plastic face shields or protective eyewear during patient treatment or whenever there is potential for aerosol spray, splashing, or spattering of the following: droplet nuclei, blood, chemical or ~~germicidal~~disinfectant agents, or OPIM. For purposes of this section, "protective eyewear" includes safety glasses with side shields bearing evidence of compliance with American National Standard for Occupational and Education Personal Eye and Face Protection Devices ANSI/ISEA Z87.1-2020 (the "Z87" marking).

(B) A new, single-use, disposable surgical facemask shall be used for each patient at the beginning of their treatment session. Surgical facemask replacement shall occur at any point during a procedure where the mask becomes moist or soiled. ~~Chemical-resistant utility gloves and appropriate, task specific PPE shall be worn when handling hazardous chemicals.~~ After each patient treatment, surgical facemasks shall be changed and disposed when leaving laboratories or areas of patient care activities.

(C) Chin-length face shields and face visors are acceptable replacements for protective eyewear when worn in combination with a surgical facemask. Face shields and face visors shall not be used as a replacement for a surgical facemask. After each patient treatment, face shields and protective eyewear shall be cleaned, disinfected, or disposed when leaving laboratories or areas of patient care activities.

(D) Chemical and puncture-resistant utility gloves and chemical-resistant PPE shall be worn when handling hazardous chemicals and shall be worn in accordance with paragraph (6).

(E) Reusable protective eyewear, face shields, and visors shall be washed with soap and water, or if visibly soiled, cleaned and disinfected between patients.

~~(5)(F)~~ Protective attire shall be worn for disinfection, sterilization, and housekeeping procedures involving the use of ~~germicides~~ disinfectants or when handling contaminated items. All DHCP shall wear reusable or disposable

protective attire during patient treatment, or whenever there is a potential for aerosol spray, splashing, or spattering of blood, OPIM, or chemicals and ~~germicidal~~ disinfectant agents. Protective attire ~~must~~shall be changed daily or between patients. Protective attire shall be changed immediately if the~~y~~ attire ~~should~~ becomes ~~moist or visibly~~ soiled with blood or OPIM. All PPE used during patient care shall be removed when leaving laboratories or areas of patient care activities. Reusable gowns shall be laundered in accordance with Cal/OSHA Bloodborne Pathogens Standards (Title 8, Cal. Code Regs., section 5193).

(5) Hand Hygiene~~:~~ Protocols and Hand Care:

~~(6)(A)~~ All DHCP shall thoroughly wash their hands with soap and water (covering all surfaces of hands and fingers) for no less than 20 seconds at the start and end of each workday. DHCP shall wash contaminated or visibly soiled hands with soap and water and put on new gloves before treating each patient. If hands are not visibly soiled or contaminated, an alcohol~~-~~-based hand rub, with an alcohol concentration between 60-95%, may be used as an alternative to soap and water. An alcohol-based hand rub shall be used according to the manufacturer's instructions. Hands shall be ~~thoroughly dried~~completely dry before donning gloves in order to prevent promotion of ~~bacterial~~ microbial growth and washed again immediately after glove removal.

(B) A DHCP shall refrain from providing direct patient care and from handling patient care equipment if hand conditions such as the presence of lesions, rash, or weeping dermatitis are present that may render DHCP or patients more susceptible to opportunistic infection or exposure.

~~(7) All DHCP who have exudative lesions or weeping dermatitis of the hand shall refrain from all direct patient care and from handling patient care equipment until the condition resolves~~.

(6) Gloves:

~~(8)(A)~~ Medical examination gloves shall be worn by DHCP whenever there is contact with mucous membranes, blood, OPIM, and during all pre-clinical, clinical, post-clinical, and laboratory procedures. Medical examination gloves are disposable, synthetic single-use only items. Gloves shall be replaced when torn or punctured, upon completion of dental treatment, and before leaving laboratories or areas of patient care activities.

(B) Chemical and puncture-resistant utility gloves shall be available at the point of use and worn by DHCP for cleaning, sterilization, and disinfectant procedures. Chemical and puncture-resistant utility gloves shall be cleaned and disinfected or

sterilized in accordance with the manufacturer's instructions. Disposable utility gloves shall be disposed of after each use.

(C) When processing contaminated sharp instruments, needles, and devices, DHCP shall wear ~~heavy-duty~~chemical and puncture-resistant utility gloves ~~to prevent puncture wounds~~. Utility gloves shall be cleaned and sterilized in accordance with the manufacturer's instructions after each use.

(D) Gloves ~~must~~shall be discarded under any of the following circumstances:

(i) when torn or punctured~~,~~;

(ii) upon completion of dental treatment when using medical examination gloves;~~,~~ and,

(iii) before leaving laboratories or areas of patient care activities when using medical examination gloves.

(E) All DHCP shall perform hand hygiene protocols and hand care procedures specified in paragraph (5) before donning gloves and after removing and discarding medical examination gloves. Medical examination ~~G~~gloves shall not be washed before or after use, or reused.

(7) Needle and Sharps Safety:

~~(9)(A)~~ Needles shall be recapped only by using the scoop technique or a protective device. Needles shall not be bent or broken for the purpose of disposal.

(B) Disposable needles, syringes, scalpel blades, or other sharp items and instruments shall be placed into sharps containers for disposal as close as possible to the point of use according to all applicable local, state, and federal regulations.

(8) Sterilization and Disinfection:

~~(10)~~(A) All ~~germicides must~~ products used to clean or disinfect items or surfaces shall be used in accordance with intended use and label instructions.

~~(11)~~(B) Standard precautions for disinfection and sterilization shall be performed in the following order:

(i) first, use appropriate hand hygiene protocols and hand care in accordance with paragraph (5);

(ii) second, ~~C~~clean~~ing must precede~~ items or surfaces prior to any disinfection or sterilization process; and,

(iii) third, use the disinfection or sterilization standards required by this section. ~~Products used to clean items or surfaces prior to disinfection procedures shall be used according to all label instructions~~ Disinfection procedures shall include use of a Cal/EPA-registered product with an applicable disinfection classification in accordance with paragraph (6) of subsection (a) to disinfect items.

~~(12)~~(C) Critical instruments, items, and devices shall be ~~discarded or~~ pre-cleaned, packaged or wrapped, and sterilized after each use. Methods of sterilization shall include steam under pressure (autoclaving), chemical vapor, and dry heat. If a critical item is heat-sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process. These instruments, items, and devices~~,~~ shall remain sealed and stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(13)~~(D) Semi-critical instruments, items, and devices shall be pre-cleaned, packaged or wrapped, and sterilized after each use. Methods of sterilization include steam under pressure (autoclaving), chemical vapor and dry heat. If a semi-critical item is heat sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process. These packages or containers shall remain sealed and shall be stored in a manner so as to prevent contamination, and shall be labeled with the date of sterilization and the specific sterilizer used if more than one sterilizer is utilized in the treatment facility. If stored, sterilized packaging is compromised (e.g., wet, torn, or punctured), the instruments shall be recleaned, packaged in new wrap, and sterilized again before use.

~~(14)~~(E) Non-critical surfaces and patient care items shall be cleaned and disinfected after every use with a ~~California Environmental Protection Agency (~~Cal/EPA~~)~~-registered hospital disinfectant (low-level disinfectant) spray or wipe ~~labeled effective against HBV and HIV~~. When the item is visibly contaminated with blood or OPIM, a Cal/EPA-registered hospital intermediate-level disinfectant with a tuberculocidal claim shall be used.

~~(15)~~(F) All high-speed dental hand pieces, low-speed hand pieces, rotary components, including the motor, and dental unit attachments such as reusable

air/water syringe tips and ultrasonic scaler tips, shall be packaged, labeled, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item.

~~(16)~~(G) Single use critical, semi-critical, and non-critical disposable items such as scalpel blades, prophylaxis angles, prophylaxis cups and brushes, tips for high-speed evacuators, saliva ejectors, air/water syringe tips, and gloves shall be used for one patient only and discarded.

~~(17)~~(H) Proper functioning of the sterilization cycle of all sterilization devices shall be verified at least weekly through the use of a biological indicator (such as a spore test) with results confirmed by either authorized DHCP or an independent laboratory. Test results shall be documented and maintained for 12 months.

(I)(i) A chemical indicator shall be used inside every sterilization package to verify that the sterilizing agent has penetrated the package and reached the instruments inside. If the internal chemical indicator is not visible from the outside of the package, an external chemical indicator shall also be used.

(ii) The chemical indicator shall be inspected immediately when removing packages from the sterilizer; if the chemical indicator did not register that the sterilizing agent has penetrated the package, the instruments shall be repackaged and sterilized again.

(9) Irrigation:

~~(18)~~(A) Sterile coolants/irrigants shall be used for surgical procedures involving soft tissue or bone.

(B) When performing procedures on exposed dental pulp, water or other irrigation solutions shall be sterile or contain disinfecting or antibacterial properties.

(C) Sterile coolants/irrigants ~~must~~shall be delivered using a sterile delivery system.

(10) Treatment Facilities:

~~(19)~~(A) If non-critical items or clinical contact surfaces likely to be contaminated ~~are~~ or manufactured in a manner preventing cleaning and disinfection, they shall be ~~protected~~physically covered with disposable impervious barriers approved by the FDA and designed by the manufacturer for that purpose. Disposable barriers shall be changed when visibly soiled or damaged and between patients.

~~(20)~~(B) Clean and disinfect all clinical contact surfaces that are not protected by impervious barriers using a ~~California Environmental Protection Agency (~~Cal/EPA~~)~~ ~~-~~ registered, hospital grade low- to intermediate-level ~~germicide~~disinfectant after each patient. The low-level disinfectants used shall be labeled effective against HBV and HIV. Use an intermediate-level disinfectant if visibly contaminated with blood. Use disinfectants in accordance with the manufacturer's instructions.

(C) Clean all housekeeping surfaces (e.g. floors, walls, sinks) with a detergent and water or a Cal/EPA~~-~~ registered, hospital grade disinfectant. Products used to clean items or surfaces prior to disinfection procedures shall be clearly labeled, and DHCP shall follow all ~~material~~ safety data sheet (~~M~~SDS) handling and storage instructions.

~~(21)~~(D) Dental unit water lines shall be anti-retractive. At the beginning of each workday, dental unit lines and devices shall be ~~purged with air or~~ flushed with water for at least two (2) minutes prior to attaching handpieces, scalers, air water syringe tips, or other devices. The dental unit lines and devices shall be flushed ~~between~~ after each patient for a minimum of twenty (20) seconds. Dental unit water lines shall be monitored or tested routinely in accordance with manufacturer's instructions.

~~(22)~~(E) Contaminated solid waste shall be disposed of according to applicable local, state, and federal environmental standards.

(11) Lab Areas:

~~(23)~~(A) Splash shields and equipment guards shall be used on dental laboratory lathes. Fresh pumice and a sterilized or new, disposable rag-wheel shall be used for each patient. ~~Devices~~

(B) Laboratory equipment, including handpieces, polishing (rag) wheels, grinding wheels, and laboratory burs, used to polish, trim, or adjust contaminated appliances and ~~intraoral~~ prosthetic devices shall be cleaned, disinfected ~~or sterilized~~, properly packaged or wrapped, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item as specified in subparagraph (D) of paragraph (8), or if a single-use item, disposed of in accordance with subparagraph (G) of paragraph (8).

(C) Laboratory equipment shall be stored in a manner consistent with the same storage practices as a semi-critical item as specified in subparagraph (D) of paragraph (8).

~~(24)~~(D) All intraoral items such as impressions, bite registrations, and prosthetic and orthodontic appliances shall be cleaned and disinfected with ~~an~~ Cal/EPA-registered intermediate-level disinfectant before and after manipulation in the laboratory and before placement in the patient's mouth. Such items shall be thoroughly rinsed prior to placement in the patient's mouth.

(12) Respiratory Hygiene/Cough Etiquette: Measures shall be implemented to contain respiratory secretions and to prevent droplet and fomites transmission of respiratory pathogens, especially during seasonal outbreaks of viral respiratory infections such as influenza, RSV, adenovirus, parainfluenza virus, or SARS-CoV-2 (COVID-19) virus, as follows.

(A) Prominently posting at least one sign at every point of entrance and reception or registration desk of the treatment facility, accessible to public view, in which case the signs shall be in at least 12-point type font. The signs shall contain instructions to patients who cough or sneeze at the treatment facility to do at least all of the following: (i) cover their mouths or noses when coughing or sneezing; (ii) use and dispose of tissues in waste receptables; and, (iii) wash hands with soap and water or use alcohol-based hand rub after coughing or sneezing.

(B) Provide tissues and no-touch receptacles (e.g. foot-pedal operated lid or open plastic-lined waste basket) for disposal of tissues.

(C) Have soap, warm running water, and paper towels, or alcohol-based hand rub available for use in or immediately adjacent to waiting areas.

(D) Offer masks to coughing or sneezing patients or other persons when they enter the treatment facility.

(E) Provide distance between patients who cough or sneeze in common waiting areas. If available, facilities shall place these patients in a separate area while waiting for care.

(c) DHCP who are employers of other DHCP shall provide those personnel with a training program on the minimum standards required by this section and the infection control plan specified in paragraph (2) of subsection (b). Such training program shall be provided at no cost to the personnel and during working hours in accordance with all of the following.

(1) The training program shall be provided as follows:

(A) Prior to assignment to tasks where OPIM exposure may take place; and,

(B) Within one year of the date of the DHCP's previous training thereafter.

(2) DHCP employers shall provide additional training prior to or by the effective date of any change to the minimum standards in this section or to the written infection control plan specified in paragraph (2) of subsection (b). The additional training may be limited to addressing the changes in the standards required by this section or the written infection control plan.

~~(c) The Dental Board of California and Dental Hygiene Committee of California shall review this regulation annually and establish a consensus.~~

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~~[1] Cal/EPA contacts: WEBSITE www.cdpr.ca.gov or Main Information Center (916) 324-0419.~~

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1680, Business and Professions Code.

**ATTACHMENT 3**

February 7, 2025

Dental Board of California
2005 Evergreen Street #1550
Sacramento, CA 95815

RE: Dental Assisting Alliance comments on Section 1005 – Minimum Standards of Infection Control

To Whom it May Concern:

At the February 6th Dental Assisting Council meeting, we provided testimony regarding issues we see that need to be addressed on the following items within the proposed new 1005 regulations:

**(a)(8**) – definition of "sterilization: it says a "mechanical process" of elimination of all forms of life …

> **Issue**: This eliminates the use of "cold sterile" with the word "mechanical" – is the intent to eliminate the use of cold sterile as an option?

**(a)(9)(A) and (B)** – mentions hand scrubbing first, which seems to indicate that hand scrubbing is the first acceptable method of removing debris.

> **Issue**: Hand scrubbing should be a last resort when other methods of cleaning are not effective. Aren't mechanical devices for debris removal recommended by OSHA for the safety of the ADHP?

**(b)(4)(F)** – "Protective attire shall be changed daily, or **immediately** if they should become moist or visibly soiled."

> **Issue**: This would indicate that when doing a coronal polish, for example, we have to change the attire as soon as we see some prophy paste specks on our gown . . . if we do that, then we would be removing it every few minutes . . . doesn't make sense. This needs to be clarified for better interpretation of intent.

**(b)(6)(B**) – …"utility gloves shall be available at the point of use and worn by DHCP for clinical care break down (**setting up** or breaking down a treatment room, cleaning, and disinfectant procedures."

> **Issue**: utility gloves are absolutely **NOT** the protocol for setting up a treatment room! We need to set up with clean hands – not with gloves and especially not with utility gloves which are meant to be used for PROCESSING INSTRUMENTS and HANDLING CHEMICALS.

**(b)(6)(B**) – …"utility gloves shall be cleaned and **sterilized** in accordance with the manufacturer's instructions **after each use**."

**Issue 1**: The requirement to sterilize utility gloves after each use is exceedingly unrealistic. It is hard enough to get offices to even use the utility gloves, but to require them to sterilize them is just not going to happen. Routine disinfection of the utility gloves is more realistic.

**Issue 2**: The verbiage here seems to indicate that disposable utility gloves are unacceptable since "utility gloves must be sterilized."

**PROPOSED CHANGE**: "utility gloves shall be cleaned and routinely disinfected and discarded if compromised in any way. Disposable utility gloves shall be disposed of after each use."

**(b)(8)(c)** – states that critical instruments . . . shall be . . . "sterilized **immediately** after each use."

**Issue**: This is unrealistic in the average dental office. ADHPs are often not able to process the instruments and get them sterilizing immediately; especially with the shortage of ADHPs. In addition, this does not allow for when the sterilizers are all full and running . . . the instruments are not going to be able to be sterilized immediately.

**PROPOSED CHANGE**: Though we understand that ambiguity is tough to enforce in regulation, better wording would be "critical instruments . . . shall be . . .processed and placed into packets or wrappers and "sterilized as soon as possible after each use."

**(b)(8)(F)** – This section has been an issue historically as it doesn't address whether or not the "motor" of a slowspeed handpiece must be sterilized after each use.

**Issue**: This is a VERY common issue in offices where there is confusion as to whether or not the motor is part of the handpiece that needs to be sterilized.

**PROPOSED CHANGE**: Add a statement specifically addressing whether or not the motor is considered part of the handpiece that needs to be sterilized – or specifically state that when the motor is deattachable from the nosecone, the motor does (or does not) need to be sterilized. Suggestion: ""Handpieces shall be processed and sterilized after each use including the motor and all component parts"

**(b)(10)(D)** – This section is on waterline maintenance.

**Issue 1**: The state of California has a law which requires the use of disinfectants in the water to control biofilm. The DBC regulations should reiterate and/or expand on that law. For example, the DBC could add a requirement for monthly water testing which would help to support the process for keeping the biofilm levels below 500 CFU.

**Issue 2**: The addition of the requirement to flush the waterlines "after the final patient of the day" is unnecessary and in contradiction to the purpose of flushing the lines. Flushing provides the freshest water for the patient, removing the free-floating biofilm so that the patient doesn't get the "stagnant" water, with a higher concentration of biofilm sprayed in their mouth. Flushing the waterlines after the last patient of the day, when the water is going to sit for 12 hours and will be flushed for 2 minutes at the beginning of the next day, is illogical and unnecessary.

We appreciate all of the hard work done by the workgroup on this project and believe **there are many great changes within this proposal.**

Sincerely,

The Dental Assisting Alliance

**From:** Leslie Canham & Associates, LLC
**To:** Cara Miyasaki; Montez. Tracy@DCA; Nelson. Brant@DCA; Bell . Christy@DCA
**Subject:** RE: Input Requested
**Date:** Tuesday, February 11, 2025 12:15:25 AM
**Attachments:** imageO0l.png
image003.png
Leslie Canham $\mathcal{O}\,\mathcal{J}$ BIO- 2024.pdf
2025-02-10 23 33 01-Topics - Dental Unit Waterline s (DUWL) .png
2025-02-10 23 36 23-Topics - Dental Unit Waterline s (DUWL) .png
2025-02-10 23 37 29-RR5217 Dental Front.pmd.png
2025-02-10 23 38 03-RR5217 Dental Front.pmd.png
2025-02-10 23 43 15-Notice-of-Intent-to-Adopt-Rule-150-8-.05 (002).pdf - Adob e Acrobat Pro.png
5075-dental-unit-water-quality-organization-for-safety-asepsis-and-prevention-white-paper-and-recommendations-2018 (2).pdf
DUWL One Page Guide Infection Control.pdf



Cara,
Thank you for bringing my name and contact information to the members of DCA.

Dr. Montez, Brant, and Christy,
I would very much like to participate in the IC working group and contribute my expertise, knowledge, and experience in providing reliable resources concerning Dental Infection Control to the working group to update the§ 1005. Minimum Standards for Infection Control. I previously participated with the Calif Dental Assistants Association workgroup for the 2011 Infection Control "draft" language and helped to form a consensus with the Dental Hygiene "Committee".

I have over 53 years of experience in dentistry, have been a Registered Dental Assistant for 48 years, and hold a Certified Dental Assistant certification. I'm also Certified in Dental Infection Prevention and Control. For the last 25 years, I have been a CA Dental Board Registered CE provider {including Infection Control and Calif Dental Practice Act) and a provider of the 8 hour Infection Control course since 2009. I'm Authorized by the Federal government as an OSHA outreach trainer and I have experience writing questions for the Dental Assisting National Board (DANB) Infection Control exam required for applicants to become Certified Dental Assistants.

In 2017, Dr. Jayanth Kumar, the state's Dental Director brought my name forward to the Orange County Public Health Agency, where Chief Eric G. Handler asked me to investigate the 2016 Nontuberculous Mycobacterium outbreak at the Children's Dental Group. My investigative report was submitted to Dr. Handler and forwarded to CDC's Division of Oral Health. Since my investigation, I have provided Expert Witness testimony in numerous depositions in the 200 lawsuits that have been filed as a result of this outbreak.

I believe I can help the IC working group form draft regulations in a quick and efficient manner that have validated scientific evidence, are consistent with CDC Guidelines for Dental Healthcare settings, ADA recommendations and CAL/OSHA regulations on bloodborne pathogen/hazard communication standards. I also have collected a library of resources and references that support my recommendations on Dental Infection Control.

I understand that DCA does not want to go back to the drawing board with more delays. I believe that my experience, expertise, and my long time relationship with the California Dental Association will expedite the review process and help move the revised draft language forward.

I attached my CV to this email for your review. And per Cara's email last week, For the DUWL – Cara asked me to provide information on how I recommend monitoring of DUWL (screen shots) and provide the CDC/OSHA or other agency where I found the information. Please see the 2nd and 3rd attachments which are screenshots of DUWL referenced and resources on the ADS (formerly OSAP) website. The 4th and 5th attachments are from the 2003 CDC Guidelines for Infection Control,
Also in addition to Washington state's requirements for Dental Unit Water testing, on 2-7-25, Georgia passed new water quality rules, (6th attachment and see the link below):
https://www.gadental.org/latest-news/2025/02/07/board-of-dentistry-adopts-new-dental-unit-water-quality-rule

The 7th attachment is the DENTAL UNIT WATER QUALITY: ORGANIZATION FOR SAFETY,
ASEPSIS AND PREVENTION WHITE PAPER AND RECOMMENDATIONS-2018
which has the current recommendations on Dental Unit Water testing and frequency.

The last attachment is a PDF on ADA's recommendation for DUWL

Disclaimer: I do not currently have a financial interest in any dental unit water testing companies.

Respectfully,

Leslie Canham, CDA, RDA, CDIPC, CSP

**From:** Cara Miyasaki <miyasakicara@fhda.edu>
**Sent:** Monday, February 10, 2025 4:54 PM
**To:** Montez, Tracy@DCA <Tracy.Montez@dca.ca.gov>; Nelson, Brant@DCA

# Dental Unit Waterlines (DUWL)

Overview | Resources | Fact Sheets & Information | Related Articles

## Overview

Biofilm is a thin, slimy film of bacteria that sticks to moist surfaces. Dental unit waterlines have unique characteristics that make them prone to biofilm formation, including long, small-diameter tubing, low flow rates, and frequent periods of stagnation.

High numbers of common water bacteria can be found in untreated dental unit water systems, including *Legionella*, *Pseudomonas aeruginosa*, and nontuberculous *Mycobacteria*. These bacteria can cause serious, sometimes life-threating infections. Source: CDC

## Resources

Centers for Disease Control and Prevention (CDC)

- Guidelines for Infection Control in Dental Health-Care Settings — 2003
  - Appendix A - Regulatory Framework for Disinfectants and Sterilants;includes Figure: Decreasing Order of Resistance of Micro-organisms to Germicidal Chemicals
  - Appendix B - Immunizations Strongly Recommended for Health-Care Personnel (HCP)
  - Appendix C - Methods for Sterilizing and Disinfecting Patient-Care Items and Environmental Surfaces
- Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care
- Infection Prevention Checklist for Dental Settings Basic Expectations for Safe Care
- HAN - October 31, 2022 - Outbreaks of Nontuberculous *Mycobacteria* Infections Highlight Importance of Maintaining and Monitoring Dental Waterlines
- *Mycobacterium absecessus* in Healthcare Settings
- Dental Unit Water Quality
- Infection Prevention & Control in Dental Settings

- Dental Unit Water Quality: Organization for Safety, Asepsis and Prevention White Paper and Recommendations– 2018
- ADS Recommendations to Clinicians
- Message to My Patients
- Questions to Help Guide Selection of Dental Waterline Devices and Chemical Treatment Options
- Checklist for Dental Unit Water Quality Improvement
- Troubleshooting Dental Water Quality Problems
- Glossary of Terminology

Food and Drug Administration (FDA)

- Dental Unit Waterlines

American Dental Association (ADA)

- Dental Unit Waterlines

### Fact Sheets & Information

Association for Dental Safety (ADS), formerly known as the Organization for Safety, Asepsis and Prevention (OSAP)

- Dental Unit Waterline Fact Sheet

### Related Articles

- Woman Dies After Contracting Legionnaires' Disease From Dentist's Office
- Notes from the Field: *Mycobacterium abscessus* Infections Among Patients of a Pediatric Dentistry Practice — Georgia, 2015
- Invasive Mycobacterium abscessus Outbreak at a Pediatric Dental Clinic

## Strategies To Improve Dental Unit Water Quality

In 1993, CDC recommended that dental waterlines be flushed at the beginning ofthe clinic day co reduce the microbial load (2). However, studies have demonstrated this practice does not affect biofilm in the waterlines or reliably improve the quality of water used during dental treatment *(315,338,343)*. Because the recommended value o f.s.500 CFU/mL cannot be achieved by using this method, other strategies should be employed. Deneal unit water that remains untteaced or unfiltered is unlikely to meet drinking water standards *(303-309)*. Commercial devices and procedures designed co improve the quality ofwater used in dental treatment are available *(316);* methods demonstrated to be effective include self-contained water systems combined with chemical treatment, in-line microfilters, and combinations of these treatmencs. Simply using source water containing .s.500 CFU/mL ofbacteria (e.g., tap, distilled, or sterile water) in a self-contained water system will not eliminate bacterial concaminacion in treatment water ifbiofilms in the water system are not controlled. Removal or inactivation ofdental waterline biofilms requires use ofchemical germicides.

## Maintenance and Monitoring of Dental Unit Water

DHCP should be trained regarding water quality, biofilm formation, water treatment methods, and appropriate maintenance protocols for water delivery systems. Water treatment and monitoring products require strict adherence to maintenance protocols, and noncompliance with treatment regimens has been associated with persistence of microbial contamination in treated systems (*345*). Clinical monitoring of water quality can ensure that procedures are correctly performed and that devices are working in accordance with the manufacturer's previously validated protocol.

Dentists should consult with the manufacturer of their dental unit or water delivery system to determine the best method for maintaining acceptable water quality (i.e., ≤500 CFU/mL) and the recommended frequency of monitoring. Monitoring of dental water quality can be performed by using commercial self-contained test kits or commercial water-testing laboratories. Because methods used to treat dental water systems target the entire biofilm, no rationale exists for routine testing for such specific organisms as *Legionella* or *Pseudomonas*, except when investigating a suspected waterborne disease outbreak (*244*).

# SYNOPSIS OF PROPOSED ADOPTIONS OF THE GEORGIA BOARD OF DENTISTRY RULE 150-8-.05 DENTAL UNIT WATER QUALITY.

**Purpose:** To require and set standards for the testing of dental unit water lines in the practice of dentistry in Georgia, and to require remedial action in the event dental unit water lines fail testing.

**Main Features:** This rule requires routine testing of dental unit water lines, establishes standards and procedures for said testing, provides criteria for a failed test and remedial action, and requires maintenance of a record of such testing.

# DIFFERENCES OF PROPOSED ADOPTIONS OF THE GEORGIA BOARD OF DENTISTRY RULE lS0-8-.0S DENTAL UNIT WATER QUALITY.

NOTE: Struck through text is proposed to be deleted. Underlined text is proposed to be added.

A copy of the draft rule approved by the Board is attached hereto.

Journal of Dental Infection Control and Safety

# DENTAL UNIT WATER QUALITY: ORGANIZATION FOR SAFETY, ASEPSIS AND PREVENTION WHITE PAPER AND RECOMMENDATIONS–2018

## Statement Editors*:

Shannon E. Mills, DDS, Concord, NH

Nuala Porteous, BDS, MPH, University of Texas Health, School of Dentistry, San Antonio, TX (Retired)

Jeff Zawada, PhD, Director, Technical Research, A-dec, Inc., Newberg OR and Chair, Subcommittee 6 - Dental Equipment, ANSI/ADA Standards Committee for Dental Products

This white paper and recommendations replaces the Organization for Safety, Asepsis and Prevention (OSAP) Dental Unit Waterline Position Paper originally published in January 1997 and revised in 2000.

**Purpose:** This OSAP white paper is intended to:

- Provide guidance for the manufacturers of dental units, dental water treatment devices and chemical agents to meet or exceed Centers for Disease Control and Prevention (CDC) recommendations for dental water quality, current US and international voluntary consensus standards and regulatory and/or registration requirements of the US Food and Drug Administration (FDA) and state and federal Environmental Protection Agencies (EPA).
- Provide recommendations for dental health care personnel (DHCP) on managing dental procedural water quality to meet or exceed current CDC recommendations to ensure the health and safety of patients and DHCPs.
- Provide recommendations regarding the adoption of voluntary consensus standards related to dental procedural water quality.

**Applicability:** The recommendations contained in this white paper apply to the design and use of devices and products that deliver water used for dental procedures or are marketed to improve, maintain or monitor the microbiological quality of dental procedural water used in patient treatment including:

- Dental units and accessories including handpieces and air-water syringes.
- Portable dental equipment.

- Ultrasonic scalers.
- Surgical handpieces.
- Dental lasers.
- Dental water treatment devices, such as slow release cartridges, water conditioning devices, antimicrobial tubing and reservoirs.
- Chemical germicides and cleaners.
- In-office test kits and third-party testing and monitoring services.

**Exclusions:** This document is not intended to serve as a manual or provide exclusive guidance for the control of waterline contamination in clinical settings. Dentists should contact the manufacturer of their dental equipment or water treatment products for specific guidance and instructions on methods to improve and maintain the quality of dental procedure water.

OSAP concurs with applicable recommendations on the general management of water used in health-care settings contained in the 2003 CDC Guidelines for *Environmental Infection Control in Health-Care Facilities* but does not provide specific guidance in this document on:

- The design, monitoring and remediation of water contamination in premise plumbing.
- The quality of water delivered by publicly owned water treatment works.
- Dental vacuum systems and amalgam separators.

## DEFINITIONS

**510(k) -** A premarket submission made to the US Food and Drug Administration to demonstrate that the device to be marketed is at least as safe and effective, that is, substantially equivalent, to a legally marketed device (21 CFR 807.92(a)(3)) that is not subject to Pre-Market Approval (PMA).

**Biofilm -** An assemblage of microbial cells that is irreversibly associated (not removed by gentle rinsing) with a surface and enclosed in a matrix of primarily polysaccharide material. (After Donlan, RM, 2002[1])

**Dental equipment -** Furniture, machines, apparatus and accessories made for use in the practice of dentistry and/or its associated procedures. (Adapted from ISO 1942:2009, definition 2.68)

**Dental unit -** Combination of interconnected dental equipment and dental instruments constituting a functional assembly for use in the provision of dental treatment. (Source: ISO 1942:2009, definition 2.86)

**Device (Medical)** - An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is:

1. recognized in the official National Formulary, or the United States Pharmacopeia, or any supplement to them;
2. intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or;
3. intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. (Source: US FDA, Food, Drug and Cosmetics Act Section 201(h))

**Heterotrophic plate count (HPC)** - Formerly known as the standard plate count. A culture method for estimating the number of live heterotrophic bacteria in water. (Source: US Environmental Protection Agency. *Fed. Regist.* 54(124): 27486–27541.)

**Oral Surgical Procedures** - The incision, excision, or reflection of tissue that exposes the normally sterile areas of the oral cavity. Examples include biopsy, periodontal surgery, apical surgery, implant surgery, and surgical extractions of teeth (e.g., removal of erupted or nonerupted tooth requiring elevation of mucoperiosteal flap, removal of bone or section of tooth, and suturing if needed). (Source: Centers for Disease Control and Prevention *Guidelines for Infection Control in Dental Health-Care Settings - 2003*[2])

**Procedural water** - Water for use in the oral cavity. Also known as dental unit water or dental treatment water. (Adapted from ISO 7494-2: 2015 *Dentistry - Dental Units*)

**Sterile water for irrigation** - Sterile, hypotonic, nonpyrogenic water prepared by distillation that contains no antimicrobial or bacteriostatic agents or added buffers. The pH is 5.7 (5.0-7.0). (Source: United States Pharmacopeia, USP 29: 2265)

**Sterile Saline** - A 0.9% solution of sodium chloride utilized for a variety of clinical indications such as sterile irrigation of body cavities, tissues or wounds that also serves as a diluent or vehicle for drugs used for irrigation or other pharmaceutical preparations. (Source: United States Pharmacopeia – USP 29-NF24:1976)

## ABBREVIATIONS

ADA - American Dental Association

ANSI - American National Standards Institute

AWWA - American Water Works Association

CDC - Centers for Disease Control and Prevention

CFU/mL - Colony forming units per milliliter

DFU - Directions for use (see also IFU)

DHCP - Dental health-care personnel

DUWL - Dental unit waterline

EPA - US Environmental Protection Agency

FDA - US Food and Drug Administration

HAI - Healthcare-associated infections

HPC - Heterotrophic plate count

IC - Infection control (or infection prevention and control)

IFU - Instructions for Use (See also DFU)

ISO - International Organization for Standardization

LPS - Lipopolysaccharide

MCL - Maximum contaminant level

NTM - Non-tuberculous mycobacteria

OSHA - US or State Occupational Safety and Health Administration

SOP - Standard operating procedure

Sterile - Free from all living microorganisms; usually described as a 1 in 1 million chance that a microorganism will survive the sterilization process

USP - United States Pharmacopeia

UVGI - Ultraviolet germicidal irradiation

## APPLICABLE GUIDELINES STANDARDS AND REGULATIONS

American Dental Association. Oral Health Topics: Dental unit waterlines, April 2016. Available at: http://www.ada.org/en/member-center/oral-health-topics/dental-unit-waterlines

Center for Biofilm Engineering, Montana State University - Interdisciplinary glossary, 1999; Available at: http://www.erc.montana.edu/Res-Lib99-SW/glossary/Gterms.html

Centers for Disease Control and Prevention - *Guidelines for Infection Control in Dental Health-Care Settings—2003.* Morbidity and Mortality Weekly Report; 52:RR-17. Available at: www.cdc.gov/mmwr/PDF/rr/rr5217.pdf

Centers for Disease Control and Prevention - *Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care* – 2016, Available at: www.cdc.gov/oralhealth/infectioncontrol/pdf/safe-care.pdf

Centers for Disease Control and Prevention and the Healthcare Infection Control Practices Advisory Committee - *Guidelines for Environmental Infection Control in Health-Care Facilities*, Morbidity and Mortality Weekly Report, June 6, 2003 /52(RR10);1-42 Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm

International Organization for Standardization - ISO 16954:2015 Dentistry — *Test Methods for Dental Unit Waterline Biofilm Treatment,* International Organization for Standards, Geneva, Switzerland. July 2015. Available at: https://www.iso.org/standard/58009.html

Occupational Safety and Health Administration. 15A, 1999. Available at: http://www.oshaslc.gov/dts/osta/otm/otm_toc.html

U.S. Environmental Protection Agency; *National Primary Drinking Water Regulations.* Available at: https://www.epa.gov/ground-water-and-drinking-water/national-primary-drinking-water-regulations

U.S. Environmental Protection Agency, *Frequently Asked Questions on the Dental Office Category Rule*. Available at: https://www.epa.gov/sites/production/files/2017-12/documents/dental-office-category_frequent-questions_nov-2017.pdf

U.S. Food and Drug Administration, *Dental Unit Waterlines.* Available at: https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/DentalProducts/ucm610545.htm

U.S. Food and Drug Administration, *Requests for Feedback on Medical Device Submissions: The Pre-Submission Program and Meetings with Food and Drug Administration Staff Guidance for Industry and Food and Drug Administration Staff*. Available at: https://www.fda.gov/downloads/medicaldevices/deviceregulationandguidance/guidancedocuments/ucm311176.pdf

## BACKGROUND

**Biofilm and Human Health:** Microbial biofilms can be found virtually anywhere there is moisture and a solid surface for bacterial attachment[1, 3]. Consisting primarily of naturally occurring, slime-producing bacteria and fungi, biofilms in dental units form on the luminal walls of the small-bore plastic tubing that delivers water for cooling and irrigation to the dental handpieces, sonic and ultrasonic scalers, air-water syringes and other devices used in patient care[4-6]. The narrow diameter of dental unit waterlines (DUWL) increases the surface area available for biofilm growth relative to the volume of water in the lines, leading to levels of microbial contamination in effluent water that may exceed 1,000,000 colony-forming units per milliliter (CFU/mL)[4].

Although bacteria of possible human origin have been reported in the literature, most of the organisms recovered from DUWLs occur naturally in aquatic environments. Water from dental units colonized with gram negative heterotrophic biofilms can have high levels of lipopolysaccharide (LPS also known as endotoxin)[7-9] that can trigger and/or exacerbate asthma in dental patients and DHCPs[10]. LPS can also cause skin rashes, gastrointestinal reactions and may result in delayed wound healing.

The presence of opportunistic human pathogens in DUWLs, such as *Pseudomonas aeruginosa*, non-tuberculous mycobacteria (NTM)[11-13] and *Legionella* species[14-16] have provided cause for concern[12, 13, 17]. Two cases of postoperative *Pseudomonas* infections in immunocompromised patients were the direct consequence of exposure to contaminated procedural water[18]. Biofilms can be important replication sites for NTM and *Legionella* species as they can survive and replicate in free-living amoebae and protozoa found in biofilms[19-22]. NTM are typically resistant to disinfectant residuals present in potable water and have been found in the effluent immediately after DUWL treatment[12]. *Mycobacterium abscessus*, isolated from DUWLs were found to be the source in separate outbreaks of pediatric post-operative infections in Georgia [23, 24] and California[25].

A fatal case of *Legionella pneumonia* in an elderly woman in Italy was reported in 2014. Investigators traced the origin of the *Legionella* species to DUWLs where the patient had received recent treatment[26]. In 2017, a case report from Sweden described a fatal case of Legionellosis in elderly immunocompromised man who received dental treatment in a hospital dental clinic. In this case, analysis of clinical specimens and isolates from the dental unit cup-filler used for oral rinsing strongly suggested that they were of common origin[27].

Serological evidence of exposure to *Legionella* bacteria have been reported in dental health-care personnel[28-30]. A post-hoc review of screening for serologic markers of *Legionella* exposure in dentists conducted as part of the American Dental Association (ADA) dentist health screening program however, found that dentists appeared to be no more likely to exhibit evidence of exposure than the general population[31].

Several investigations studying the quality of water in hospitals have established that potable, non-sterile water contains naturally occurring bacteria (some of which are opportunistic pathogens). Typically, only rare infections have occurred in healthy persons from ingestion or contact. However, there is an increased risk of infection for exposed immune compromised patients. Health care-associated infections have been linked to contaminated potable water, tap water, and other hospital water systems, especially among patients who are immune compromised or severely ill[32-35]. Distillers and reverse osmosis devices can remove contaminants including microorganisms from water, but membranes, tubing and holding tanks connected to them can also become colonized with biofilm[36, 37].

There are currently no case reports of infections, nor is there a scientific basis for determining a threshold limit of risk associated with the use of water for non-surgical dental procedures that meets current CDC recommendations for water used in dental treatment. The use of water with high levels of bacterial contamination for dental therapeutic procedures however, is inconsistent with recognized standards of infection control and can potentially undermine public confidence in the dental profession. For these reasons, OSAP urges all stakeholders to strive to achieve the lowest possible levels of microbial contamination achievable within the limitations of current technology.

**CDC Recommendations for Dental Water Quality:** The Centers for Disease Control and Prevention *Guidelines for Infection Control in Dental Health-Care Settings—2003*[2] include specific recommendations on the use of coolant and irrigating solutions in dentistry and on the control of microbial contamination in water used for dental treatment:

- Use water that meets the CDC recommended limit for dental procedural water (i.e., <500 CFU/mL of heterotrophic water bacteria) for routine dental treatment.
- Consult with the dental unit manufacturer for appropriate methods and equipment to maintain the recommended quality of dental water.
- Follow recommendations for monitoring water quality provided by the manufacturer of the unit or waterline treatment product.
- Discharge water and air for a minimum of 20–30 seconds after each patient, from any device connected to the dental water system that enters the patient's mouth (e.g., handpieces, ultrasonic scalers, and air/water syringes).
- Consult with the dental unit manufacturer on the need for periodic maintenance of anti-retraction mechanisms.

The CDC recommended limit is derived from recommendations for HPC bacterial counts under the U.S. EPA's Surface Water Treatment Rule for systems using surface water or groundwater under the direct influence of surface water.

According to the EPA, heterotrophic plate count (HPC) and related methods such as those described above do not provide a measure of health effects. They are analytic methods used to measure the variety of bacteria that are common in water and demonstrates how well maintained the water system is.

EPA does not have a Maximum Contaminant Level (MCL) for HPC and cannot specify a scientifically rational level (other than zero) at which no adverse health effects occur because HPC analysis measures both pathogenic and harmless (innocuous) bacteria. Drinking water with any level of HPC might contain numerous, few, or no pathogens.

EPA considers the health benefits of complying with a bacteria concentration near zero versus some higher level (e.g., 500/mL) as unquantifiable and probably negligible. Additionally, high concentrations of disinfectant would be needed to achieve a near-zero level and could result in excessive levels of disinfection byproducts (which carry their own health risks) in finished drinking water.

The CDC recommended 500 CFU/mL limit for heterotrophic mesophilic water bacteria in water used for non-surgical dental procedures is an engineering standard that does not represent a threshold limit for the avoidance of adverse health outcomes. OSAP concurs with CDC that this limit provides a useful goal for manufacturers of devices, or germicides intended to improve the quality of dental treatment water.

**CDC Guidelines for "Boil Water" Advisories:** The 2003 dental guideline[2] also addresses "boil water" advisories by advising dentists not to deliver water from the public water system through the dental operative unit, ultrasonic scaler, or other dental equipment that uses the public water system until the advisory is lifted. Engineering solutions that isolate dental devices from municipal water provide an additional margin of safety when municipal water supplies are unsafe.

**The CDC Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care. 2016, Mobile App and Checklist:** The CDC issued an online publication and mobile app in 2016 that provides an infection control checklist, which includes a DUWL section that can be used as published or modified for use by dental facilities to assist with IC compliance.

**Progress in Dental Water Quality Management Since 2000:** Since the OSAP position papers of 1997 and 2000, there has been significant progress in developing reliable and economical engineering methods to mitigate the formation of biofilm in dental unit waterlines. There are now numerous FDA-cleared and/or EPA-registered products available for use by the profession. When as directed, these agents and devices enable dentists to provide procedural water of acceptable quality with minimal impact on dental equipment or materials. Products currently marketed to control, eliminate or prevent biofilm formation in dental equipment include:

- EPA-registered chemical germicides or antimicrobial surface treatments.
- Non-EPA-registered waterline cleaners without germicidal claims.
- Independent water reservoirs that isolate dental units from municipal water systems that can be used with intermittent or continuously present cleaners or germicides.
- Automated germicide metering or slow release devices which may also include filtration technology that can be used with independent reservoirs or municipal water connections.
- Sterile water delivery systems, which employ either sterile, disposable or heat sterilized reusable components that are independent of the dental unit water supply.
- Distillers, reverse osmosis and microfiltration devices that can remove microorganisms from procedural water, but which do not effectively limit the growth of biofilm in DUWL or reservoirs without addition of germicidal agents or other anti-biofilm treatment.

Methods for the clinical monitoring of water quality and compliance with treatment protocols include:

- In office test kits for drinking water quality using various media.
- Mail-in or local water laboratory testing services.

**Monitoring Water Quality in Clinical Settings:**

Recent water related outbreaks have heightened awareness of the risks posed by contaminated dental procedural water and have reinforced the importance of monitoring procedural water quality[23, 24]. CDC Guidelines provide general recommendations for monitoring of dental procedural water but do not provide IFU for monitoring by DHCPs using manufacturer validated methods. Monitoring procedural water quality and inspection of dental procedural water systems provides an important margin of safety for DHCPs and patients by confirming that dental equipment and/or water treatment products are achieving water quality objectives. Regular monitoring and inspection can also identify problems with water quality management including but not limited to:

- Staff non-compliance with directions for use.
- Dental unit or device design variables such as dead legs that compromise water quality management.
- Units with excessive biofilm growth that may be refractory to treatment.
- Incompatibility of water treatment products or devices with dental units or other devices.
- Contaminated source water.

While recent reports of outbreaks of NTM and a report of a fatal Legionellosis death in dental settings have raised concerns about current monitoring recommendations, OSAP concurs with current CDC guidelines that do not recommend routine microbiological testing for potential pathogens such as *Legionella* species, *Pseudomonas aeruginosa*, NTM or other waterborne pathogen in health-care settings. Testing as directed by local or state health authorities for specific pathogens in procedural water, should only be performed to investigate the source of infection(s) caused by a water-associated opportunistic pathogen. A negative test for a difficult-to-culture potential pathogen such as *Legionella* may give false reassurance of the safety of dental treatment water.

In the United States, manufacturers of dental units and other equipment have not consistently provided specific recommendations for the control and monitoring of microbial contamination in procedural water. For example, most units presently on the market come with independent water reservoirs as a default option, but the choice of approaches to ensuring water quality including monitoring procedural water quality may be left up to the purchaser.

Similarly, the manufacturers of germicides, cleaners, water conditioning systems, antimicrobial tubing, slow release cartridges and other products, do not always provide specific recommendations on monitoring procedural water quality.

Successful management of water quality is subject to many variables including dental unit design characteristics, efficacy and compatibility of germicidal or cleaning products, input water quality, and

staff compliance. This inherent complexity can lead to treatment failure even with products that have shown excellent results in laboratory or controlled clinical settings.

While FDA and EPA requirements for labeling of products and directions for use clearly apply to products marketed to manage procedural water, consensus appears lacking among product manufacturers on the appropriate methods and frequency of monitoring necessary to ensure the safety of patients and health-care practitioners.

To address these concerns, OSAP recommends that monitoring be performed periodically regardless of the product or protocol used to manage dental procedural water quality, even when manufacturer directions for monitoring are absent or unclear.

OSAP believes that providing minimum baseline guidance for monitoring methods, frequency and for troubleshooting problems with water quality management will assist DHCPs in achieving compliance and guide manufacturers in the development of more effective directions for use.

**Voluntary Consensus Standards:** Voluntary consensus standards are developed within an international framework that sets regional national, regional and global technical standards for products and services. The American Dental Association (ADA) is recognized by the American National Standards Institute (ANSI) as the US representative to International Organization for Standardization (ISO) Technical Committee 106 – Dentistry (TC 106). Regulatory agencies including the US Food and Drug Administration and the US Environmental Protection Agency use voluntary consensus standards in lieu of government-unique standards in their procurement and regulatory activities, except where inconsistent with law or otherwise impractical.

ISO 16954:2015(ANSI/ADA Standard 167) --*Test methods for dental unit waterline biofilm treatment* -- establishes laboratory test methods for evaluating the effectiveness of treatment methods intended to prevent or inhibit the formation of biofilm or to remove biofilm present in dental unit procedural water delivery systems under laboratory conditions.

It does not apply to devices intended to deliver sterile procedural water or sterile solution. It also does not apply to lines, tubing, or hoses that deliver compressed air within the dental unit.

The standard does not establish specific upper limits for bacterial contamination or describe test methods to be used in clinical situations. It also does not establish test methods for evaluating any deleterious side effects potentially caused by treatment methods.

The test methods provided in ISO 16954:2015 can be used to test other dental equipment that delivers non-sterile water to the oral cavity.

With modification, the test methods described in ISO 16954:2015 should also be applicable for evaluating the effectiveness of devices and germicides that are sold separately from dental delivery systems.

**Off-label use of chemical germicides and cleaners:** OSAP does not recommend off-label use of germicides or cleaning agent that do not have regulatory approval or registration for the control of biofilm in dental equipment.

**Areas for Further Research and Development:** Much progress has been made over the last four decades in understanding the nature of biofilm and its role in human disease. In dentistry we have seen the development of procedures and marketing of technology to improve the quality of water used for clinical dental procedures[38-56].

Recent case reports of multiple infections with non-tuberculous Mycobacteria in two pediatric dental practices and a fatal case of Legionellosis linked to dental treatment reinforce the need for research to understand how such cases occur and how they can be prevented.

A limited number of studies have suggested that chronic exposure among dental health-care workers to contaminated dental procedural water in the form of aerosols and droplets containing bacteria and bacterial byproducts including lipopolysaccharide may lead to exacerbation of asthma and onset of other respiratory conditions[7, 9, 10, 57, 58]. Additional investigations may help determine the frequency and consequences of chronic occupational exposure to waterborne contaminants and lead to more effective ways to protect health-care workers.

Continued efforts to conduct research and develop technologies for controlling or eliminating biofilm in dental units and other devices can lead to more safe, effective, and less costly methods for managing dental procedural water quality in dentistry. These efforts should be combined with efforts by manufacturers of dental units and other devices to develop engineering solutions that simplify and where possible, automate water management practices using products that are safe, compatible with dental materials, and that minimize environmental impact.

Monitoring and testing methods currently in use rely on culture recovery methods that use growth media to recover and count viable bacteria. Although they are based on currently accepted standard methods for examination of water, both point-of-use test kits and outsourced laboratory culture methods may undercount bacterial numbers to varying degrees[59]. This phenomenon may be complicated by the presence of non-neutralized residual germicide in samples that may damage organisms and prevent their recovery[60].

Researchers and services that provide dental procedural water testing, should investigate the adoption

of other approaches including non-culture methods that can provide more accurate counts even in the presence of residual germicide.

**Application of the Precautionary Principle:** The precautionary principle[61, 62] is a strategy for decision-making when extensive scientific knowledge relating to potential health risks are lacking but there is plausible risk of harm to patients or health-care workers if the risk is not remediated. In this situation, reasonable measures to avoid threats that are serious and plausible based on anecdotal evidence or extrapolation may be warranted.

OSAP's position is that the presence of high numbers of potentially pathogenic microorganisms in procedural water used for dental treatment is inconsistent with best health-care practices and warrants the application of the precautionary principle to create guidance for improving and maintaining the quality of water used in dentistry even where direct scientific evidence of harm may be lacking. The following recommendations and statements are intended to provide guidance to all stakeholders to help ensure a safe and healthy dental treatment environment.

## OSAP RECOMMENDATIONS FOR MANAGEMENT AND MONITORING OF WATER USED IN DENTAL TREATMENT:

**1. General Statements Regarding the Use of Coolant and Irrigating Solutions in Dentistry**

1.1. OSAP concurs with the recommendation in the CDC *Guidelines for Infection Control in Dental Health-Care Settings—2003* that water used for non-surgical dental procedures should, at a minimum, meet nationally recognized microbiological standards for drinking water according to standard test methods from the American Water Works Association (AWWA) at no more than 500 CFU/mL of heterotrophic, mesophilic water bacteria.

1.2. OSAP supports this limit as a useful goal for manufacturers of devices or germicides intended to improve the quality of dental treatment water, as well as for dental practitioners, but recommends that manufacturers and practitioners should strive to **reduce levels of bacterial contamination to the lowest levels achievable** as measured using standard microbiological methods including new technologies as they become available.

1.3. **Boil Water Advisories:** OSAP concurs with CDC recommendations for the management of water for dental treatment during and after boil water advisories by public health authorities, but further advises that methods for managing dental water quality that isolate dental units from municipal water systems may provide an additional margin of safety.

**2. Recommendations for Dental Health-Care Personnel**

2.1. **General Recommendations:** OSAP recommends that dental practices implement current CDC recommendations for microbial quality in dental procedural water to ensure a safe and healthy environment for patients and staff. To accomplish this, OSAP recommends that DHCP:

- Make a reasonable effort to stay informed about current recommendations on the use of water for dental treatment and on the control of microbial biofilm contamination in DUWLs.
- Review instructions for use from the dental unit or device manufacturer for controlling contamination in the waterlines and maintaining the quality of dental procedural water.
- Obtain and review information on the safety, effectiveness and compatibility with dental equipment when selecting germicidal products and devices for controlling biofilm colonization in dental water systems.
- Flush waterlines for 20-30 seconds at the beginning and end of day and between patients to remove patient material potentially retracted during treatment (refer to Section 2.2 for specific flushing recommendations).
- Use only sterile solutions for coolant and irrigation supplied by a sterile device for surgical procedures that involve the incision, excision, or reflection of tissue that exposes initially sterile areas of the oral cavity (refer to Section 2.3 for specific recommendations on solutions for surgical procedures).
- Monitor and document dental unit water quality regularly according to the directions for use provided for the dental device, germicidal product or biofilm prevention device (refer to Section 2.4 for specific monitoring recommendations).
- Develop and implement Standard Operating Procedures (SOP) for maintaining, monitoring and documenting dental procedural water quality that are consistent with the recommendations presented here and manufacturer IFUs for the equipment, devices, germicides and monitoring methods used in the clinic as part of the clinic's overall Infection Control Plan (refer to Section 2.5 for specific SOP recommendations).
- Educate all members of the dental team on the importance of managing dental water quality and provide training in compliance with SOPs to ensure a safe, infection free environment for patients and DHCPs.

2.2. **Discharging Dental Water and Air Lines between Patients:** OSAP agrees with CDC recommendations to discharge water and air for a minimum of 20-30 seconds after each patient from any device connected to the dental water system that enters the patient's mouth but does not recommend flushing between patients as a sole means to improve dental procedural water quality.

2.3. **Indications for Use of Sterile Irrigating Solutions:** OSAP concurs with the 2003 recommendation of the CDC that only sterile solutions be used for procedures that involve the incision, excision, or reflection of tissue that exposes the normally sterile areas of the oral cavity. Examples include biopsy, periodontal surgery, apical endodontic surgery, implant surgery, and surgical extractions of teeth (e.g., removal of erupted or nonerupted tooth requiring elevation of mucoperiosteal flap, removal of bone or section of tooth, and suturing if needed). The following statements expand on this guideline:

- OSAP recommends that sterile irrigating solutions used in surgical dental procedures conform to standards for sterile water for irrigation or sterile saline solution from the United States Pharmacopeia (USP).
- **Non-surgical tooth extractions:** Use of sterile irrigation should also be considered for all dental extractions other than exfoliating deciduous teeth.
- **Gingival procedures:** The decision to use sterile irrigation for gingival procedures such as prophylaxis, non-surgical periodontal therapy (scaling and root planing) and periodontal maintenance is a matter of clinical judgment based on the extent of exposure of vascular system and the patient's risk for infection due to compromised immune status (e.g., immunosuppressive therapies, cancer chemotherapy, neutropenia).
- **Non-surgical endodontic procedures:** Procedural water that meets CDC recommendations for microbial quality may be used when creating access to the pulp chamber for either pediatric or adult endodontic procedures. Irrigation during manipulation, amputation and/or debridement of pulpal tissues should employ either sterile water, sterile saline solutions and/or antimicrobials such as diluted sodium hypochlorite. The pulp chamber should be thoroughly irrigated with a sterile and/or antimicrobial solution prior to interim or final closure.

  (Refer to Section 3.44 for information on design characteristics of sterile water delivery systems.)

2.4. **Clinical Monitoring:** Dental procedural water monitoring is intended to identify failures in clinical water management practices and can also provide a positive-reinforcement feed-back loop for the dental staff.

- **Action limits:** The CDC recommendation that water used for non-surgical dental treatment not exceed 500 colony forming units per milliliter using standard test methods should serve as an action limit for water management interventions as directed by the device manufacturer.
- **Monitoring methods:** Dental procedural water monitoring can be accomplished using water-testing laboratory services or in-office, chairside kits. The method used for dental treatment water monitoring should correlate to the extent possible with assessment methods based on AWWA standard methods.
- **Laboratory testing:** When using a laboratory testing service, users should request that water be tested using the most current version of the spread plate R2A agar method (9215C) or membrane filtration method (9215D) from *Standard Methods for the Evaluation of Water and Wastewater* published by the American Water Works Association (AWWA) or the most current equivalent method.
  - Users should follow laboratory instructions for aseptic collection, germicide neutralization and shipping/transport of samples.
  - Samples may be collected from individual lines or by combining samples from all water bearing lines on an individual dental unit.
  - Tests should be conducted for longer incubation times at lower recommended temperature to allow growth of slow-growing water bacteria.
- **In-office test kits:** When using in-office test kits, select a product designed to test drinking water that correlates with AWWA Method 9215 or heterotrophic plate count (HPC) methods.
  - Collect samples aseptically according to the manufacturer's instructions and incubate as directed at room temperature.
  - Neutralize residual germicide according to manufacturer IFU and use longer recommended incubation times to allow for growth of slower growing water bacteria.

- **Laboratory versus in-office monitoring:** All culture based counting methods will underestimate the numbers of microorganisms in water samples.
  - Laboratory testing using standard agar plate test methods can provide more accurate counts than in-office test kits and provide better baseline measures and provide an external validation of in-office monitoring program.
  - In-office test kits used on a more frequent basis however, may help ensure staff compliance with biofilm mitigation protocols and provide early warning of problems with biofilm control.
- **Testing for specific organisms:** Test for specific pathogens in procedural water only to investigate the source of infection(s) caused by a water-associated opportunistic pathogen as directed by local or state health authorities.
- **Frequency recommendations for monitoring, inspection, maintenance and replacement of dental units and water treatment products:**
  - Review information from the manufacturer of the equipment or device providing dental procedural water for patients and from the manufacturer of the device or germicide for controlling dental procedural water quality for recommendations for frequency for monitoring dental procedural water quality, as well as inspection and maintenance of devices.
  - When there are no manufacturer directions available for dental units (e.g., older equipment), OSAP recommends that periodic monitoring and inspection should be performed according to directions for use provided by the treatment product manufacturer or at least monthly on each dental unit or device.
  - OSAP recommends that periodic monitoring and inspection should be performed at least monthly on each dental unit or device following installation of treatment devices or initiation of new protocols.
  - If monitoring results indicate that water quality is acceptable for two consecutive monthly cycles, the frequency of testing may be reduced, but should not be less than every three months.
  - When a dental unit exceeds the action limit for an initial or periodic test, the unit should be treated according to manufacturer IFU, and re-tested immediately after treatment.
- **Other indications for monitoring:** In addition to scheduled periodic monitoring, all

dental devices that provide procedural water for patient treatment should be tested for bacterial contamination in the following circumstances:

- Following installation of new equipment such as water reservoirs or procedural water treatment devices.
- Following initiation of new procedural water treatment protocols using chemical germicides or cleaners.
- After extended periods of disuse or lack of maintenance.
- Following changes to manufacturer IFU or clinic protocols.
- Following maintenance or repair of dental units or devices.

2.5. **Standard Operating Procedures (SOPs) for maintaining and monitoring dental procedural water quality:** SOPs are an important measure for assuring the current processes established by the clinic for maintaining and monitoring dental procedural water quality are consistently followed. SOPs are useful for training new staff as well as for reference by all involved in infection control in the clinic. SOPs should be updated when process changes occur. SOP updates and training should be provided for clinic staff as needed.

- SOPs for maintaining dental procedural water quality should follow the manufacturer's IFUs for cleaning and disinfecting the dental unit and provide:
  - Input water specifications (e.g. sterile, bottled drinking water, distilled water),
  - Instructions for inspecting and maintaining devices for preparation of procedural water such as distillers, deionizers, reverse osmosis systems and other purification systems (if used),
  - Instructions and schedule for periodic and/or continuous application of germicidal agents (if used),
  - Instructions and schedule for replacement of water treatment devices, and other manufacturer recommended maintenance (if used), and
  - Precautions regarding disposal of germicidal agents and potential interactions with amalgam in amalgam separators.
- **SOPs for monitoring and documenting dental procedural water quality** should be based on manufacturer IFUs and standard methods for microbiological analysis of water including:
  - Type and frequency of monitoring (e.g. in-office chairside test kits or external

laboratory services)

- Instructions for all steps to be performed within the clinic including:
  - Sample collection including labeling to specify source (unit, handpiece, three-way syringe etc.) and date/time collected.
  - Germicide neutralization if indicated
  - Storage and shipping including need for refrigeration if applicable
  - In-office test kit procedure if applicable
- Action limits and recommended interventions when test results exceed recommended levels
- Instructions for documenting monitoring results including:
  - Source, date and time of sample collection
  - Identity of person performing monitoring
  - Date and method of analysis
  - Test results
  - Remediation efforts for failed tests and follow-up test results including removal and return to service of units where indicated
  - Where documentation of monitoring results is to be maintained

**3. Recommendations for Manufacturers**

3.1. **General recommendations:** Manufacturers of dental units, other devices that provide irrigation and/or coolant solutions for dental procedures as well as products for controlling or improving dental procedural water quality must meet applicable Federal and state regulatory requirements (refer to Section 4 for further information on regulatory requirements). OSAP recommends the following to dental product manufacturers:

- **Manufacturers of dental units and other devices which deliver dental procedural water** should develop a scientifically validated procedure for maintaining the water delivery system, verifying that the device can provide water that meets or exceeds current CDC recommendations for the microbial quality of dental procedural water when used as directed.

- **Manufacturers of products intended to control or improve dental procedural water quality** should develop a scientifically validated procedure for the use of their product with dental units and other devices which deliver dental procedural water, verifying that their product is capable of meeting or exceeding current CDC recommendations for the microbial quality of dental procedural water when used as directed.
- **Manufacturers of products intended to control or improve dental procedural water quality** should provide users with instructions for collection of germicide free samples or neutralization of germicide residual to obtain the most accurate bacterial counts using plate count methods. If neutralization is not possible, other enumeration methods such as microfiltration and staining may be necessary to obtain reliable results.
- **All manufacturers** should provide complete and easily understood instructions for the validated procedures associated with their product to meet or exceed current CDC recommendations for the microbial quality of water used in dentistry.
- Where applicable, **manufacturers** should verify the effectiveness of products and associated procedures using standard test methods such as those described in ISO 16954:2015 (ANSI/ADA 167).
- **Manufacturers of dental units and other devices which deliver dental procedural water** should provide comprehensive and easily understood guidance for periodic inspection, maintenance, replacement and trouble-shooting of dental units and devices intended to control or improve dental procedural water quality.
- **All manufacturers** should continuously improve the design and performance of dental devices and waterline treatment products to provide cost effective methods for controlling the quality of dental procedural water delivered by dental units and other devices (refer to Sections 3.2 and 3.3 for further information on design considerations for dental units and sterile water delivery systems).

3.2. **Design Considerations for Dental Units:**

- **Waterline length and dead legs:** OSAP encourages designers of dental equipment to minimize the amount of surface area for biofilm formation by using the shortest practical pathway from the water source to handpieces and irrigating devices, limiting the surface area available in control blocks and avoiding “dead legs” where biofilm can proliferate and continuously re-contaminate the water delivery system.

- **Unused waterlines:** IFUs should include recommendations to block or disconnect waterlines that are connected to devices not currently in use such as low-speed handpieces, air-water syringes, and ultrasonic scaler ports to avoid creating "dead legs" that are inaccessible to antimicrobial agents and that will harbor biofilm and continuously re-contaminate the water system.
- **Low temperature water heaters:** OSAP discourages the use of low-temperature water-heating systems designed to maintain dental treatment water at, or near body temperature due to the potential to increase the quantity of biofilm, create a more hospitable environment for growth of pathogens such as *Legionella* species and stimulate the expression of virulence factors such as heat tolerance in opportunistic water bacteria.
- **Anti-retraction valves:** OSAP encourages manufacturers to design dental water systems that are passively non-retracting without the use of anti-retraction valves that require periodic replacement or maintenance. Manufacturers who install anti-retraction devices must provide instructions for maintenance or replacement frequency in their IFUs.

3.3. **Safety and efficacy of germicidal agents and treatment devices used with dental equipment not supplied by the manufacturer:** OSAP recommends that manufacturers that do not offer factory installed devices or methods for water quality management specifically recommend and provide IFUs for methods to ensure acceptable water quality that they have determined to be safe and effective when used with their procedural water delivery systems.

3.4. **Considerations for Sterile Water Delivery Systems**: Devices that provide surgical irrigation in the oral cavity must use sterile tubing and reservoirs for solutions that enter the surgical site.

- All components including handpieces must be single-use disposable or compatible with heat sterilization methods used in outpatient dental settings.
- Manufacturers should validate the efficacy of recommended re-processing and sterilization procedures. Examples include oral surgery and implant handpieces, sonic and ultrasonic scalers used during periodontal surgery, and surgical irrigation devices such as bulb syringes.

**4. Regulatory Requirements and Recommendation - US Food and Drug Administration**

4.1. Instructions for use must comply with relevant FDA, Environmental Protection Agency, and state and local regulations applicable to the disinfection and maintenance of the dental unit waterlines.

4.2. FDA encourages manufacturers to follow recommended practices, including the FDA Guidance *Document "Reprocessing Medical Devices in Health Care Settings: Validation Methods and Labeling"* issued on March 17, 2015. Specifically, as outlined in this guidance FDA expects that:

- Reprocessing methods for dental unit waterlines should be validated, and validations should be completed prior to submission of a 510(k).
- Reprocessing instructions should reflect the validated methods. Consistent with our current practice for dental unit waterlines, submission of reprocessing validation data should be provided in your 510(k).

4.3. FDA recommends that the reprocessing instructions for devices be updated to contain comprehensive reprocessing instructions based on validation and recommends that manufacturers:

- Review current reprocessing instructions to identify if Instructions are comprehensive according to Section VI – "FDA's Six Criteria for Reprocessing Instructions" of the FDA Guidance.
- Conduct an assessment to evaluate if additional validation testing is necessary to provide up-to-date comprehensive reprocessing instructions.
- Ensure that customers are notified promptly of any available updated Instructions for Use.
- Consult the FDA Guidance, "Deciding When to Submit a 510(k) for a Change to an Existing Device" to determine if a new 510(k) submission may be necessary for any labeling or design changes.
- Submit reprocessing validation test reports in future dental operative unit 510(k)s and describe how reprocessing was considered in the design of the device (e.g., water source, materials, connectors).
- Contact the FDA with any questions related to new validation and labeling instructions for dental unit waterlines.

4.4. FDA recommends submission of reprocessing validation protocols via the Pre-Submis-

sion process prior to conducting testing as described in the FDA Guidance document *"Requests for Feedback on Medical Device Submissions: The Pre-Submission Program and Meetings with Food and Drug Administration Staff*" issued on September 29, 2017.

**5. Regulatory Requirements - State or Federal Environmental Protection Agencies:** Products with germicidal claims must conform to applicable state and Federal requirements under the Federal Fungicide Insecticide and Rodenticide Act (FIFRA) for registration of germicidal agents including directions for use and disposal.

5.1. EPA best management practice (BMP) specified in 441.30(b)(2) of the "Effluent Limitations Guidelines and Standards for the Dental Category" prohibits the use of oxidizing cleaners that solubilize mercury from dental amalgam in the wastewater lines in a dental facility.

5.2. EPA has clarified in *Frequently Asked Questions on the Dental Office Category Rule* that this prohibition does not apply to dental unit water line cleaning products when those products are used in water supply lines to ensure the safety of the water that dentists place in their patient's mouth due to the de minimus quantities that will be indirectly discharged through a wastewater line in a dental facility.

5.3. Dental vacuum lines connected to amalgam separators should not be used to dispose of oxidizing waterline products when performing shock treatment of procedural waterline systems or for bulk disposal of used or outdated waterline treatment products.

5.4. Oxidizing waterline cleaners may be discarded in municipal sewer systems as permitted by local ordinances and regulations governing disposal of germicidal or cleaning agents.

**6. Voluntary Consensus Standards Related to Dental Water Quality**

6.1. OSAP supports the adoption of ISO 16954:2015 - *Dentistry -- Test methods for dental unit waterline biofilm treatment* as an American National Standard (ANSI/ADA 167) by the American Dental Association and the American National Standards Institute and recommends that the U.S. Food and Drug Administration (FDA) recognize ISO 16954:2015 and ANSI/ADA Standard 167 as standard test methods in reviewing clearance-to-market submissions for dental waterline treatment products. OSAP also recommends that Federal and state environmental protection agencies recognize ISO 16954:2015 and ANSI/ADA Standard 167 as standard test methods in reviewing submissions for the registration of chemical agents and germicides with claims for prevention, inhibition or removal of dental waterline biofilm.

6.2. OSAP supports a proposal by the ANSI/ADA Standards Committee on Dental Products (SCDP) to develop an additional standard based on ISO 16954:2015 and ANSI/ADA Standard 167 to simplify and generalize the test method by specifying a model water delivery system.

6.3. When approved as ADA and American National Standards, OSAP recommends that these standard test methods be considered for adoption by state and Federal environmental protection agencies for registration of germicides intended for the control and prevention of biofilm formation in dental equipment.

**7. Conclusions:** All members of the dental profession and dental industry have an obligation to ensure the health and safety of dental patients and staff. OSAP encourages all stakeholders to take immediate measures to conform with current recommendations for water quality and to continuously strive to develop new approaches to ensure the quality of water used in dental practices.

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## Expert Panel Members*:

Matt Arduino, MS, Dr.PH, Senior Advisor, Division of Healthcare Quality, Centers for Disease Control and Prevention, Atlanta, GA

Nancy Dewhurst, RDH, West Coast University, Anaheim, CA

Mark Frampton, Pro-Edge Dental Products, Denver, CO

Michele Junger, DDS, MPH, Dental Officer, Division of Oral Health, Centers for Disease Control and Prevention, Atlanta, GA

Don Marianos, DDS, MS, CAPT, US Public Health Service (Retired), Pine Top, AZ

John Molinari, PhD, Professor Emeritus, University of Detroit Mercy School of Dentistry Director of Infection Control, The Dental Advisor

*Affiliations are listed for identification only. The opinions expressed in this position paper are those of the Organization for Safety, Asepsis and Prevention do not necessarily express the official position of any other organization, corporation, government agency, or academic institution.

## OSAP Organizational information

OSAP is a group of dentists, auxiliary staff, allied health professionals, government representatives, industry members, academicians, and researchers devoted to advancing the art and science of dental infection control and practice safety. A clearinghouse of information on dental asepsis and safety issues, OSAP works to educate the dental community through its publications, annual conference, and website (www.osap.org). For additional information on the organization and the efforts of its educational foundation, contact OSAP at 800-298-6727.

# DENTAL UNIT WATERLINE INFECTION CONTROL

A GUIDE TO DENTAL WATER INFECTION CONTROL FROM:

ADA® HuFriedyGroup

Every practice should have a designated **infection control coordinator**

Water used in dental units should have **less than 500 CFU/mL**

## Every practice should have a policy & procedure manual for maintaining dental unit waterlines.

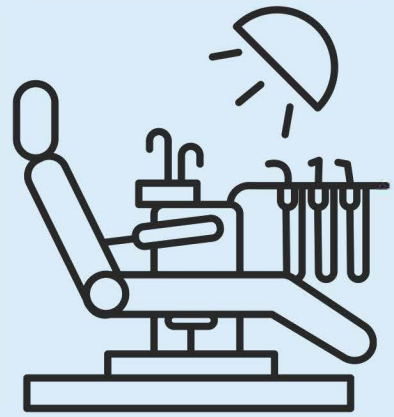
### Where should they come from?

- CDC, state, and local guidance ✓
- Dental waterline treatment products ✓
- Dental unit manufacturer instructions ✓
- Secondhand knowledge ✗

### What should be included?

- Frequency of dental waterlines testing ✓
- Remediation protocol following failed testing (results >500 CFU/ml) ✓
- What to do in the event of a water boil advisory ✓
- Special circumstance protocol (boil-water, extended office closure) ✓

## WHICH LINES SHOULD BE REGULARLY TESTED?



- High-speed handpiece(s) lines ✓
- Air/water syringe(s) lines ✓
- Ultrasonic scaler(s) lines ✓
- Unused waterlines ✓

*If these dental unit waterlines have been shocked and a contamination problem persists, source water or reservoirs should be tested

## WHEN SHOULD DENTAL UNIT WATERLINES BE FLUSHED?

- According to manufacturers' instructions ✓
- 20-30 seconds after each patient ✓
- 2 minutes at the end of each day ✓
- After the final patient of the day ✓

Additionally, **waterlines should be emptied and dried overnight** to remove as much water as possible.

## WHAT TO DOCUMENT WHEN TESTING DENTAL UNIT WATERLINES

- Test date ✓
- Location (i.e. , chair/operatory #) ✓
- Water source ✓
- Test results ✓
- Waterline maintenance/shock product name ✓
- Waterline maintenance/shock product lot # ✓
- Pooling details* (if samples pooled) ✓
- Name of team member sampling ✓

*Pooling: Sampling from multiple waterlines that is then combined for testing

Source: Centers for Disease Control and Prevention, Dental unit waterline infection control guidance

**From:** Amy Condrin
**To:** Nelson, Brant@DCA
**Subject:** Re: Urgent: Dental Board of California Contact to Submit Feedback on Proposed Infection Control Language
**Date:** Saturday, March 1, 2025 8:14:26 PM
**Attachments:** image001.png
CDC Dental IC Recs-2003 - Appendix A.pdf



Hi Brant,
Hope you are having a nice weekend so far. Here is some feedback on the proposed amendments to the DBC's Infection Control Regulation, to be considered by the Infection Control Reg Working Group/Committee as the amendments are being drafted. As I mentioned in a previous email, since this is not the official 45-day comment period comments, I am emailing this feedback informally, but I feel as necessary.

OSHA Review, Inc., the company for which I work, is a DBC-registered CE provider for the last 30+ years. I have worked there as senior consultant for over 21 years. OSHA Review, Inc. also sells a disinfectant (low-level according to the CDC) that is registered with EPA for US distribution and Cal/EPA for distribution in California.

My feedback regarding the proposed rules concerns Section 1005(a)(7):

*"Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Environmental Protection Agency (Cal EPA) that has demonstrated bactericidal, fungicidal, and virucidal activity. The product used shall include a label from the manufacturer that indicates the level of disinfection (low, intermediate, or high) and both the EPA registration number and the California Department of Pesticide Regulation (Cal DPR) registration number.*

The concerns with proposed Section 1005(a)(7) are the following:

1. Disinfectants' labels approved/registered by EPA and then DPR (if sold in CA) are not required to be labeled with the terms "low, intermediate, or high". Therefore, the rule is mandating something that is not a legal requirement, and the disinfectants may or may not have these terms on their labels since they are not required, only optional. I am attaching the CDC's *Guidelines for Infection Control in Dental Health-Care Settings – 2003 Appendix A: Regulatory Framework for Disinfectants and Sterilants*. Please refer to the yellow-highlighted sections in the attached document, which describe clearly how EPA regulates disinfectants.

2. Disinfectants' labels do not have two separate Federal EPA and CA DPR (Cal/EPA) registration numbers. They only have one – the registration number provided by Federal EPA.

3. As a point of information, EPA (and/or Cal/EPA) does not regulate high-level disinfectants. FDA is responsible for regulating both chemical sterilants and high-level disinfectants for use on medical devices, while EPA regulates CDC-defined low- and intermediate-level disinfectants for environmental surfaces (although EPA does not refer to them as low-level or intermediate-level). Again, please refer to the attached document (green highlights).

Thank you again for getting back to me and for forwarding this feedback to the IC Reg Working Group/Committee members for their information and consideration. Please feel free to contact me with

any questions or concerns about the information in this email.

Best regards,
Amy

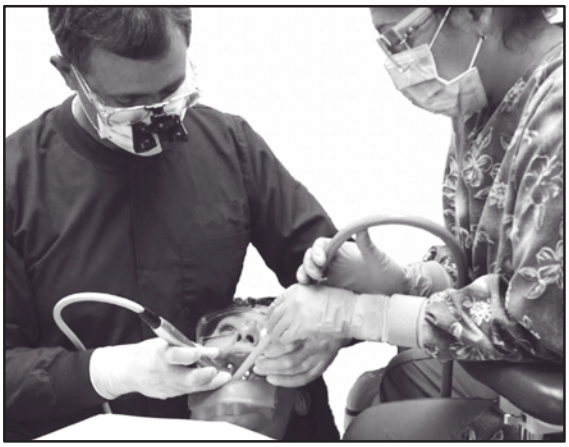
Amy Knepshield Condrin, MPH
Senior Consultant
OSHA Review, Inc.
11306 Sunco Drive, Ste 7
Rancho Cordova, CA 95742
800-555-6248 x3030
916-362-7891 - Fax

MMWR™

Morbidity and Mortality Weekly Report

Recommendations and Reports | December 19, 2003 / Vol. 52 / No. RR-17

# Guidelines for Infection Control in Dental Health-Care Settings — 2003





department of health and human services
Centers for Disease Control and Prevention

# Appendix A

## Regulatory Framework for Disinfectants and Sterilants

When using the guidance provided in this report regarding use of liquid chemical disinfectants and sterilants, dental health-care personnel (DHCP) should be aware of federal laws and regulations that govern the sale, distribution, and use of these products. In particular, DHCPs should know what requirements pertain to them when such products are used. Finally, DHCP should understand the relative roles of the U.S. Environmental Protection Agency (EPA), the U.S. Food and Drug Administration (FDA), the Occupational Safety and Health Administration (OSHA) and CDC.

The choice of specific cleaning or disinfecting agents is largely a matter of judgment, guided by product label claims and instructions and government regulations. A single liquid chemical germicide might not satisfy all disinfection requirements in a given dental practice or facility. Realistic use of liquid chemical germicides depends on consideration of multiple factors, including the degree of microbial killing required; the nature and composition of the surface, item, or device to be treated; and the cost, safety, and ease of use of the available agents. Selecting one appropriate product with a higher degree of potency to cover all situations might be more convenient.

In the United States, liquid chemical germicides (disinfectants) are regulated by EPA and FDA (*A-1–A-3*). In healthcare settings, EPA regulates disinfectants that are used on environmental surfaces (housekeeping and clinical contact surfaces), and FDA regulates liquid chemical sterilants/high-level disinfectants (e.g., glutaraldehyde, hydrogen peroxide, and peracetic acid) used on critical and semicritical patient-care devices. Disinfectants intended for use on clinical contact surfaces (e.g., light handles, radiographic-ray heads, or drawer knobs) or housekeeping surfaces (e.g., floors, walls, or sinks) are regulated in interstate commerce by the Antimicrobials Division, Office of Pesticide Programs, EPA, under the authority of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) of 1947, as amended in 1996 (*A-4*). Under FIFRA, any substance or mixture of substances intended to prevent, destroy, repel, or mitigate any pest, including microorganisms but excluding those in or on living man or animals, must be registered before sale or distribution. To obtain a registration, a manufacturer must submit specific data regarding the safety and the effectiveness of each product.

EPA requires manufacturers to test formulations by using accepted methods for microbicidal activity, stability, and toxicity to animals and humans. Manufacturers submit these data to EPA with proposed labeling. If EPA concludes a product may be used without causing unreasonable adverse effects, the product and its labeling are given an EPA registration number, and the manufacturer may then sell and distribute the product in the United States. FIFRA requires users of products to follow the labeling directions on each product explicitly. The following statement appears on all EPA-registered product labels under the Directions for Use heading: "It is a violation of federal law to use this product inconsistent with its labeling." This means that DHCP must follow the safety precautions and use directions on the labeling of each registered product. Not following the specified dilution, contact time, method of application, or any other condition of use is considered misuse of the product.

FDA, under the authority of the 1976 Medical Devices Amendment to the Food, Drug, and Cosmetic Act, regulates chemical germicides if they are advertised and marketed for use on specific medical devices (e.g., dental unit waterline or flexible endoscope). A liquid chemical germicide marketed for use on a specific device is considered, for regulatory purposes, a medical device itself when used to disinfect that specific medical device. Also, this FDA regulatory authority over a particular instrument or device dictates that the manufacturer is obligated to provide the user with adequate instructions for the safe and effective use of that device. These instructions must include methods to clean and disinfect or sterilize the item if it is to be marketed as a reusable medical device.

OSHA develops workplace standards to help ensure safe and healthful working conditions in places of employment. OSHA is authorized under Pub. L. 95-251, and as amended, to enforce these workplace standards. In 1991, OSHA published Occupational Exposure to Bloodborne Pathogens; final rule [29 CFR Part 1910.1030] (*A-5*). This standard is designed to help prevent occupational exposures to blood or other potentially infectious substances. Under this standard, OSHA has interpreted that, to decontaminate contaminated work surfaces, either an EPA-registered hospital tuberculocidal disinfectant or an EPA-registered hospital disinfectant labeled as effective against human immunodeficiency virus (HIV) and hepatitis B virus (HBV) is appropriate. Hospital disinfectants with such HIV and HBV claims can be used, provided surfaces are not contaminated with agents or concentration of agents for which higher level (i.e., intermediate-level) disinfection is recommended. In addition, as with all disinfectants, effectiveness is governed by strict adherence to the label instructions for intended use of the product.

CDC is not a regulatory agency and does not test, evaluate, or otherwise recommend specific brand-name products of chemical germicides. This report is intended to provide overall guidance for providers to select general classifications of products based on certain infection-control principles. In this report, CDC provides guidance to practitioners regarding appropriate application of EPA- and FDA-registered liquid chemical disinfectants and sterilants in dental health-care settings.

CDC recommends disinfecting environmental surfaces or sterilizing or disinfecting medical equipment, and DHCP should use products approved by EPA and FDA unless no such products are available for use against certain microorganisms or sites. However, if no registered or approved products are available for a specific pathogen or use situation, DHCP are advised to follow the specific guidance regarding unregistered or unapproved (e.g., off-label) uses for various chemical germicides. For example, no antimicrobial products are registered for use specifically against certain emerging pathogens (e.g., Norwalk virus), potential terrorism agents (e.g., variola major or *Yersinia pestis*), or Creutzfeldt-Jakob disease agents.

One point of clarification is the difference in how EPA and FDA classify disinfectants. FDA adopted the same basic terminology and classification scheme as CDC to categorize medical devices (i.e., critical, semicritical, and noncritical) and to define antimicrobial potency for processing surfaces (i.e., sterilization, and high-, intermediate- and low-level disinfection) (*A-6*). EPA registers environmental surface disinfectants based on the manufacturer's microbiological activity claims when registering its disinfectant. This difference has led to confusion on the part of users because the EPA does not use the terms intermediate- and low-level disinfectants as used in CDC guidelines.

CDC designates any EPA-registered hospital disinfectant without a tuberculocidal claim as a low-level disinfectant and any EPA-registered hospital disinfectant with a tuberculocidal claim as an intermediate-level disinfectant. To understand this comparison, one needs to know how EPA registers disinfectants. First, to be labeled as an EPA hospital disinfectant, the product must pass Association of Official Analytical Chemists (AOAC) effectiveness tests against three target organisms: *Salmonella choleraesuis* for effectiveness against gram-negative bacteria; *Staphylococcus aureus* for effectiveness against gram-positive bacteria; and *Pseudomonas aeruginosa* for effectiveness against a primarily nosocomial pathogen. Substantiated label claims of effectiveness of a disinfectant against specific microorganisms other than the test microorganisms are permitted, but not required, provided that the test microorganisms are likely to be present in or on the recommended use areas and surfaces. Therefore, manufacturers might also test specifically against organisms of known concern in health-care practices (e.g., HIV, HBV, hepatitis C virus [HCV], and herpes) although it is considered likely that any product satisfying AOAC tests for hospital disinfectant designation will also be effective against these relatively fragile organisms when the product is used as directed by the manufacturer.

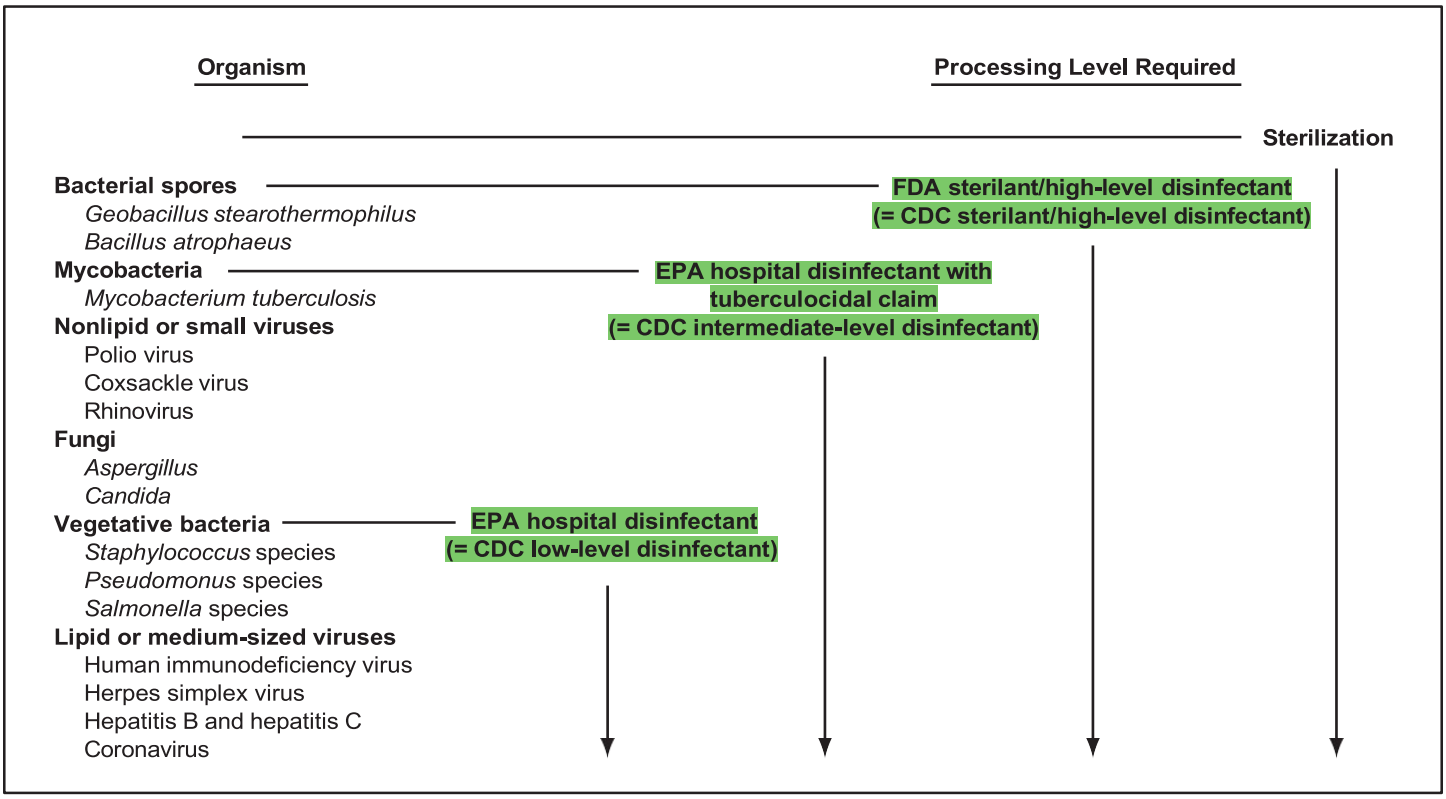
Potency against *Mycobacterium tuberculosis* has been recognized as a substantial benchmark. However, the tuberculocidal claim is used only as a benchmark to measure germicidal potency. Tuberculosis is not transmitted via environmental surfaces but rather by the airborne route. Accordingly, use of such products on environmental surfaces plays no role in preventing the spread of tuberculosis. However, because mycobacteria have among the highest intrinsic levels of resistance among the vegetative bacteria, viruses, and fungi, any germicide with a tuberculocidal claim on the label is considered capable of inactivating a broad spectrum of pathogens, including such less-resistant organisms as bloodborne pathogens (e.g., HBV, HCV, and HIV). It is this broad-spectrum capability, rather than the product's specific potency against mycobacteria, that is the basis for protocols and regulations dictating use of tuberculocidal chemicals for surface disinfection.

EPA also lists disinfectant products according to their labeled use against these organisms of interest as follows:

- **List B**. Tuberculocide products effective against *Mycobacterium* species.
- **List C**. Products effective against human HIV-1 virus.
- **List D**. Products effective against human HIV-1 virus and HBV.
- **List E**. Products effective against *Mycobacterium* species, human HIV-1 virus, and HBV.
- **List F**. Products effective against HCV.

Microorganisms vary in their resistance to disinfection and sterilization, enabling CDC's designation of disinfectants as high-, intermediate-, and low-level, when compared with EPA's designated organism spectrum (Figure). However, exceptions to this general guide exist, and manufacturer's label claims and instructions should always be followed.

**FIGURE. Decreasing order of resistance of microorganisms to germicidal chemicals**




**Source:** Adapted from Bond WW, Ott BJ, Franke K, McCracken JE. Effective use of liquid chemical germicides on medical devices; instrument design problems. In: Block SS, ed. Disinfection, sterilization and preservation. 4th ed. Philadelphia, PA: Lea & Gebiger, 1991:1100.

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A-4. US Environmental Protection Agency. 40 CFR Parts 152, 156, and 158. Exemption of certain pesticide substances from federal insecticide, fungicide, and rodenticide act requirements. Amended 1996. Federal Register 1996;61:8876–9.

A-5. US Department of Labor, Occupational Safety and Health Administration. 29 CFR Part 1910.1030. Occupational exposure to bloodborne pathogens; needlesticks and other sharps injuries; final rule. Federal Register 2001;66:5317–25. As amended from and includes 29 CFR Part 1910.1030. Occupational exposure to bloodborne pathogens; final rule. Federal Register 1991;56:64174–82. Available at http://www.osha.gov/SLTC/dentistry/index.html.

A-6. Spaulding EH. Role of chemical disinfection in preventing nosocomial infections. In: Proceedings of the International Conference on Nosocomial Infections, 1970. Brachman PS, Eickhoff TC, eds. Chicago, IL: American Hospital Association, 1971:247–54.

**From:** Amy Condrin
**To:** Nelson, Brant@DCA
**Subject:** Re: Urgent: Dental Board of California Contact to Submit Feedback on Proposed Infection Control Language
**Date:** Sunday, March 2, 2025 6:21:52 AM
**Attachments:** image001.png



Hi again,
I wanted to add another point of information to item #2:

2. Disinfectants' labels do not have two separate Federal EPA and CA DPR (Cal/EPA) registration numbers. They only have one – the registration number provided by Federal EPA.
A point of information about this... Similar to checking on which dental unit waterline cleaners (considered antimicrobial pesticides by Federal EPA and Cal/EPA) are registered for use by CDPR in California, the easiest way to tell that a surface disinfectant has been registered with CDPR is by going to their website (cdpr.ca.gov) and using their search tool that links to CDPR's pesticide database. Also, surface disinfectants must be registered by Federal EPA first, before obtaining approval for use in CA by CDPR.

That's it! Thanks!
:)
Amy

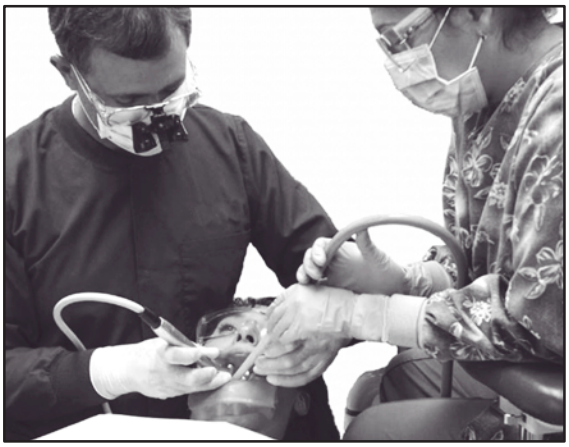
Amy Knepshield Condrin, MPH
Senior Consultant
OSHA Review, Inc.
11306 Sunco Drive, Ste 7
Rancho Cordova, CA 95742
800-555-6248 x3030
916-362-7891 - Fax

MMWR™

Morbidity and Mortality Weekly Report

Recommendations and Reports | December 19, 2003 / Vol. 52 / No. RR-17

# Guidelines for Infection Control in Dental Health-Care Settings — 2003





department of health and human services
Centers for Disease Control and Prevention

# Appendix A

## Regulatory Framework for Disinfectants and Sterilants

When using the guidance provided in this report regarding use of liquid chemical disinfectants and sterilants, dental health-care personnel (DHCP) should be aware of federal laws and regulations that govern the sale, distribution, and use of these products. In particular, DHCPs should know what requirements pertain to them when such products are used. Finally, DHCP should understand the relative roles of the U.S. Environmental Protection Agency (EPA), the U.S. Food and Drug Administration (FDA), the Occupational Safety and Health Administration (OSHA) and CDC.

The choice of specific cleaning or disinfecting agents is largely a matter of judgment, guided by product label claims and instructions and government regulations. A single liquid chemical germicide might not satisfy all disinfection requirements in a given dental practice or facility. Realistic use of liquid chemical germicides depends on consideration of multiple factors, including the degree of microbial killing required; the nature and composition of the surface, item, or device to be treated; and the cost, safety, and ease of use of the available agents. Selecting one appropriate product with a higher degree of potency to cover all situations might be more convenient.

In the United States, liquid chemical germicides (disinfectants) are regulated by EPA and FDA (*A-1–A-3*). In healthcare settings, EPA regulates disinfectants that are used on environmental surfaces (housekeeping and clinical contact surfaces), and FDA regulates liquid chemical sterilants/high-level disinfectants (e.g., glutaraldehyde, hydrogen peroxide, and peracetic acid) used on critical and semicritical patient-care devices. Disinfectants intended for use on clinical contact surfaces (e.g., light handles, radiographic-ray heads, or drawer knobs) or housekeeping surfaces (e.g., floors, walls, or sinks) are regulated in interstate commerce by the Antimicrobials Division, Office of Pesticide Programs, EPA, under the authority of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) of 1947, as amended in 1996 (*A-4*). Under FIFRA, any substance or mixture of substances intended to prevent, destroy, repel, or mitigate any pest, including microorganisms but excluding those in or on living man or animals, must be registered before sale or distribution. To obtain a registration, a manufacturer must submit specific data regarding the safety and the effectiveness of each product.

EPA requires manufacturers to test formulations by using accepted methods for microbicidal activity, stability, and toxicity to animals and humans. Manufacturers submit these data to EPA with proposed labeling. If EPA concludes a product may be used without causing unreasonable adverse effects, the product and its labeling are given an EPA registration number, and the manufacturer may then sell and distribute the product in the United States. FIFRA requires users of products to follow the labeling directions on each product explicitly. The following statement appears on all EPA-registered product labels under the Directions for Use heading: "It is a violation of federal law to use this product inconsistent with its labeling." This means that DHCP must follow the safety precautions and use directions on the labeling of each registered product. Not following the specified dilution, contact time, method of application, or any other condition of use is considered misuse of the product.

FDA, under the authority of the 1976 Medical Devices Amendment to the Food, Drug, and Cosmetic Act, regulates chemical germicides if they are advertised and marketed for use on specific medical devices (e.g., dental unit waterline or flexible endoscope). A liquid chemical germicide marketed for use on a specific device is considered, for regulatory purposes, a medical device itself when used to disinfect that specific medical device. Also, this FDA regulatory authority over a particular instrument or device dictates that the manufacturer is obligated to provide the user with adequate instructions for the safe and effective use of that device. These instructions must include methods to clean and disinfect or sterilize the item if it is to be marketed as a reusable medical device.

OSHA develops workplace standards to help ensure safe and healthful working conditions in places of employment. OSHA is authorized under Pub. L. 95-251, and as amended, to enforce these workplace standards. In 1991, OSHA published Occupational Exposure to Bloodborne Pathogens; final rule [29 CFR Part 1910.1030] (*A-5*). This standard is designed to help prevent occupational exposures to blood or other potentially infectious substances. Under this standard, OSHA has interpreted that, to decontaminate contaminated work surfaces, either an EPA-registered hospital tuberculocidal disinfectant or an EPA-registered hospital disinfectant labeled as effective against human immunodeficiency virus (HIV) and hepatitis B virus (HBV) is appropriate. Hospital disinfectants with such HIV and HBV claims can be used, provided surfaces are not contaminated with agents or concentration of agents for which higher level (i.e., intermediate-level) disinfection is recommended. In addition, as with all disinfectants, effectiveness is governed by strict adherence to the label instructions for intended use of the product.

CDC is not a regulatory agency and does not test, evaluate, or otherwise recommend specific brand-name products of chemical germicides. This report is intended to provide overall guidance for providers to select general classifications of products based on certain infection-control principles. In this report, CDC provides guidance to practitioners regarding appropriate application of EPA- and FDA-registered liquid chemical disinfectants and sterilants in dental health-care settings.

CDC recommends disinfecting environmental surfaces or sterilizing or disinfecting medical equipment, and DHCP should use products approved by EPA and FDA unless no such products are available for use against certain microorganisms or sites. However, if no registered or approved products are available for a specific pathogen or use situation, DHCP are advised to follow the specific guidance regarding unregistered or unapproved (e.g., off-label) uses for various chemical germicides. For example, no antimicrobial products are registered for use specifically against certain emerging pathogens (e.g., Norwalk virus), potential terrorism agents (e.g., variola major or *Yersinia pestis*), or Creutzfeldt-Jakob disease agents.

One point of clarification is the difference in how EPA and FDA classify disinfectants. FDA adopted the same basic terminology and classification scheme as CDC to categorize medical devices (i.e., critical, semicritical, and noncritical) and to define antimicrobial potency for processing surfaces (i.e., sterilization, and high-, intermediate- and low-level disinfection) (*A-6*). EPA registers environmental surface disinfectants based on the manufacturer's microbiological activity claims when registering its disinfectant. This difference has led to confusion on the part of users because the EPA does not use the terms intermediate- and low-level disinfectants as used in CDC guidelines.

CDC designates any EPA-registered hospital disinfectant without a tuberculocidal claim as a low-level disinfectant and any EPA-registered hospital disinfectant with a tuberculocidal claim as an intermediate-level disinfectant. To understand this comparison, one needs to know how EPA registers disinfectants. First, to be labeled as an EPA hospital disinfectant, the product must pass Association of Official Analytical Chemists (AOAC) effectiveness tests against three target organisms: *Salmonella choleraesuis* for effectiveness against gram-negative bacteria; *Staphylococcus aureus* for effectiveness against gram-positive bacteria; and *Pseudomonas aeruginosa* for effectiveness against a primarily nosocomial pathogen. Substantiated label claims of effectiveness of a disinfectant against specific microorganisms other than the test microorganisms are permitted, but not required, provided that the test microorganisms are likely to be present in or on the recommended use areas and surfaces. Therefore, manufacturers might also test specifically against organisms of known concern in health-care practices (e.g., HIV, HBV, hepatitis C virus [HCV], and herpes) although it is considered likely that any product satisfying AOAC tests for hospital disinfectant designation will also be effective against these relatively fragile organisms when the product is used as directed by the manufacturer.

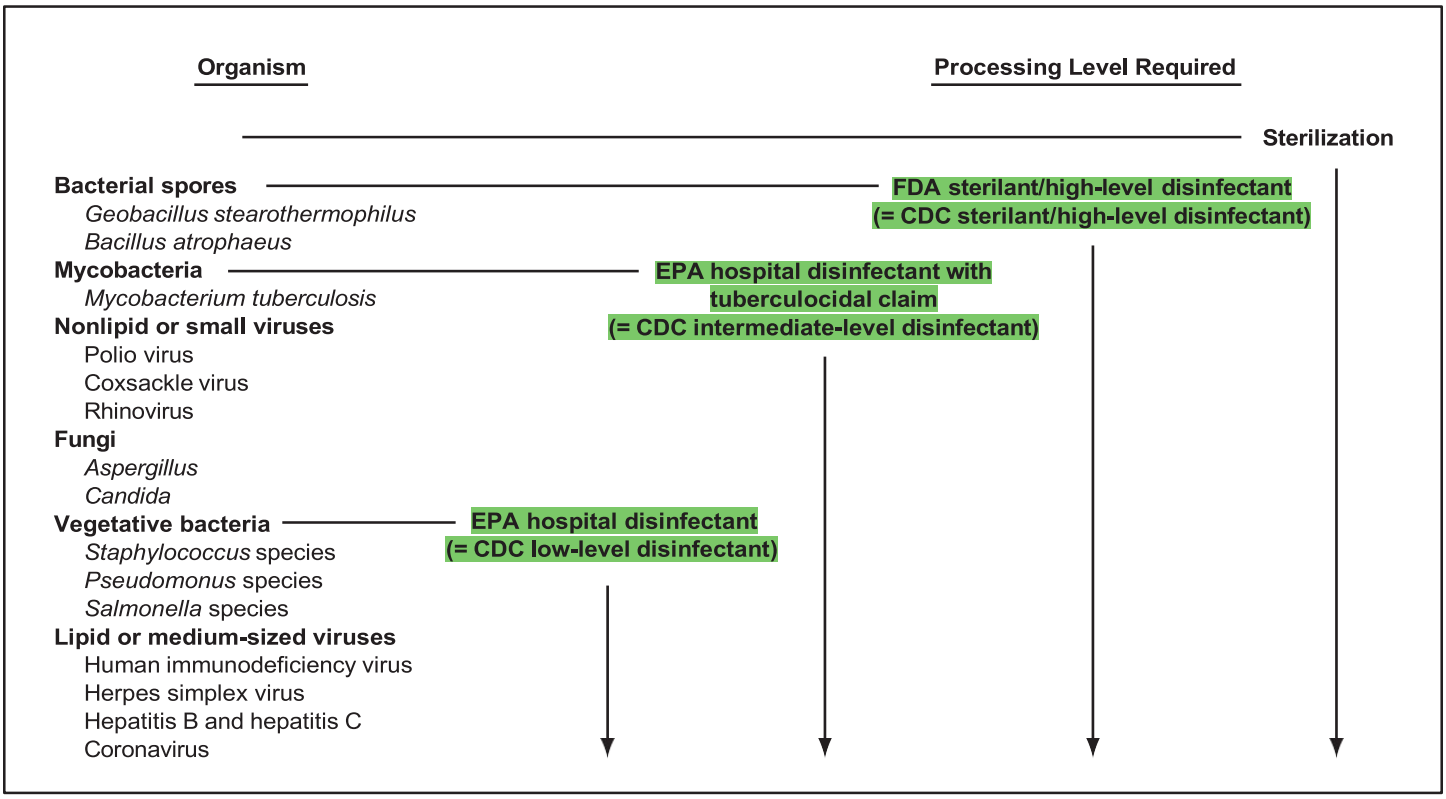
Potency against *Mycobacterium tuberculosis* has been recognized as a substantial benchmark. However, the tuberculocidal claim is used only as a benchmark to measure germicidal potency. Tuberculosis is not transmitted via environmental surfaces but rather by the airborne route. Accordingly, use of such products on environmental surfaces plays no role in preventing the spread of tuberculosis. However, because mycobacteria have among the highest intrinsic levels of resistance among the vegetative bacteria, viruses, and fungi, any germicide with a tuberculocidal claim on the label is considered capable of inactivating a broad spectrum of pathogens, including such less-resistant organisms as bloodborne pathogens (e.g., HBV, HCV, and HIV). It is this broad-spectrum capability, rather than the product's specific potency against mycobacteria, that is the basis for protocols and regulations dictating use of tuberculocidal chemicals for surface disinfection.

EPA also lists disinfectant products according to their labeled use against these organisms of interest as follows:

- **List B**. Tuberculocide products effective against *Mycobacterium* species.
- **List C**. Products effective against human HIV-1 virus.
- **List D**. Products effective against human HIV-1 virus and HBV.
- **List E**. Products effective against *Mycobacterium* species, human HIV-1 virus, and HBV.
- **List F**. Products effective against HCV.

Microorganisms vary in their resistance to disinfection and sterilization, enabling CDC's designation of disinfectants as high-, intermediate-, and low-level, when compared with EPA's designated organism spectrum (Figure). However, exceptions to this general guide exist, and manufacturer's label claims and instructions should always be followed.

**FIGURE. Decreasing order of resistance of microorganisms to germicidal chemicals**




**Source:** Adapted from Bond WW, Ott BJ, Franke K, McCracken JE. Effective use of liquid chemical germicides on medical devices; instrument design problems. In: Block SS, ed. Disinfection, sterilization and preservation. 4th ed. Philadelphia, PA: Lea & Gebiger, 1991:1100.

## References

A-1. Food and Drug Administration (FDA) and US Environmental Protection Agency (EPA). Memorandum of understanding between the FDA and EPA: notice regarding matters of mutual responsibility—regulation of liquid chemical germicides intended for use on medical devices. Rockville, MD: US Department of Health and Human Services, Public Health Service, Food and Drug Administration, US Environmental Protection Agency, 1993.

A-2. Food and Drug Administration (FDA). Interim measures for registration of antimicrobial products/liquid chemical germicides with medical device use claims under the memorandum of understanding between EPA and FDA. Rockville, MD: US Department of Health and Human Services, Food and Drug Administration, 1994.

A-3. Food and Drug Administration. Guidance for industry and FDA reviewers: content and format of premarket notification [510(k)] submissions for liquid chemical sterilants/high level disinfectants. Rockville, MD: US Department of Health and Human Services, Food and Drug Administration, 2000. Available at http://www.fda.gov/cdrh/ode/397.pdf.

A-4. US Environmental Protection Agency. 40 CFR Parts 152, 156, and 158. Exemption of certain pesticide substances from federal insecticide, fungicide, and rodenticide act requirements. Amended 1996. Federal Register 1996;61:8876–9.

A-5. US Department of Labor, Occupational Safety and Health Administration. 29 CFR Part 1910.1030. Occupational exposure to bloodborne pathogens; needlesticks and other sharps injuries; final rule. Federal Register 2001;66:5317–25. As amended from and includes 29 CFR Part 1910.1030. Occupational exposure to bloodborne pathogens; final rule. Federal Register 1991;56:64174–82. Available at http://www.osha.gov/SLTC/dentistry/index.html.

A-6. Spaulding EH. Role of chemical disinfection in preventing nosocomial infections. In: Proceedings of the International Conference on Nosocomial Infections, 1970. Brachman PS, Eickhoff TC, eds. Chicago, IL: American Hospital Association, 1971:247–54.

## 16 CCR 1005 Summary of Stakeholder Comments with the Board's Working Group's Responses and Other Recommendations

### Comments from the Dental Assisting Alliance (Alliance) (Summary of Letter in Attachment 3):

1. **Comment:** On top of page 3, (a)(8) – definition of "sterilization: it says a "mechanical process" of elimination of all forms of life. The Alliance is concerned that this eliminates the use of "cold sterile" with the word "mechanical" – is the intent to eliminate the use of cold sterile as an option?

   **Response:** Cold sterilization using "high level disinfection" would still be an option for heat-sensitive items in lieu of using a mechanical device since the current proposal would retain the following standards for sterilizing critical and non-critical instruments in subsections (b)(8)(C) and (D), which reads, in pertinent part:

   > If a critical item is heat-sensitive, it shall, at minimum, be processed with high-level disinfection and packaged or wrapped upon completion of the disinfection process.
   >
   > If a semi-critical item is heat sensitive, it shall, at minimum, be processed with high -level disinfection and packaged or wrapped upon completion of the disinfection process.

   However, to avoid an apparent conflict between the above-referenced sections and the definition for Sterilization, the Infection Control Working Group (Working Group) revised the definition of "Sterilization" to remove references to "mechanical process" and instead proposes to retain the existing text referencing a "validated process". The revised definition would read as follows:

   > ~~(9)~~(8) "Sterilization" is a validated process used to ~~render a product free of all forms of viable microorganisms.~~ eliminate all forms of microbial life using acceptable methods of sterilization set forth in this section.

2. **Comment:** Hand scrubbing on page 3, (a)(9)(A) and (B) – being mentioned first is a problem for the Alliance as it seems to be an acceptable alternative to using the ultrasonic. The Alliance recommends putting hand scrubbing last and states that hand scrubbing should be a last resort when other methods of cleaning are not effective.

   **Response:** The Board's Infection Control Working Group, in consultation with the

DHBC's working group ("Working Group"), believes that manual cleaning prior to the use of a sterilization device or disinfectant for surface disinfection is an important additional level of infection control for consumer protection. However, the Working Group agrees that it does not necessarily mean that it be done by "hand" and therefore has proposed to eliminate the reference to "hand" scrubbing and instead proposes to simply require "scrubbing" for subsections (a)(9)(A) and (B).

3. **Comment:** Top of page 6, (b)(4)(F), where it "says protective attire shall be changed daily, or immediately if they become soiled" … The Alliance says there might be a question on the use of the word "immediately" where you'd have to stop the procedure if your gown is "visibly soiled" "as soon as we see some prophy paste specks on our gown which would be problematic." The Alliance states that this needs to be clarified for better interpretation of intent.

   **Response:** Changes were made to address these concerns and ensure greater worker protections in accordance with the Working Group's understanding of the dental community's current minimum standards for infection control, which would require changing attire immediately when attire becomes soiled with blood or OPIM during a patient procedure. The Working Group revised (b)(4)(F) to state, ". . . Protective attire shall be changed immediately if the~~y~~ attire ~~should~~ becomes ~~moist or visibly~~ soiled with blood or OPIM."

4. **Comment:** Bottom of page 6, (b)(6)(B), where it says "chemical and puncture resistant utility gloves shall be available at the point of use" … for "clinical breakdown" … The Alliance is concerned this implies that setting up or breaking down a treatment room requires gloves. Alliance says this is not the protocol for setting up a treatment room and that clean hands, not gloves are needed. Utility gloves are meant to be used for "PROCESSING INSTRUMENTS and HANDLING CHEMICALS."

   **Response:** The Working Group agreed with these comments and has revised (b)(6)(B) by removing the language concerning clinical care breakdown (setting up or breaking down a treatment room).

5. **Comment:** Bottom of page 6, (b)(6)(B), sterilizing utility gloves after each use is overkill. The Alliance suggests the word "sterilize" should be changed to "disinfect". Routine disinfection of the utility gloves is more realistic according to the Alliance. The Alliance proposes that the Board use the language, "utility gloves shall be cleaned and routinely disinfected and discarded if compromised in any way. Disposable utility gloves shall be disposed of after each use."

**Response:** It is the understanding of the Working Group that depending on the type of glove used, the manufacturer may require disinfection or sterilization. The Working Group agreed that, to the extent that an office uses disposable utility gloves, they should be disposed of after each use. As a result, the Working Group revised (b)(6)(B) to state, ". . . Chemical and puncture-resistant utility gloves shall be cleaned and disinfected or sterilized in accordance with the manufacturer's instructions. Disposable utility gloves shall be disposed of after each use."

6. **Comment:** On page 8, (b)(8)(C), use of the word "immediately" in connection with sterilization of instruments. The Alliance says that a lot of times dental offices cannot immediately sterilize instruments and instruments will sit in a preclean/presoak (maybe an hour or so before sterilization). The Alliance feels sterilizing "immediately" is unrealistic. The Alliance states that ADHPs are often not able to process the instruments and get them sterilizing immediately; especially with the shortage of ADHPs. The Alliance feels better wording would be "critical instruments . . . shall be . . . processed and placed into packets or wrappers and sterilized as soon as possible after each use."

   **Response:** The Working Group agrees with the comments and revised (b)(8)(C) by removing the word "immediately" in connection with sterilization of critical instruments, so that it would read:

   Critical instruments, items, and devices shall be ~~discarded or~~ pre-cleaned, packaged or wrapped, and sterilized after each use.

   A similar change was made to remove the reference to "immediately" when referring to semi-critical instruments in subsection (b)(8)(D). To avoid ambiguity, the Working Group did not add "as soon as possible" to the proposed changes noted above.

7. **Comment:** Bottom of page 8, (b)(8)(F), language about having to sterilize all slow-speed hand pieces. The Alliance would like more clarification added to the existing standard. There is a question of if disinfecting should include the motor (or "quick connector") in addition to the nose cone. The Alliance said it would be great to have some clarification added as to if the motor needs to be sterilized. The Alliance suggests adding a statement specifically addressing whether the motor is considered part of the handpiece that needs to be sterilized. Alternatively, the Alliance recommends that the Board specify that when the motor is detachable from the nosecone, the motor does (or does not) need to be sterilized. The Alliance proposes the Board use the following language, "Handpieces shall be processed and sterilized after each use including the motor and all component parts."

**Response:** The Working Group believe that the existing text referring to "rotary components" would necessarily include the motor since it is in fact a rotary component of a hand piece. However, since commenters state that whether the motor should be sterilized has been "an issue historically," the Working Group revised (b)(8)(F) to state, "All high-speed dental hand pieces, low-speed hand pieces, rotary components, including the motor, and dental unit attachments such as reusable air/water syringe tips and ultrasonic scaler tips, shall be packaged, labeled, and heat-sterilized in a manner consistent with the same sterilization practices as a semi-critical item."

8. **Comment**: On page 10, (b)(10)(D), dental unit waterlines.
    - Disinfectants – The Alliance says California has a law which requires the use of disinfectants in the water to control biofilm. The DBC regulations should reiterate and/or expand on that law. For example, the DBC could add a requirement for monthly water testing which would help to support the process for keeping the biofilm levels below 500 CFU.
    - The Alliance asserts that the addition of the requirement to flush the waterlines "after the final patient of the day" is unnecessary and in contradiction to the purpose of flushing the lines.
    - Flushing - Flushing provides the freshest water for the patient, removing the free-floating biofilm so that the patient doesn't get the "stagnant" water, with a higher concentration of biofilm sprayed in their mouth. Flushing the waterlines after the last patient of the day, when the water is going to sit for 12-hours and will be flushed for 2-minutes at the beginning of the next day, is illogical and unnecessary.

    **Response:** After review of the CDC 's Guidelines on Best Practices for Dental Unit Water Quality | Dental Infection Prevention and Control, the Working Groups revised (b)(10)(D) to remove language that would require flushing water lines after the last patient of the day and add the following: "Dental unit water lines shall be monitored or tested routinely in accordance with manufacturer's instructions."

**Comments from Leslie Canham, CDA, RDA:**

**Comment:** At the Board's and Council's meetings in February 2025, Ms. Canham testified that she is concerned that there is no recommendation or requirement for dental unit waterline testing on page 10 of the Board's proposed regulations. Ms. Canham says that monitoring waterlines is essential and recommended by the CDC Best practices. Ms. Canham stated studies show that without monitoring we don't know if we have colonization of bacteria in the waterlines. Waterborne bacteria in dental plumbing systems have caused children to be hospitalized for infection with nontuberculous Mycobacteria.

Ms. Canham emailed Board staff with additional reference material as provided in Attachment 4 to the meeting materials.

**Response:** In response to these and other concerns raised by commenters about water line testing standards, the Infection Control Working Group revised (b)(10)(D) to state, "Dental unit water lines shall be monitored or tested routinely in accordance with manufacturer's instructions." This is the direction that the CDC has provided in the Guidelines noted above for dental unit water quality.

**Comments from Amy Condrin, MPH (Summary of emailed comments in Attachments 5 and 6):**

**Comment:** My feedback regarding the proposed rules concerns Section 1005(a)(7):

"Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Environmental Protection Agency (Cal EPA) that has demonstrated bactericidal, fungicidal, and virucidal activity. The product used shall include a label from the manufacturer that indicates the level of disinfection (low, intermediate, or high) and both the EPA registration number and the California Department of Pesticide Regulation (Cal DPR) registration number.

The concerns with proposed Section 1005(a)(7) are the following:

1. Disinfectants' labels approved/registered by EPA and then DPR (if sold in CA) are not required to be labeled with the terms "low, intermediate, or high". Therefore, the rule is mandating something that is not a legal requirement, and the disinfectants may or may not have these terms on their labels since they are not required, only optional. I am attaching the CDC's *Guidelines for Infection Control in Dental Health-Care Settings – 2003 Appendix A: Regulatory Framework for Disinfectants and Sterilants*. Please refer to the yellow-highlighted sections in the attached document, which describe clearly how EPA regulates disinfectants.
2. Disinfectants' labels do not have two separate Federal EPA and CA DPR (Cal/EPA) registration numbers. They only have one – the registration number provided by Federal EPA. Disinfectants' labels do not have two separate Federal EPA and CA DPR (Cal/EPA) registration numbers. They only have one – the registration number provided by Federal EPA.
3. A point of information about this... Similar to checking on which dental unit waterline cleaners (considered antimicrobial pesticides by Federal EPA and Cal/EPA) are registered for use by CDPR in California, the easiest way to tell that a surface disinfectant has been registered with CDPR is by going to their website (cdpr.ca.gov) and using their search tool that links to CDPR's pesticide database. Also, surface disinfectants must be registered by Federal EPA first, before obtaining approval for use in CA by CDPR.

4. As a point of information, EPA (and/or Cal/EPA) does not regulate high-level disinfectants. FDA is responsible for regulating both chemical sterilants and high-level disinfectants for use on medical devices, while EPA regulates CDC-defined low- and intermediate-level disinfectants for environmental surfaces (although EPA does not refer to them as low-level or intermediate-level). Again, please refer to the attached document (green highlights).

**Response:** Upon review, the Working Group agrees with the concerns raised and, on page 2, has revised (a)(7) to state, "Cal/EPA-registered" means a product registered by the U.S. Environmental Protection Agency (EPA) and the California Department of Pesticide Regulation for sale and use in California as a pesticide." To avoid confusion about the meaning of Cal/EPA registered, references to the type of disinfectant classification and registration numbers in the prior proposal were deleted since these items can be confirmed independently by staff when investigating compliance with these regulations.

**Additional Changes Recommended by the DHBC's and Board's Working Groups:**

On page 2, replacing the word "kills" in (a)(6)(A) and (a)(6)(B) with "inactivates" wherever listed in these subparagraphs. This ensures more accurate and consistent use of terminology throughout the proposal and avoids confusion since the introductory paragraph refers to "inactivates", and not "kills".

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento CA 95815
P [916] 263-2300 | F [916] 263-2140 | www.dbc.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | April 14, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Jodi Ortiz, Staff Services Manager II<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 11.a.:** Update on Dental Licensure and Permit Statistics |

## Dental License Application Statistics

The following tables present monthly dental license application statistics by pathway for fiscal year 2021–22, 2022–23, 2023–24 and 2024–25 as of March 31, 2025.

***NOTE: Canceled and Withdrawn applications have been removed from reporting as they are used internally for cleanup and not pertinent to reporting.***

| Dental Applications Received by Month | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Totals |
| WREB 21/22 | 138 | 85 | 75 | 22 | 28 | 27 | 38 | 31 | 71 | 83 | 109 | 123 | **830** |
| WREB 22/23 | 71 | 58 | 42 | 35 | 29 | 28 | 38 | 26 | 31 | 41 | 48 | 80 | **527** |
| WREB 23/24 | 38 | 32 | 21 | 14 | 8 | 7 | 10 | 9 | 15 | 8 | 10 | 7 | **179** |
| WREB 24/25 | 5 | 6 | 5 | 3 | 8 | 4 | 7 | 5 | 4 | 0 | 0 | 0 | **47** |
| Residency 21/22 | 93 | 23 | 12 | 5 | 1 | 6 | 3 | 8 | 8 | 6 | 3 | 14 | **182** |
| Residency 22/23 | 13 | 5 | 1 | 2 | 4 | 1 | 2 | 4 | 4 | 6 | 3 | 12 | **57** |
| Residency 23/24 | 11 | 2 | 0 | 0 | 1 | 1 | 3 | 0 | 5 | 3 | 3 | 3 | **32** |
| Residency 24/25 | 8 | 2 | 0 | 1 | 2 | 3 | 1 | 1 | 0 | 0 | 0 | 0 | **18** |
| Credential 21/22 | 45 | 51 | 44 | 20 | 8 | 17 | 19 | 19 | 23 | 14 | 19 | 27 | **306** |
| Credential 22/23 | 20 | 17 | 18 | 20 | 12 | 20 | 28 | 17 | 30 | 20 | 28 | 20 | **250** |
| Credential 23/24 | 27 | 26 | 19 | 19 | 17 | 16 | 25 | 17 | 21 | 19 | 36 | 18 | **260** |
| Credential 24/25 | 25 | 19 | 27 | 22 | 22 | 28 | 29 | 24 | 29 | 0 | 0 | 0 | **225** |
| Portfolio 21/22 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | **3** |
| Portfolio 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | **2** |
| Portfolio 23/24 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **2** |
| Portfolio 24/25 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| ADEX 21/22 | 82 | 34 | 17 | 11 | 5 | 9 | 17 | 20 | 19 | 22 | 78 | 117 | **431** |
| ADEX 22/23 | 69 | 51 | 23 | 22 | 17 | 12 | 30 | 18 | 55 | 118 | 137 | 188 | **740** |
| ADEX 23/24 | 56 | 34 | 32 | 36 | 32 | 33 | 41 | 31 | 64 | 140 | 200 | 213 | **912** |
| ADEX 24/25 | 89 | 74 | 53 | 38 | 36 | 43 | 54 | 47 | 75 | 0 | 0 | 0 | **509** |

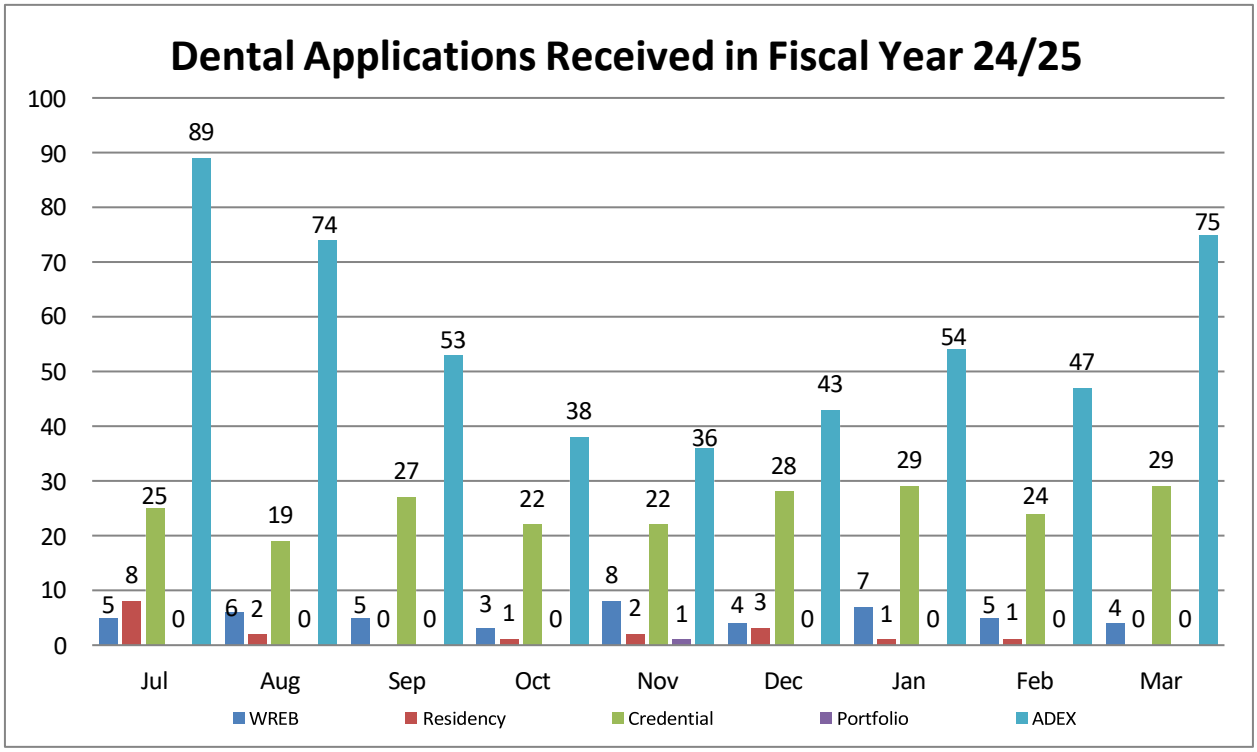
| Dental Applications Approved by Month | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Totals** |
| WREB 21/22 | 367 | 128 | 98 | 29 | 12 | 48 | 44 | 35 | 21 | 20 | 29 | 48 | **879** |
| WREB 22/23 | 79 | 134 | 135 | 58 | 18 | 43 | 35 | 39 | 17 | 20 | 25 | 18 | **621** |
| WREB 23/24 | 10 | 27 | 44 | 13 | 5 | 10 | 6 | 18 | 12 | 12 | 8 | 8 | **173** |
| WREB 24/25 | 6 | 8 | 6 | 6 | 5 | 5 | 6 | 5 | 1 | 0 | 0 | 0 | **48** |
| Residency 21/22 | 110 | 54 | 27 | 12 | 6 | 7 | 2 | 4 | 0 | 1 | 7 | 5 | **235** |
| Residency 22/23 | 2 | 18 | 14 | 5 | 1 | 1 | 3 | 2 | 3 | 1 | 4 | 1 | **55** |
| Residency 23/24 | 0 | 2 | 18 | 4 | 0 | 1 | 2 | 4 | 1 | 2 | 3 | 1 | **38** |
| Residency 24/25 | 4 | 9 | 4 | 1 | 3 | 3 | 1 | 2 | 0 | 0 | 0 | 0 | **27** |
| Credential 21/22 | 36 | 60 | 38 | 20 | 9 | 19 | 9 | 13 | 14 | 4 | 24 | 5 | **251** |
| Credential 22/23 | 11 | 18 | 24 | 21 | 13 | 29 | 13 | 28 | 13 | 17 | 16 | 12 | **215** |
| Credential 23/24 | 1 | 18 | 27 | 23 | 28 | 4 | 17 | 15 | 22 | 11 | 16 | 9 | **191** |
| Credential 24/25 | 10 | 19 | 31 | 35 | 17 | 26 | 17 | 28 | 27 | 0 | 0 | 0 | **210** |
| Portfolio 21/22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| ADEX 21/22 | 189 | 79 | 43 | 21 | 4 | 7 | 13 | 5 | 3 | 5 | 16 | 31 | **416** |
| ADEX 22/23 | 43 | 95 | 98 | 40 | 14 | 23 | 23 | 25 | 16 | 22 | 34 | 52 | **485** |
| ADEX 23/24 | 91 | 199 | 228 | 58 | 36 | 37 | 18 | 59 | 32 | 35 | 39 | 126 | **958** |
| ADEX 24/25 | 126 | 263 | 134 | 81 | 56 | 55 | 42 | 35 | 51 | 0 | 0 | 0 | **843** |
| **Dental Licenses Issued by Month** | | | | | | | | | | | | | |
| | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Totals** |
| WREB 21/22 | 198 | 71 | 48 | 35 | 14 | 42 | 35 | 28 | 22 | 20 | 24 | 51 | **588** |
| WREB 22/23 | 71 | 127 | 131 | 58 | 27 | 39 | 30 | 40 | 18 | 16 | 32 | 20 | **609** |
| WREB 23/24 | 14 | 26 | 46 | 11 | 5 | 9 | 9 | 15 | 12 | 9 | 8 | 11 | **175** |
| WREB 24/25 | 6 | 9 | 6 | 4 | 9 | 9 | 3 | 6 | 3 | 0 | 0 | 0 | **55** |
| Residency 21/22 | 51 | 30 | 15 | 12 | 6 | 5 | 4 | 2 | 1 | 3 | 7 | 5 | **141** |
| Residency 22/23 | 3 | 15 | 12 | 6 | 2 | 2 | 3 | 2 | 1 | 1 | 3 | 2 | **52** |
| Residency 23/24 | 1 | 2 | 18 | 4 | 0 | 1 | 0 | 2 | 2 | 3 | 2 | 2 | **37** |
| Residency 24/25 | 3 | 10 | 5 | 1 | 3 | 0 | 2 | 2 | 1 | 0 | 0 | 0 | **27** |
| Credential 21/22 | 8 | 16 | 22 | 19 | 10 | 19 | 11 | 9 | 9 | 4 | 18 | 10 | **155** |
| Credential 22/23 | 8 | 19 | 23 | 23 | 12 | 18 | 18 | 25 | 12 | 16 | 18 | 18 | **210** |
| Credential 23/24 | 4 | 14 | 22 | 24 | 25 | 13 | 17 | 9 | 23 | 11 | 21 | 8 | **191** |
| Credential 24/25 | 14 | 22 | 22 | 34 | 15 | 21 | 18 | 28 | 26 | 0 | 0 | 0 | **200** |
| Portfolio 21/22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |

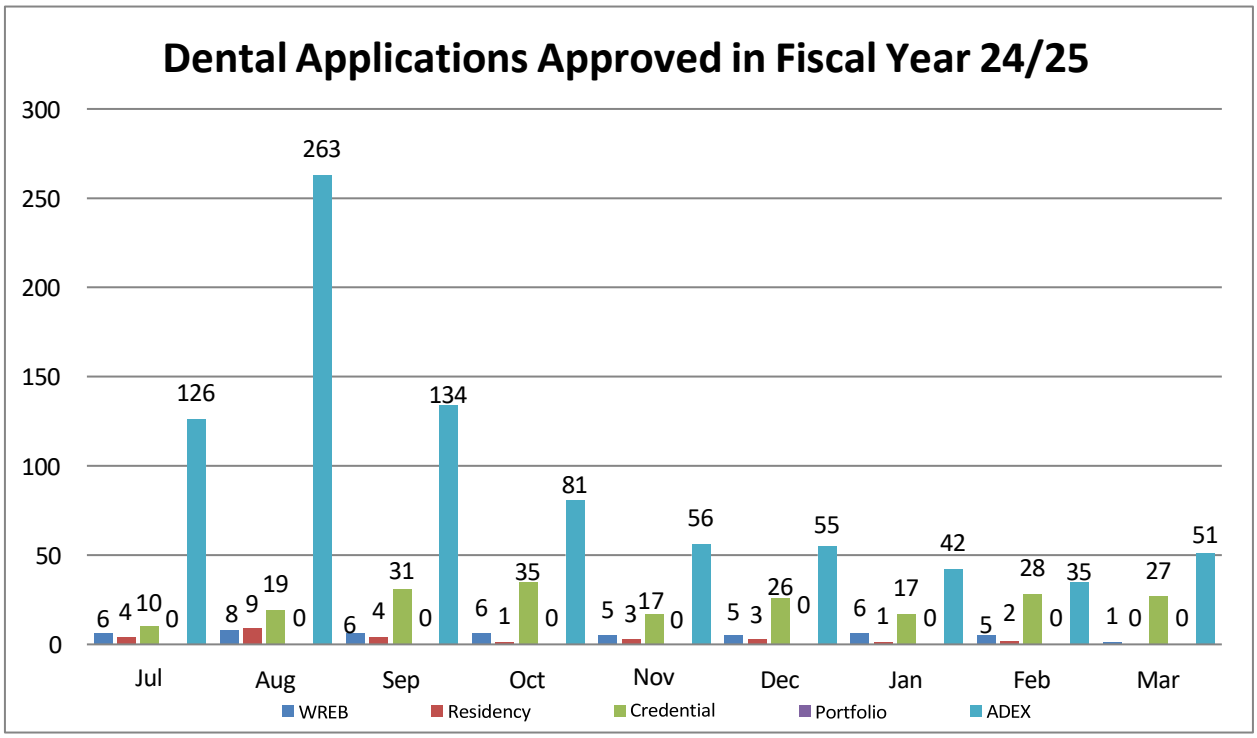
| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Portfolio 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| ADEX 21/22 | 107 | 40 | 22 | 23 | 6 | 7 | 9 | 5 | 5 | 5 | 17 | 26 | **272** |
| ADEX 22/23 | 39 | 94 | 96 | 40 | 20 | 22 | 19 | 24 | 17 | 23 | 33 | 53 | **480** |
| ADEX 23/24 | 80 | 190 | 217 | 57 | 43 | 38 | 28 | 60 | 35 | 29 | 44 | 117 | **938** |
| ADEX 24/25 | 123 | 249 | 141 | 79 | 54 | 46 | 52 | 34 | 50 | 0 | 0 | 0 | **828** |
| **Denied Dental Applications by Month** | | | | | | | | | | | | | |
| | **Jul** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Totals** |
| WREB 21/22 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **1** |
| WREB 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| WREB 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| WREB 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Residency 21/22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Residency 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Residency 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Residency 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Credential 21/22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Credential 22/23 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | **2** |
| Credential 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Credential 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 21/22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Portfolio 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| ADEX 21/22 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| ADEX 22/23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| ADEX 23/24 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| ADEX 24/25 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |

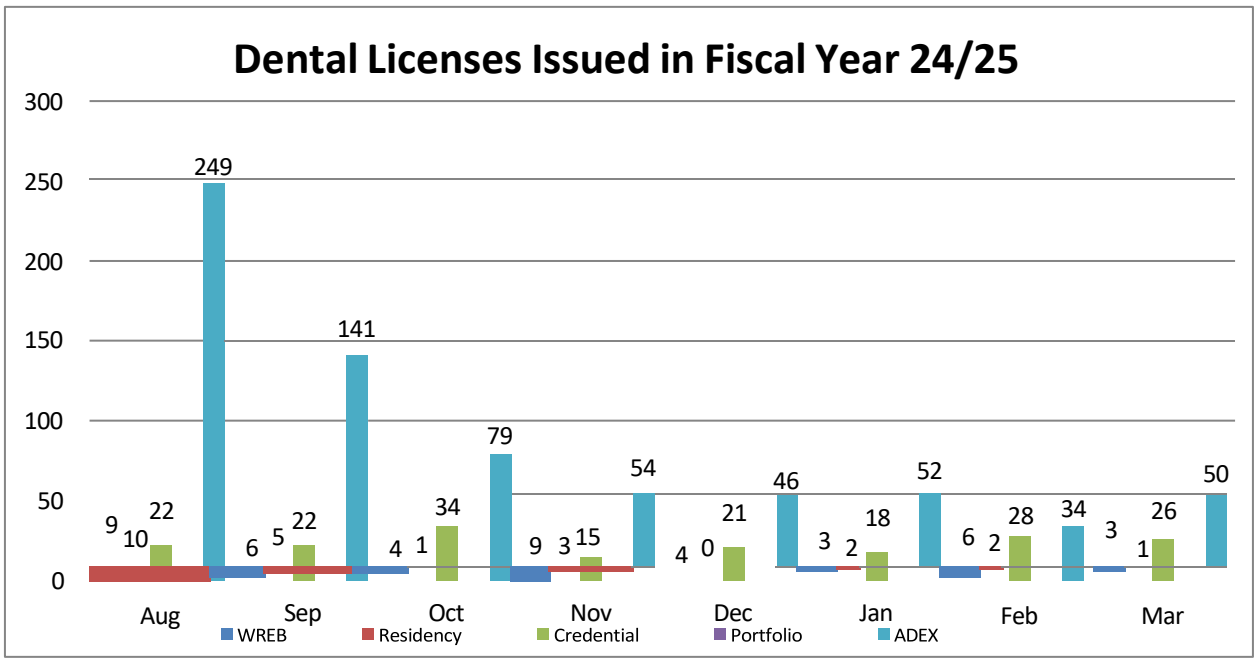
| **Application Definitions** | |
|---|---|
| **Received** | Application submitted in physical form or digitally through Breeze system. |
| **Approved** | Application for eligibility of licensure processed with all required documentation. |
| **License Issued** | Application processed with required documentation and paid prorated fee for initial license. |
| **Denied** | The Board denies an application on the on the grounds that the applicant has been convicted of a crime or has been subject to formal discipline; in accordance with Business and Professions Code, Division 1.5, Chapter 2, Denial of Licenses. |

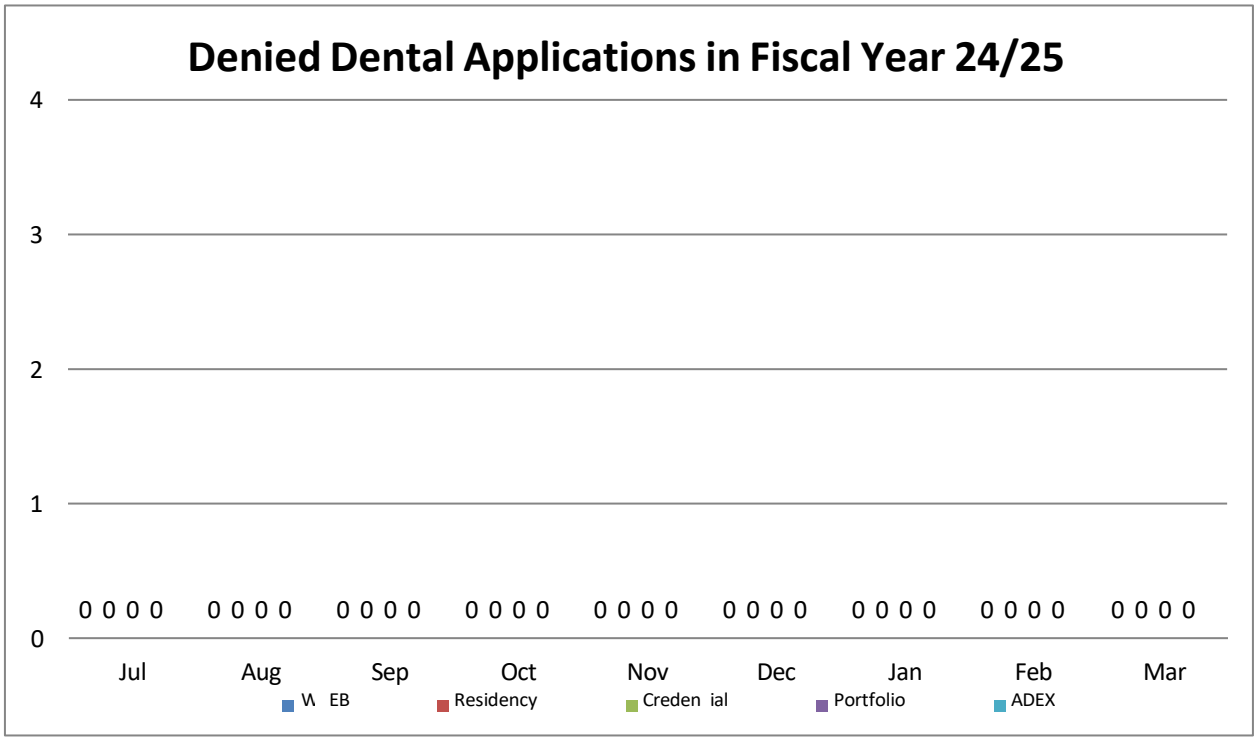
**Dental License Application Statistic Graphs**

The following graphs represent monthly dental license application statistics by pathway for fiscal year 2024–25 as of March 31, 2025.




Dental Licenses Issued in Fiscal Year 24/25
300
250
200
150
100
50
0
9 10 22
249
6 5 22
141
4 1 34
79
9 3 15
54
4 0 21
46
3 2 18
52
6 2 28
34
3
1 26
50
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
WREB
Residency
Credential
Portfolio
ADEX


Denied Dental Applications in Fiscal Year 24/25
4
3
2
1
0
0 0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
0 0 0 0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
WREB
Residency
Credential
Portfolio
ADEX

## Dental Law and Ethics Written Examination Statistics

| License Type | | DDS | | | | |
|---|---|---|---|---|---|---|
| **Exam Title** | | **Dental Law and Ethics Examination** | | | | |
| **Licensure Pathway** | | **WREB** | **LBR** | **PORT** | **ADEX** | ***Pathway not chosen** |
| **2021/22** | # of 1st Time Candidates | 55 | 85 | 0 | 271 | 73 |
| | Pass % | 70.60% | 81.18% | N/A | 74.17% | 71.23% |
| **2022/23** | # of 1st Time Candidates | 444 | 52 | N/A | 761 | 199 |
| | Pass % | 74.55% | 88.46% | N/A | 83.57% | 69.35% |
| **2023/24** | # of 1st Time Candidates | 90 | 18 | N/A | 587 | 563 |
| | Pass % | 91.11% | 94.44% | N/A | 90.12% | 82.42% |
| **2024/25** | # of 1st Time Candidates | 32 | 9 | N/A | 456 | 180 |
| | Pass % | 93.75% | 100.00% | N/A | 92.76% | 86.67% |
| **Date of Last Occupational Analysis:** 2024 | | | | | | |
| **Name of Developer:** Office of Professional Examination Services | | | | | | |
| **Target Occupational Analysis Date:** 2029 | | | | | | |

*Pathway not chosen denotes applicants who have tested, but not yet chosen a pathway to licensure.

## Dental License and Permits Statistics

The following table provides statistics on dental licenses issued by pathway to licensure by fiscal year 2021–22, 2022–23, 2023–24 and 2024–25 as of March 31, 2025.

| Dental Licenses Issued via Pathway | Total Issued in 21/22 | Total Issued 22/23 | Total Issued 23/24 | Total Issued 24/25 | Total Issued to Date | Date Pathway Implemented |
|---|---|---|---|---|---|---|
| WREB Exam | 588 | 609 | 175 | 50 | 12,899 | January 1, 2006 |
| Licensure by Residency | 141 | 52 | 38 | 27 | 2,431 | January 1, 2007 |
| Licensure by Credential | 155 | 210 | 191 | 152 | 3,987 | July 1, 2002 |
| (LBC Clinic Contract) | 14 | 13 | 16 | 4 | 85 | July 1, 2002 |
| (LBC Faculty Contract) | 1 | 5 | 4 | 2 | 28 | July 1, 2002 |
| Portfolio | 0 | 0 | 0 | 0 | 79 | November 5, 2014 |
| ADEX | 272 | 480 | 958 | 843 | 3,230 | November 15, 2019 |
| **Total** | **1,156** | **1,351** | **1,362** | **1,078** | **22,739** | |

The following table provides statistics on dental license and permit status statistics by fiscal year 2021–22, 2022–23, 2023–24, and 2024–25 as of March 31, 2025.

***Updated name of License Type to reflect the correct license type name and prior numbers contained duplicates.***

| License Type | License Status | FY 21/22 | FY 22/23 | FY 23/24 | FY 24/25 |
|---|---|---|---|---|---|
| Dental License | Active | 34,619 | 34,710 | 35,078 | 35,448 |
| | Inactive | 1,727 | 1,691 | 1,661 | 1,628 |
| | Reduced Renewal Fee | 1,251 | 1,168 | 1,132 | 935 |
| | Disabled | 95 | 87 | 94 | 93 |
| | Delinquent | 6,002 | 6,180 | 6,069 | 6,103 |
| | Cancelled | 19,604 | 20,703 | 21,735 | 22,477 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Additional Office Permit | Active | 2,556 | 2,375 | 2,522 | 2,610 |
| | Delinquent | 1,204 | 1,390 | 1,285 | 1,297 |
| | Cancelled | 7,418 | 7,726 | 7,979 | 8,142 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Conscious Sedation Certificate | Active | 554 | 380 | 126 | 0 |
| | Delinquent | 63 | 219 | 0 | 0 |
| | Cancelled | 606 | 625 | 1,098 | 1,224 |

| License Type | License Status | FY 21/22 | FY 22/23 | FY 23/24 | FY 24/25 |
|---|---|---|---|---|---|
| Continuing Education Registered Provider Permit | Active | 744 | 746 | 724 | 775 |
| | Delinquent | 776 | 660 | 625 | 550 |
| | Cancelled | 2,471 | 2,663 | 2,782 | 2,871 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Elective Facial Cosmetic Surgery Permit | Active | 29 | 27 | 27 | 31 |
| | Delinquent | 6 | 6 | 6 | 5 |
| | Cancelled | 3 | 4 | 5 | 6 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Extramural Facility Registration | Active | 205 | 60 | 67 | 87 |
| | Delinquent | N/A | N/A | N/A | N/A |
| | Cancelled | N/A | N/A | N/A | N/A |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Fictitious Name Permit | Active | 6,782 | 6,485 | 6,877 | 7,259 |
| | Delinquent | 2,394 | 2,855 | 2,731 | 2,732 |
| | Cancelled | 7,808 | 8,350 | 8,875 | 9,173 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| General Anesthesia Permit | Active | 925 | 949 | 941 | 941 |
| | Delinquent | 38 | 41 | 49 | 37 |
| | Cancelled | 1,067 | 1,095 | 1,131 | 1,170 |
| | PE Under 7 | - | - | - | 121 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Mobile Dental Clinic Permit | Active | 44 | 45 | 50 | 57 |
| | Delinquent | 44 | 39 | 40 | 42 |
| | Cancelled | 81 | 88 | 96 | 98 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Medical General Anesthesia Permit | Active | 156 | 153 | 150 | 151 |
| | Delinquent | 27 | 32 | 39 | 38 |
| | Cancelled | 226 | 242 | 267 | 288 |
| | PE Under 7 | - | - | - | 100 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Moderate Sedation Permit | Active | N/A | 192 | 445 | 601 |
| | Delinquent | N/A | 1 | 4 | 1 |
| | Cancelled | N/A | 3 | 10 | 35 |
| | PE Under 13 | - | - | - | 55 |
| | PE Under 7 | - | - | - | 53 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Oral Conscious Sedation Adults Certificate | Active | 2,352 | 1,971 | 1,460 | 1,219 |
| | Delinquent | 702 | 386 | 412 | 421 |
| | Cancelled | 1,185 | 1,960 | 2,562 | 2,876 |

| License Type | License Status | FY 21/22 | FY 22/23 | FY 23/24 | FY 24/25 |
|---|---|---|---|---|---|
| Oral and Maxillofacial Surgery Permit | Active | 94 | 96 | 96 | 94 |
| | Delinquent | 10 | 9 | 10 | 12 |
| | Cancelled | 25 | 27 | 27 | 27 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Pediatric Minimal Sedation Permit | Active | N/A | 102 | 309 | 399 |
| | Delinquent | N/A | 1 | 3 | 11 |
| | Cancelled | N/A | 0 | 0 | 1 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Referral Service Registration | Active | 161 | 7 | 7 | 6 |
| | Delinquent | N/A | 0 | 0 | 0 |
| | Cancelled | N/A | 2 | 2 | 3 |
| **License Type** | **License Status** | **FY 21/22** | **FY 22/23** | **FY 23/24** | **FY 24/25** |
| Special Permit | Active | 35 | 34 | 38 | 36 |
| | Delinquent | 7 | 6 | 8 | 10 |
| | Cancelled | 195 | 203 | 207 | 213 |

| Status Definitions | |
|---|---|
| **Active** | Current and can practice without restrictions *(BPC §1625)* |
| **Inactive** | Current but cannot practice, continuing education not required (*CCR §1017.2)* |
| **Reduced Renewal Fee** | Current, has practiced over 20 years, eligible for Social Security and can practicewith restrictions *(BPC §1716.1a)* |
| **Disabled** | Current with disability but cannot practice *(BPC §1716.1b)* |
| **Delinquent** | Renewal fee not paid within one month after expiration date *(BPC §163.5)* |
| **Cancelled** | Renewal fee not paid 5 years after its expiration and may not be renewed *(BPC §1718.3a)* Total number of licenses / permits cancelled to date. |

The following table provides statistics on population, current and active dental licenses by County, and population (Pop.) per dental license by County for fiscal years 2022–23, 2023–24 and 2024–25 as of March 31, 2025. These statistics represent the licensee's address of record and not necessarily the licensee's workplace address.

| County | DDS per County in 2022/23 | Pop. in 2022/23 | Pop. per DDS in 2022/23 | DDS per County in 2023/24 | Pop. in 2023/24 | Pop. per DDS in 2023/24 | DDS per County in 2024/25 | Pop. In 2024/25 | Pop. per DDS in 2024/25 |
|---|---|---|---|---|---|---|---|---|---|
| Alameda | 1,485 | 1,651,979 | 1,112 | 1,472 | 1,651,979 | 1,112 | 1,468 | 1,641,869 | 1,118 |
| Alpine | 0 | 1,200 | 0 | 0 | 1,200 | 0 | 0 | 1,179 | 0 |
| Amador | 21 | 40,297 | 1,918 | 23 | 40,297 | 1,918 | 25 | 39,611 | 1,584 |
| Butte | 124 | 201,608 | 1,625 | 118 | 201,608 | 1,625 | 112 | 205,928 | 1,838 |
| Calaveras | 21 | 45,049 | 2,145 | 21 | 45,049 | 2,145 | 16 | 44,842 | 2,802 |
| Colusa | 6 | 21,807 | 3,634 | 4 | 21,807 | 3,634 | 3 | 21,743 | 7,247 |
| Contra Costa | 1,103 | 1,156,555 | 1,048 | 1,092 | 1,156,555 | 1,048 | 1,096 | 1,146,626 | 1,046 |
| Del Norte | 11 | 27,218 | 2,474 | 11 | 27,218 | 2,474 | 13 | 26,345 | 2,026 |
| El Dorado | 152 | 190,465 | 1,253 | 148 | 190,465 | 1,253 | 145 | 188,583 | 1,300 |
| Fresno | 620 | 1,011,273 | 1,631 | 625 | 1,011,273 | 1,631 | 634 | 1,017,431 | 1,604 |
| Glenn | 7 | 28,750 | 4,107 | 7 | 28,750 | 4,107 | 8 | 28,736 | 3,592 |
| Humboldt | 63 | 135,168 | 2,145 | 66 | 135,168 | 2,145 | 66 | 133,100 | 2,016 |
| Imperial | 39 | 179,329 | 4,598 | 40 | 179,329 | 4,598 | 40 | 182,881 | 4,572 |
| Inyo | 5 | 18,978 | 3,795 | 7 | 18,978 | 3,795 | 7 | 18,856 | 2,693 |
| Kern | 341 | 909,813 | 2,668 | 350 | 909,813 | 2,668 | 350 | 910,300 | 2,600 |
| Kings | 61 | 152,023 | 2,492 | 58 | 152,023 | 2,492 | 56 | 152,627 | 2,725 |
| Lake | 39 | 67,407 | 1,728 | 37 | 67,407 | 1,728 | 41 | 67,001 | 1,634 |
| Lassen | 22 | 30,274 | 1,376 | 18 | 30,274 | 1,376 | 18 | 28,197 | 1,566 |
| Los Angeles | 8,416 | 9,861,224 | 1,171 | 8,464 | 9,861,224 | 1,171 | 8,470 | 9,824,091 | 1,159 |
| Madera | 44 | 157,396 | 3,577 | 47 | 157,396 | 3,577 | 54 | 159,328 | 2,950 |
| Marin | 290 | 257,135 | 886 | 279 | 257,135 | 886 | 271 | 252,844 | 933 |
| Mariposa | 7 | 17,045 | 2,435 | 6 | 17,045 | 2,435 | 6 | 16,966 | 2,827 |
| Mendocino | 49 | 89,999 | 1,836 | 45 | 89,999 | 1,836 | 49 | 89,476 | 1,826 |
| Merced | 92 | 284,338 | 3,090 | 98 | 284,338 | 3,090 | 96 | 287,303 | 2,992 |

| County | DDS per County in 2022/23 | Pop. in 2022/23 | Pop. per DDS in 2022/23 | DDS per County in 2023/24 | Pop. in 2023/24 | Pop. per DDS in 2023/24 | DDS per County in 2024/25 | Pop. In 2024/25 | Pop. per DDS in 2024/25 |
|---|---|---|---|---|---|---|---|---|---|
| Modoc | 3 | 8,690 | 2,896 | 5 | 8,690 | 1,738 | 5 | 8,484 | 1,696 |
| Mono | 5 | 13,379 | 2,675 | 5 | 13,379 | 2,675 | 3 | 12,861 | 4,287 |
| Monterey | 248 | 433,716 | 1,748 | 244 | 433,716 | 1,777 | 250 | 437,614 | 1,750 |
| Napa | 110 | 136,179 | 1,237 | 106 | 136,179 | 1,284 | 101 | 135,029 | 1,336 |
| Nevada | 72 | 101,242 | 1,406 | 69 | 101,242 | 1,467 | 66 | 100,177 | 1,517 |
| Orange | 4,073 | 3,162,245 | 776 | 4,183 | 3,162,245 | 755 | 4,212 | 3,150,835 | 748 |
| Placer | 472 | 409,025 | 866 | 482 | 409,025 | 848 | 488 | 412,844 | 845 |
| Plumas | 13 | 18,942 | 1,457 | 13 | 18,942 | 1,457 | 12 | 18,841 | 1,570 |
| Riverside | 1,142 | 2,435,525 | 2,132 | 1,163 | 2,435,525 | 2,094 | 1,180 | 2,442,378 | 2,069 |
| Sacramento | 1,176 | 1,576,618 | 1,340 | 1,207 | 1,576,618 | 1,306 | 1,213 | 1,578,938 | 1,301 |
| San Benito | 23 | 65,479 | 2,846 | 26 | 65,479 | 2,518 | 27 | 65,853 | 2,439 |
| San Bernardino | 1,398 | 2,187,665 | 1,564 | 1,403 | 2,187,665 | 1,559 | 1,435 | 2,181,433 | 1,520 |
| San Diego | 2,820 | 3,287,306 | 1,165 | 2,853 | 3,287,306 | 1,152 | 2,852 | 3,291,101 | 1,153 |
| San Francisco | 1,151 | 842,754 | 732 | 1,127 | 842,754 | 747 | 1,122 | 843,071 | 751 |
| San Joaquin | 376 | 784,298 | 2,085 | 393 | 784,298 | 1,995 | 391 | 791,408 | 2,024 |
| San Luis Obispo | 210 | 280,721 | 1,336 | 217 | 280,721 | 1,293 | 213 | 278,469 | 1,307 |
| San Mateo | 843 | 744,662 | 883 | 829 | 744,662 | 898 | 840 | 741,565 | 882 |
| Santa Barbara | 307 | 445,164 | 1,450 | 312 | 445,164 | 1,426 | 309 | 443,623 | 1,435 |
| Santa Clara | 2,289 | 1,894,783 | 827 | 2,283 | 1,894,783 | 829 | 2,274 | 1,903,198 | 836 |
| Santa Cruz | 168 | 255,564 | 1,586 | 171 | 255,564 | 1,494 | 169 | 262,572 | 1,553 |
| Shasta | 100 | 180,531 | 1,805 | 109 | 180,531 | 1,656 | 110 | 179,195 | 1,629 |
| Sierra | 0 | 3,229 | 0 | 0 | 3,229 | 0 | 0 | 3,171 | 0 |
| Siskiyou | 23 | 43,830 | 1,905 | 23 | 43,830 | 1,905 | 22 | 43,409 | 1,973 |
| Solano | 279 | 447,241 | 1,603 | 277 | 447,241 | 1,614 | 279 | 446,426 | 1,600 |
| Sonoma | 382 | 482,404 | 1,262 | 374 | 482,404 | 1,289 | 379 | 478,152 | 1,261 |
| Stanislaus | 274 | 549,466 | 2,005 | 277 | 549,466 | 1,983 | 283 | 548,744 | 1,939 |
| Sutter | 51 | 99,145 | 1,944 | 49 | 99,145 | 2,023 | 52 | 100,110 | 1,925 |

| County | DDS per County in 2022/23 | Pop. in 2022/23 | Pop. per DDS in 2022/23 | DDS per County in 2023/24 | Pop. in 2023/24 | Pop. per DDS in 2023/24 | DDS per County in 2024/25 | Pop. In 2024/25 | Pop. per DDS in 2024/25 |
|---|---|---|---|---|---|---|---|---|---|
| Tehama | 31 | 65,052 | 2,194 | 28 | 65,052 | 2,323 | 29 | 64,308 | 2,217 |
| Trinity | 3 | 16,023 | 5,341 | 2 | 16,023 | 8,011 | 2 | 15,915 | 7,957 |
| Tulare | 217 | 475,014 | 2,131 | 218 | 475,014 | 2,178 | 225 | 478,918 | 2,128 |
| Tuolumne | 47 | 55,291 | 1,209 | 45 | 55,291 | 1,228 | 43 | 54,407 | 1,265 |
| Ventura | 627 | 833,652 | 1,265 | 634 | 833,652 | 1,314 | 628 | 823,863 | 1,311 |
| Yolo | 122 | 221,165 | 1,874 | 125 | 221,165 | 1,769 | 120 | 221,666 | 1,847 |
| Yuba | 7 | 82,275 | 11,653 | 10 | 82,275 | 8,227 | 11 | 83,721 | 7,611 |
| Out of State/Country** | 2,343 | N/A | N/A | 2,284 | N/A | N/A | 2,385 | N/A | N/A |
| Total | 34,423 | 39,185,605 | N/A | 34,582 | 39,174,605 | N/A | 34,774 | 39,128,162 | N/A |

*Population data obtained from Department of Finance, Demographic Research Unit as of 7/1/2024.
**Prior numbers updated and placed in correct columns.

| | | | |
|---|---|---|---|
| *The counties with the highest Population per DDS are: | Trinity County (1:7,957) | *The counties with the lowest Population per DDS are: | Orange County (1:748) |
| | Yuba County (1:7,611) | | San Francisco County (1:751) |
| | Colusa County (1:7,247) | | Santa Clara (1:836) |
| | Imperial County (1:4,572) | | Placer (1:845) |
| | Mono County (1:4,287) | | San Mateo (1:882) |

* Alpine County (0:1,179) and Sierra County (0:3,171)
No reported address of record in county.

## Action Requested

No action is requested.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 10, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Ryan Blonien, Enforcement Chief<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 12.a.:** Enforcement – Review of Statistics and Trends |

The following are the Enforcement Division statistics:

## Complaint and Compliance Unit (CCU)

### Number of Complaint Cases Received between January 1, 2025 to March 31, 2025

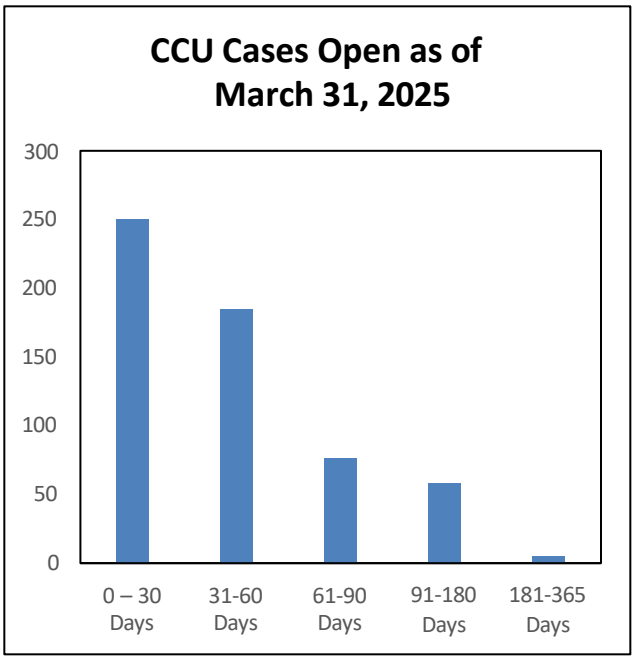
During this period, CCU received **1,015** complaints. The monthly average of complaints received was **398**.

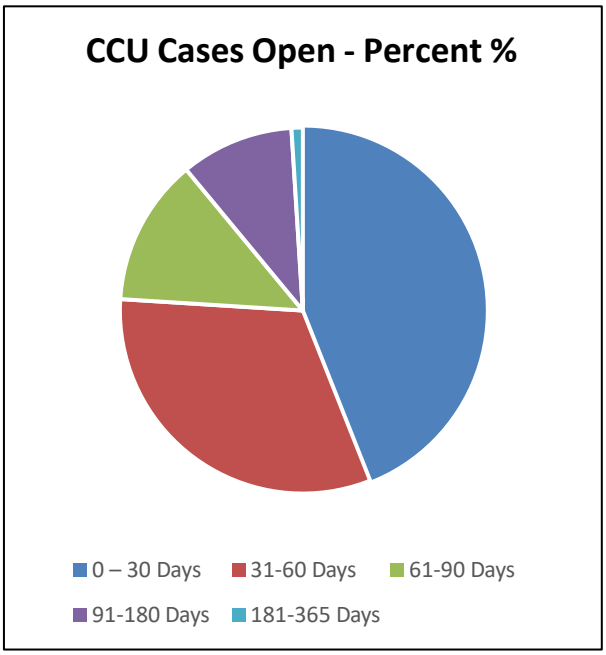
The number of online complaints received was **487** and the number of physical complaint forms received was **329**. The remaining number of complaints fall into various categories including Subsequent Arrest Records, Hospitalization Reports and Settlements.

### Number of Complaint Cases Open

Between January 1, 2025 to March 31, 2025 there were **574** complaint cases open in CCU. A breakdown of the case aging is as follows:

| Complaint and Compliance Cases Open | | |
|---|---|---|
| **Complaint Age** | **January 1- March 31, 2025** | **Percent (%)** |
| 0 – 30 Days | 250 | 44 |
| 31 – 60 Days | 185 | 32 |
| 60 – 90 Days | 76 | 13 |
| 91 – 180 Days | 58 | 10 |
| 181 – 365 Days | 5 | 1 |
| **Total** | **574** | **100%** |




**Number of Complaint Cases Closed**

Between January 1, 2025 to March 31, 2025 a total of **655** complaint cases were closed in CCU. The monthly average of complaints closed during this time was **218.**

**Number of Complaint Cases Received**

| Complaints Received | |
|---|---|
| **License Type** | **January 1, 2025 and March 31, 2025** |
| Dentists | 691 |
| Registered Dental Assistants | 83 |
| Other* | 241 |
| **Total** | **1,015** |

*All other types of Complaints

## Subsequent Arrest Report (SAR) Cases

**Number of SAR Cases Open in IAU**

As of March 31, 2025, there are **398** SAR cases are open in the Investigative Analysis Unit (IAU). A breakdown of the case aging is as follows:

| SARS Cases Open | | |
|---|---|---|
| **SAR Age** | **As of March 31, 2025** | **Percent (%)** |
| 0 – 3 Months | 82 | 20% |
| 3 – 6 Months | 89 | 23% |
| 6 – 9 Months | 59 | 15% |
| 9 – 12 Months | 41 | 10% |
| 1 – 2 Years | 100 | 25% |
| 2 – 3 Years | 17 | 4% |
| 3+ Years | 10 | 3% |
| **Total** | **398** | **100%** |

***SARS are classified as investigative cases once all records requested are received and have been recommended for investigation by either Supervising Investigator or Enforcement Chief**

## Number of SAR Cases Closed

Between January 1, 2025 and March 31, 2025 a total of **86** SAR cases were closed in the IAU.

## Enforcement Units

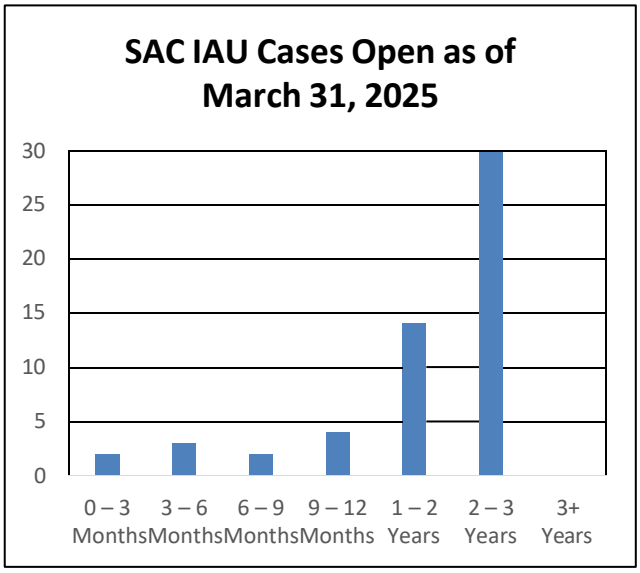
As of March 31,2025 there **930 i**nvestigative cases open in the Board's Enforcement Units. A breakdown of the cases is as follows:

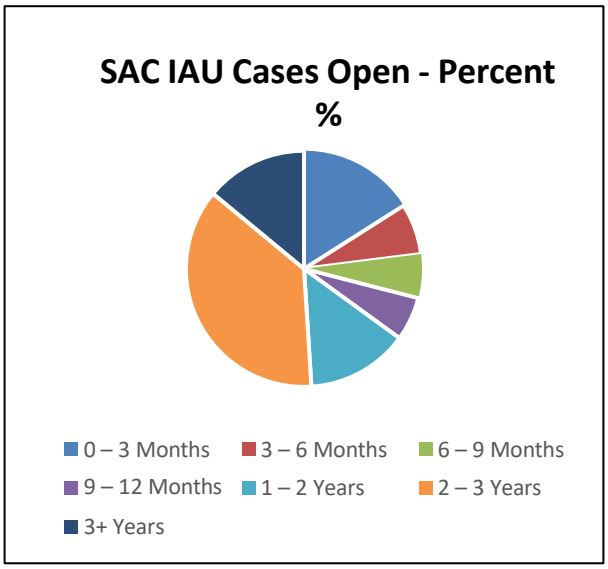
| Enforcement Cases Open | |
|---|---|
| **Enforcement Units** | **March 31, 2025** |
| Sacramento IAU (Non-Sworn) | 52 |
| Orange IAU (Non-Sworn) | 56 |
| Sacramento Field Office (Sworn) | 46 |
| Orange Field Office (Sworn) | 150 |
| Pending Assignment | 626 |
| **Total** | **930** |

**Number of Investigative Cases Open in the Sacramento IAU**

As of March 31, 2025, there are **52** investigative cases open in the Sacramento IAU. A breakdown of the cases is as follows:

| Sacramento IAU Cases Open | | |
|---|---|---|
| **Investigation Age** | **As of March 31, 2025** | **Percent (%)** |
| 0 – 3 Months | 2 | 16% |
| 3 – 6 Months | 3 | 7% |
| 6 – 9 Months | 2 | 6% |
| 9 – 12 Months | 4 | 6% |
| 1 – 2 Years | 14 | 14% |
| 2 – 3 Years | 27 | 37% |
| 3+ Years | 0 | 14% |
| **Total** | **52** | **100%** |

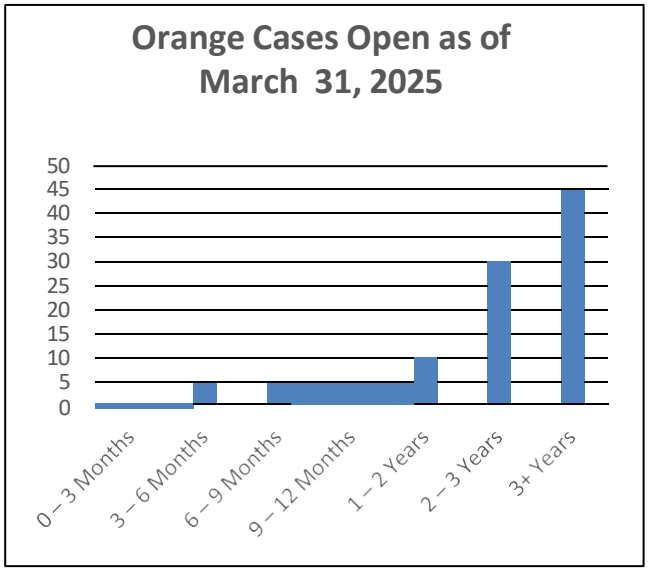


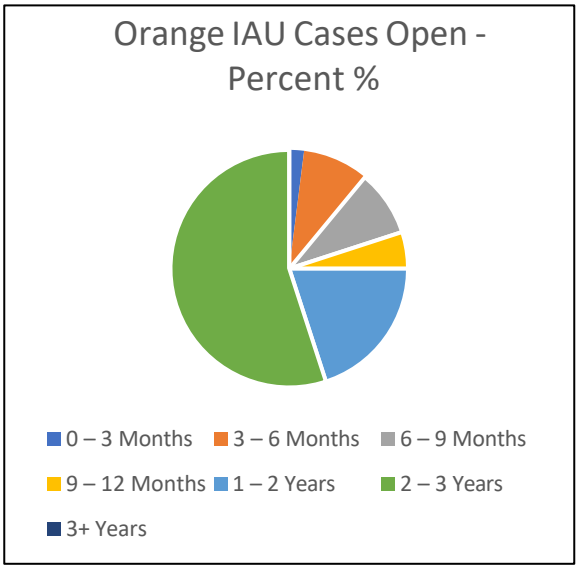



**Number of Investigative Cases Open in the Orange IAU**

As of March 31, 2025, there are **56** investigative cases open in the Orange IAU. A breakdown of the case aging is as follows:

| Orange IAU Cases Open | | |
|---|---|---|
| **Investigation Age** | **As of March 31, 2025** | **Percent (%)** |
| 0 – 3 Months | 1 | 2% |
| 3 – 6 Months | 5 | 9% |
| 6 – 9 Months | 5 | 9% |
| 9 – 12 Months | 3 | 5% |
| 1 – 2 Years | 11 | 20% |
| 2 – 3 Years | 31 | 55% |
| 3+ Years | 0 | 0% |
| **Total** | **56** | **100%** |

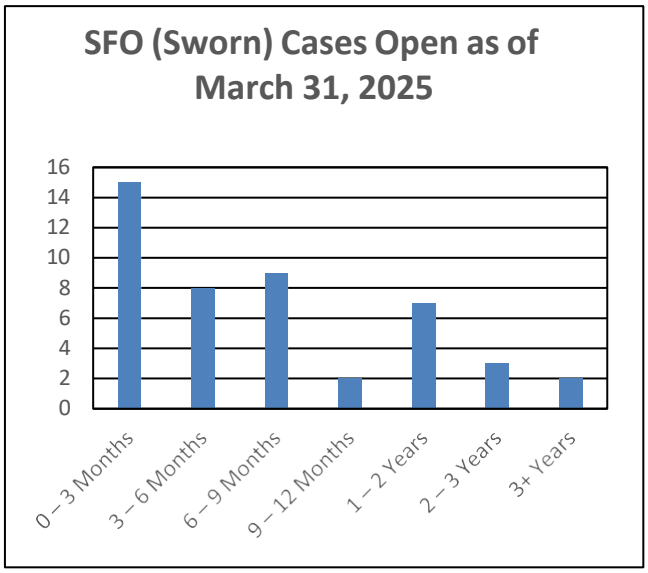


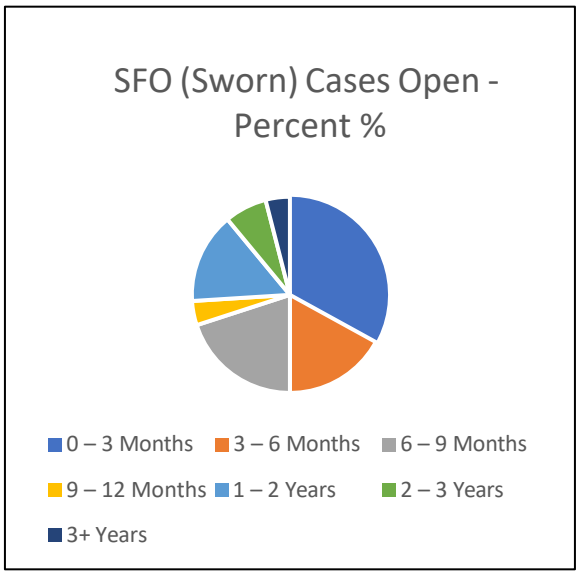



**Number of Investigative Cases Open in the Sacramento Field Office (Sworn)**

As of March 31, 2025, there are **46** investigative cases open in the Sacramento Field Office. A breakdown of the case aging is as follows:

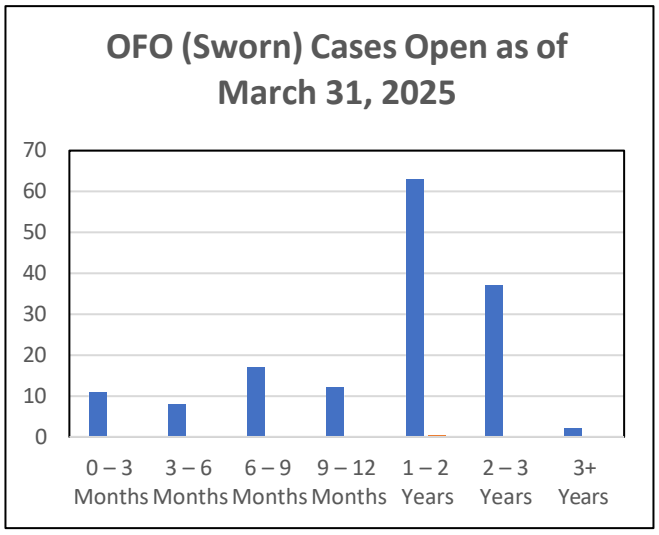
| Sacramento Field Office (Sworn) Cases Open | | |
|---|---|---|
| **Investigation Age** | **As of March 31, 2025f** | **Percent (%)** |
| 0 – 3 Months | 15 | 33% |
| 3 – 6 Months | 8 | 17% |
| 6 – 9 Months | 9 | 20% |
| 9 – 12 Months | 2 | 4% |
| 1 – 2 Years | 7 | 15% |
| 2 – 3 Years | 3 | 7% |
| 3+ Years | 2 | 4% |
| **Total** | **46** | **100%** |

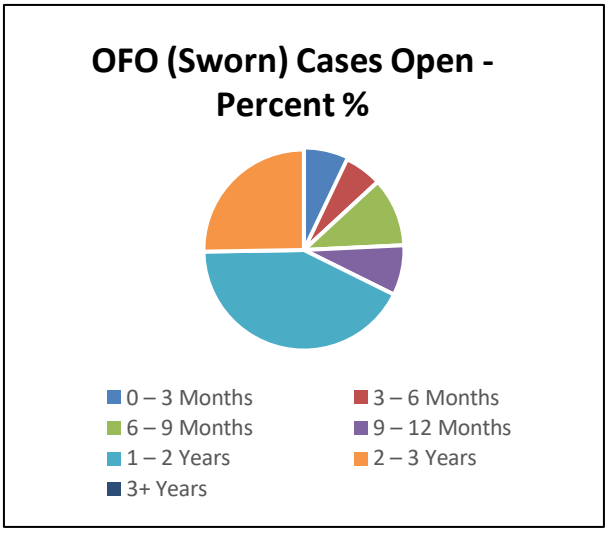


As of March 31, 2025, there are **150** investigative cases open in the Orange Field Office. A breakdown of the case aging is as follows:

| Orange Field Office (Sworn) Cases Open | | |
|---|---|---|
| **Investigation Age** | **March 31, 2025** | **Percent (%)** |
| 0 – 3 Months | 11 | 7% |
| 3 – 6 Months | 8 | 6% |
| 6 – 9 Months | 17 | 11% |
| 9 – 12 Months | 12 | 8% |
| 1 – 2 Years | 63 | 42% |
| 2 – 3 Years | 37 | 25% |
| 3+ Years | 2 | 1% |
| **Total** | **150** | **100%** |




## Number of Investigation Cases Closed

Between January 1, 2025 and March 31, 2025, a total of **177** investigative cases were closed in IAU, the Sacramento Field Office, and the Orange Field Office.

## Number of Inspection Cases Open

As of March 31, 2025 there are **65** Inspection Cases open in the Sacramento and Orange Field Offices. A breakdown is as follows:

| Field Office | Number of Cases |
|---|---|
| Sac IAU | 30 |
| Orange IAU | 35 |
| **Total** | **65** |

## Administrative and Disciplinary Action

As of March 31, 2025, there are **174** open cases in the Discipline Coordination Unit.

### Accusations/Petitions to Revoke/Statement of Issues/Amended Pleadings

Between January 1, and March 31, 2025, there were **35** pleadings filed with the AG.

### Cases Assigned to the Office of the Attorney General

Between January 1, and March 31, 2025, there were **38** cases transmitted to the AG. Of those 38 cases, 23 were referred for dentists and 15 were referred for dental auxiliaries.

As of March 31, 2025, there are **171** cases pending at the AG.

### Citations

Between January 1, 2025 and March 31, 2025, there were **60** citations issued.

### Number of Probation Cases Open

As of March 31, 2025, there are **145** probationer cases being monitored. Of those, **140** active probationers and **5** are tolling. A breakdown of the probation cases is as follows:

| Field Office | Active Probationers | Tolling Probationers |
|---|---|---|
| Sacramento IAU | 47 | 0 |
| Sacramento Field Office | 1 | 0 |
| Orange IAU | 87 | 4 |
| Orange Field Office | 5 | 1 |
| **Total** | **140** | **5** |

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 11, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Paige Ragali, Chief of Administration and Compliance Division<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 13.a.:** Diversion Program Report and Statistics |

## Background

The Diversion Evaluation Committee (DEC) program statistics for the quarter ending on March 31, 2025, are provided below. These statistics reflect the participant activity in the Diversion (Recovery) Program and are presented for informational purposes only.

The DEC met in person at the Dental Board of California's Sacramento office on both January 22, 2025, and April 2, 2025. The next two quarterly meetings are scheduled for July 2, 2025, and October 1, 2025.

As of January 1, 2025, Premier Health Group has assumed the administration of the Diversion (Recovery) Program.

| Diversion | FY 2024/2025 | | | | FY 23/24 | FY 22/23 | FY 21/22 |
|---|---|---|---|---|---|---|---|
| | Quarter 3 | | | YTD | | | |
| | Jan | Feb | Mar | Totals | | | |
| New Participants (Close of Qtr) | 0 | 1 | 0 | 3 | 2 | 3 | 3 |
| Total Participants (Close of Qtr/FY) | 4 | 5 | 5 | 5 | 4 | 7 | 12 |
| Total Completed Cases | 0 | 0 | 0 | 0 | 2 | 5 | 5 |
| Positive Drug Tests for Current Participants | 0 | 0 | 0 | 1 | | | |

## Action Requested

None.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 7, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | John Tran, Associate Governmental Program Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 14.a.:** General Anesthesia and Sedation Permits: Inspections and Evaluations Statistics |

## Background

General Anesthesia (GA), Medical General Anesthesia (MGA), and Moderate Sedation (MS) permitholders are subject to an onsite inspection and evaluation prior to the issuance or renewal of a permit at the discretion of the Dental Board of California (Board). The Board must conduct an inspection and evaluation for GA and MGA permitholders at least once every five years, and for MS permitholders at least once every six years to keep a permit active and in good standing. This memo provides a statistical overview of onsite inspections and evaluations administered by the Board for GA, MGA, and MS permits.

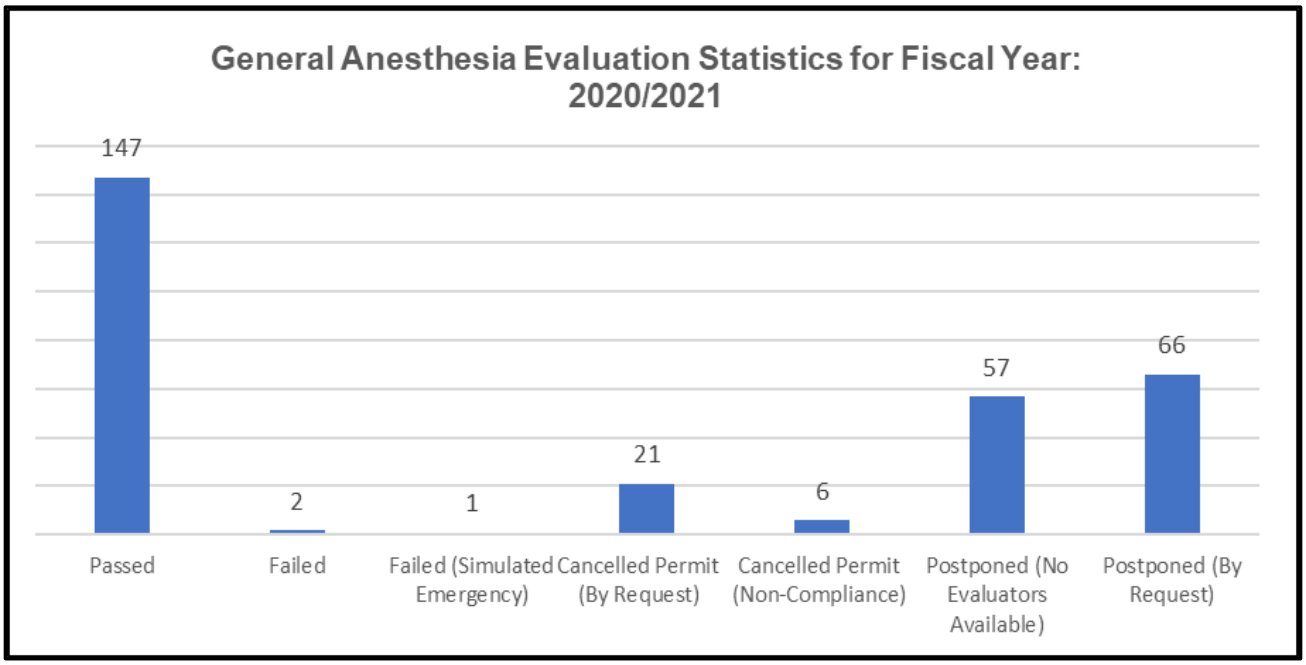
### General Anesthesia Evaluation Statistics for Fiscal Year 2024–25

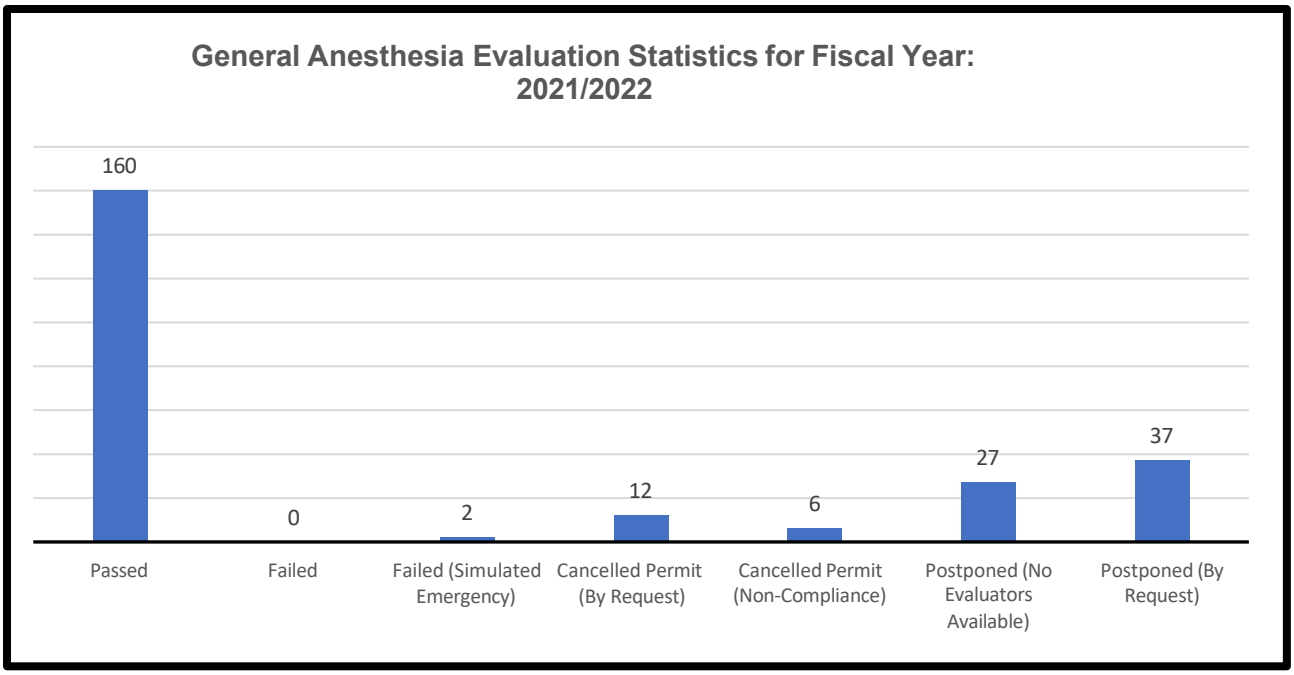
| | Passed Evaluation | Failed Evaluation | Failed Simulated Emergency | Cancelled Permit by Request | Cancelled Permit for Non-compliance | Postponed (No Evaluators Available) | Postponed (By Request) |
|---|---|---|---|---|---|---|---|
| **Jul 2024** | 12 | 0 | 0 | 0 | 0 | 0 | 3 |
| **Aug 2024** | 12 | 0 | 0 | 2 | 2 | 0 | 0 |
| **Sep 2024** | 20 | 0 | 0 | 1 | 3 | 0 | 0 |
| **Oct 2024** | 15 | 0 | 0 | 6 | 3 | 0 | 1 |
| **Nov 2024** | 18 | 0 | 1 | 2 | 2 | 0 | 2 |
| **Dec 2024** | 16 | 1 | 0 | 1 | 6 | 0 | 0 |
| **Jan 2025** | 15 | 0 | 0 | 1 | 3 | 1 | 2 |
| **Feb 2025** | 18 | 0 | 0 | 0 | 1 | 0 | 3 |
| **Mar 2025** | 29 | 0 | 0 | 3 | 0 | 1 | 1 |
| **Apr 2025** | | | | | | | |

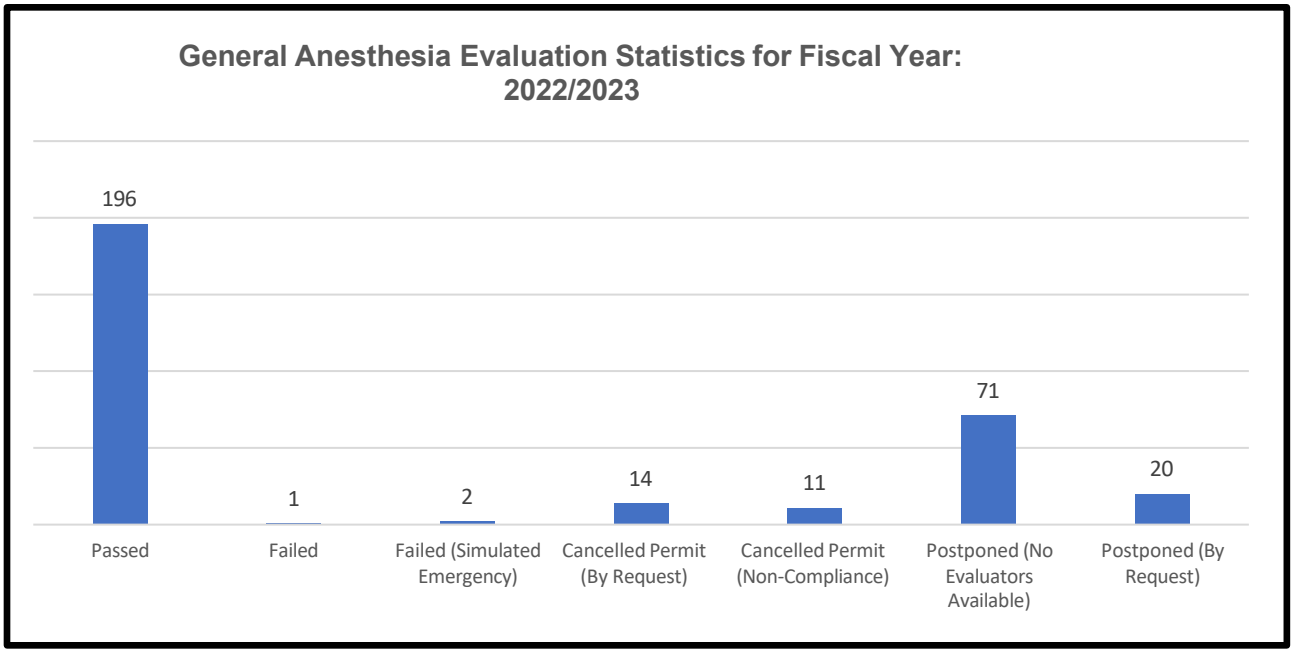
| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **May 2025** | | | | | | | |
| **Jun 2025** | | | | | | | |
| **Total** | **155** | **1** | **1** | **16** | **20** | **2** | **12** |

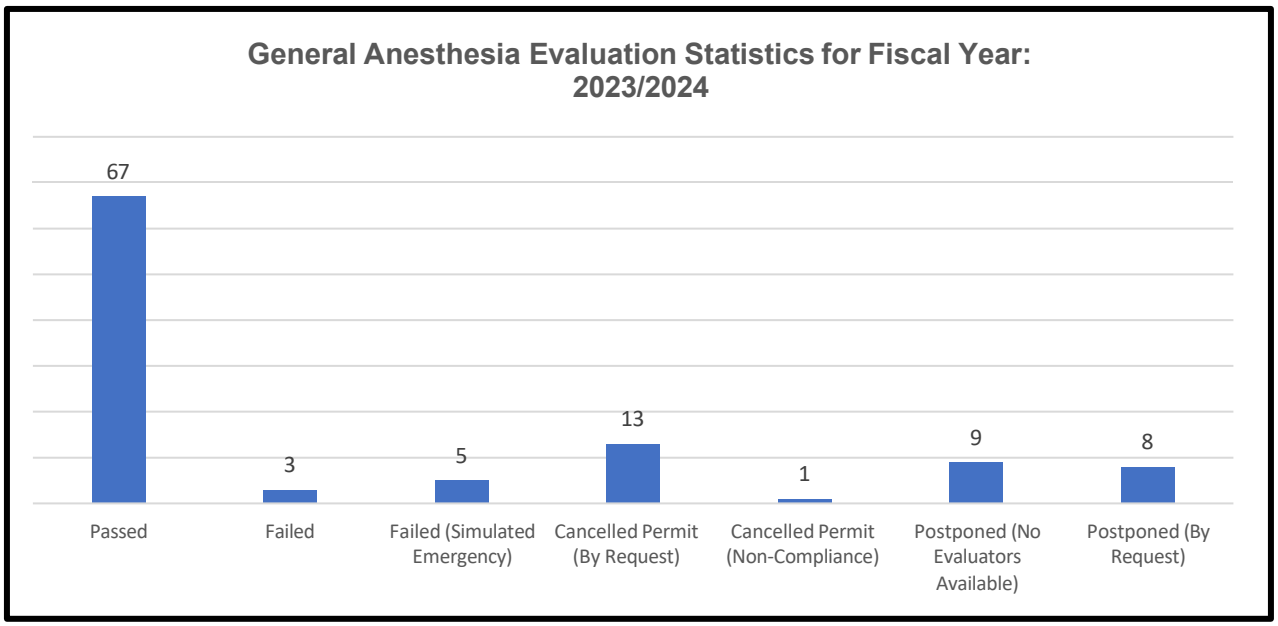
## General Anesthesia Evaluation Statistics for Fiscal Years, 2020–21, 2021–22, 2022–23, 2023–24, and 2024–25

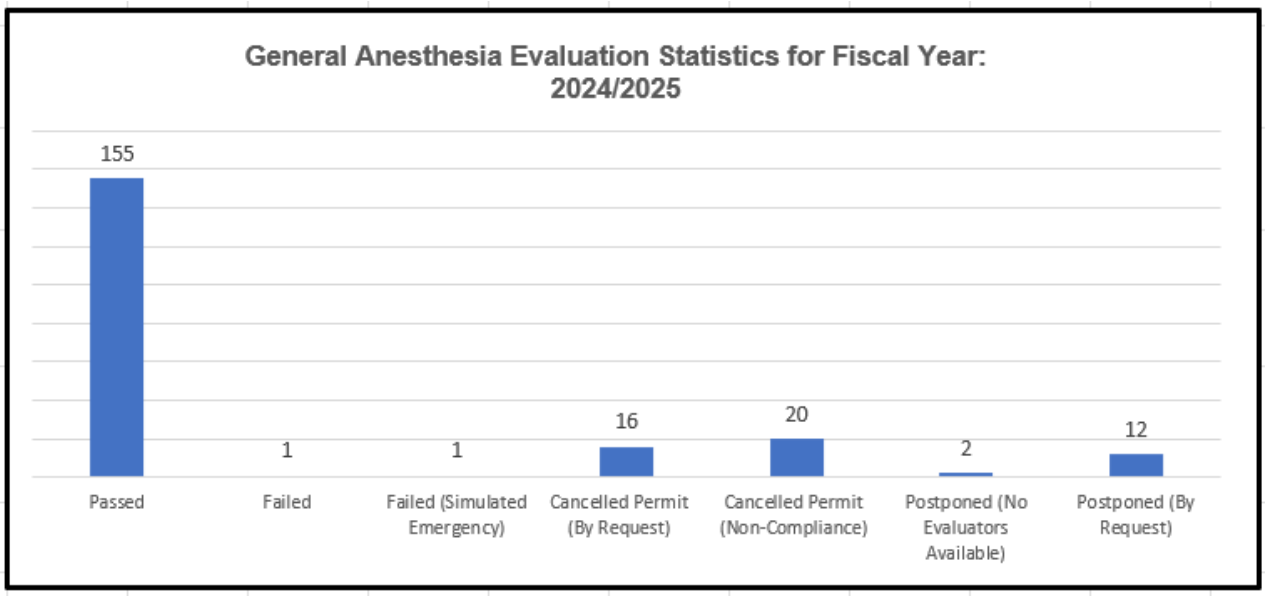
| | **20–21** | **21–22** | **22–23** | **23–24** | **24–25** |
|---|---|---|---|---|---|
| **Passed Evaluation** – Permitholder met all required components of the onsite evaluation. | 147 | 160 | 196 | 202 | 155 |
| **Failed Evaluation** – Permitholder failed due to multiple deficient components that were required for the onsite evaluation. | 2 | 0 | 1 | 0 | 1 |
| **Failed Simulated Emergency** – Permitholder failed one or more simulated emergency scenarios required for the onsite evaluation. | 1 | 2 | 2 | 3 | 1 |
| **Cancelled Permit by Request** – Permitholder no longer wanted permit. | 21 | 12 | 14 | 13 | 16 |
| **Cancelled Permit for Noncompliance** – Permitholder did not complete required onsite evaluation. | 6 | 6 | 11 | 20 | 20 |
| **Postponed (No Evaluators Available)** – Permitholder evaluation was postponed due to no available evaluators. | 57 | 27 | 71 | 16 | 2 |
| **Postponed (By Request)** – Permitholder requested postponement due to scheduling conflict, emergencies, or COVID-related issues. | 66 | 37 | 20 | 18 | 12 |




General Anesthesia Evaluation Statistics for Fiscal Year: 2021/2022
160
0
2
12
6
27
37
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


General Anesthesia Evaluation Statistics for Fiscal Year: 2022/2023
196
1
2
14
11
71
20
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


General Anesthesia Evaluation Statistics for Fiscal Year: 2023/2024
67
3
5
13
1
9
8
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

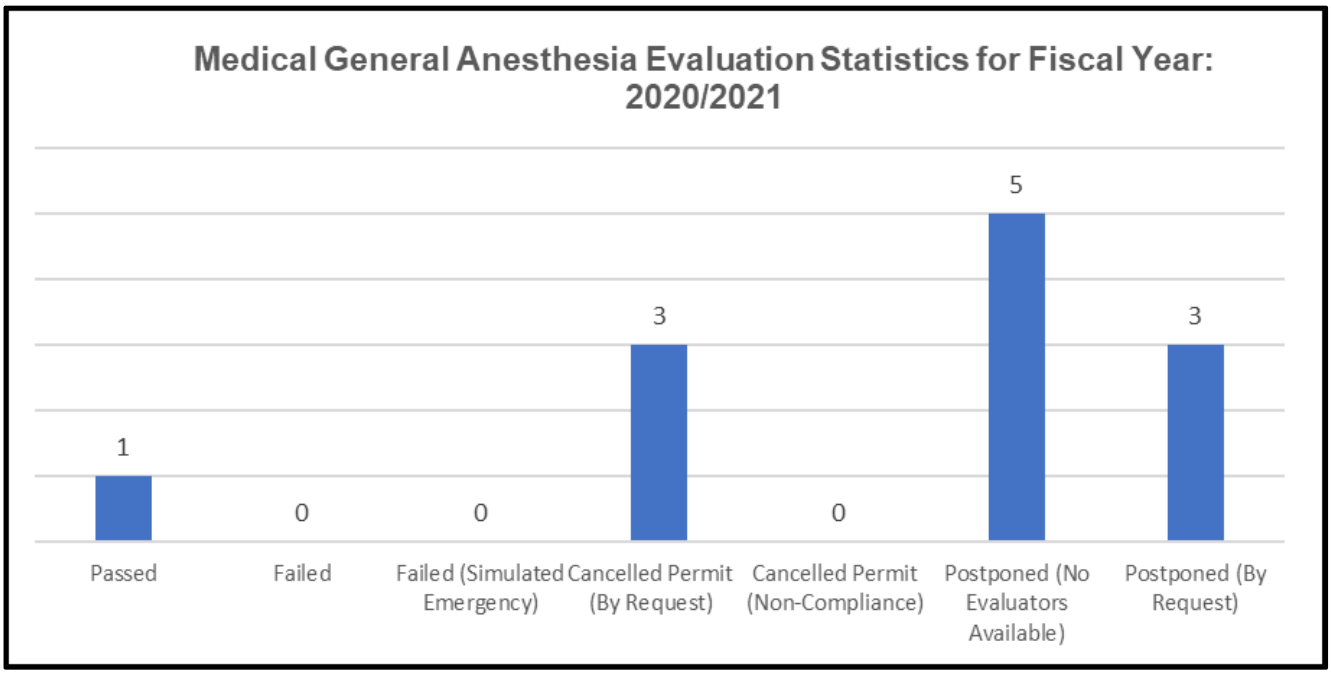

General Anesthesia Evaluation Statistics for Fiscal Year: 2024/2025
155
1
1
16
20
2
12
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

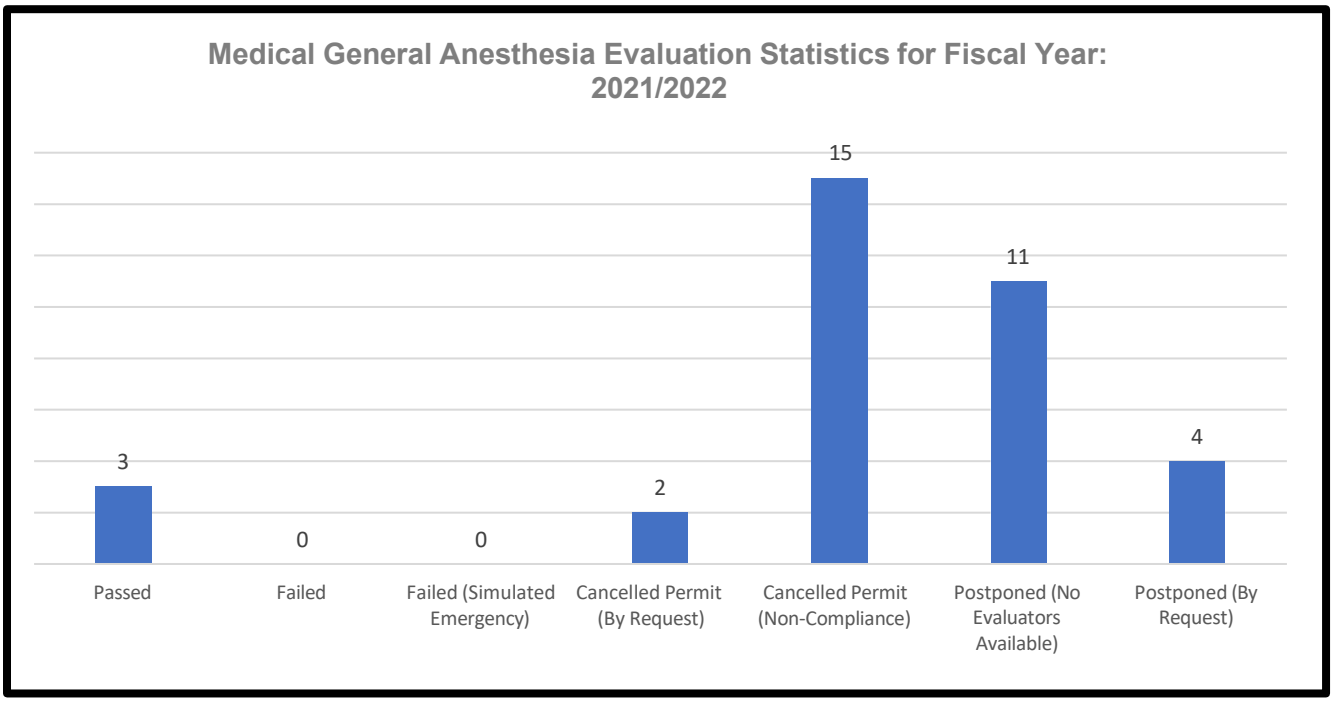
## Medical General Anesthesia Evaluation Statistics for Fiscal Year 2024–25

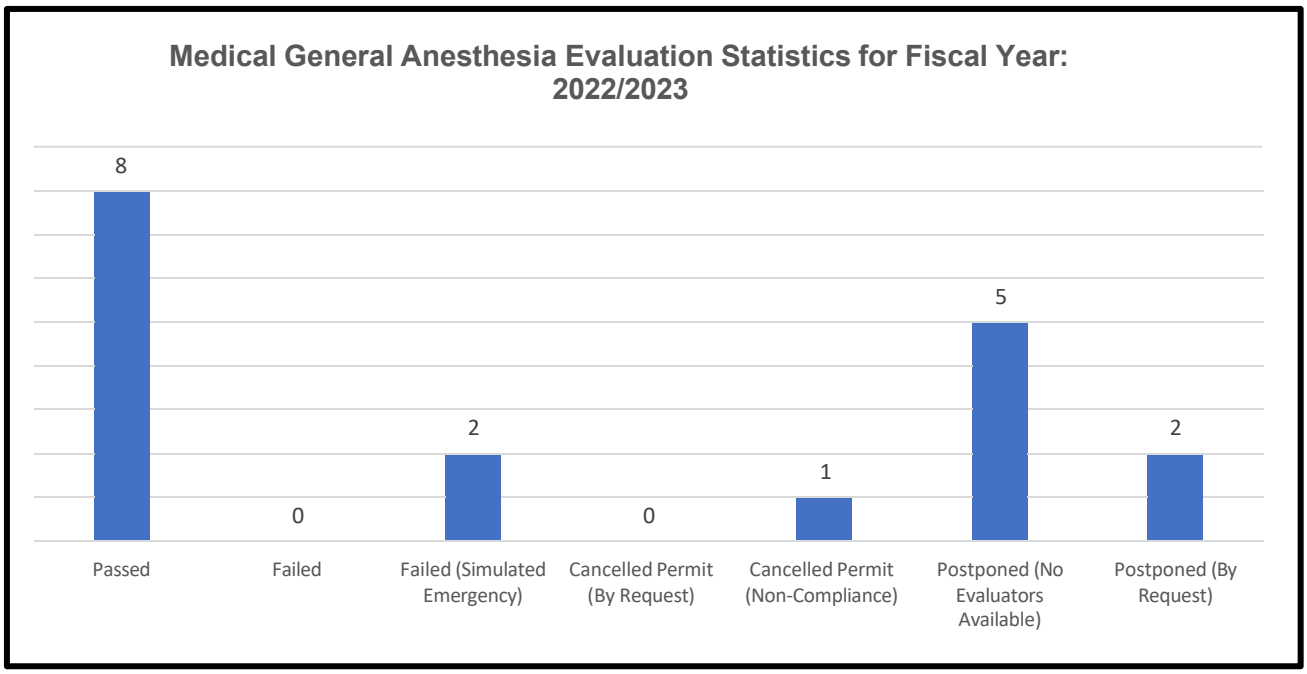
| | Passed Evaluation | Failed Evaluation | Failed Simulated Emergency | Cancelled Permit by Request | Cancelled Permit for Non-Compliance | Postponed (No Evaluators Available) | Postponed (By Request) |
|---|---|---|---|---|---|---|---|
| **Jul 2024** | 1 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Aug 2024** | 2 | 0 | 0 | 0 | 2 | 0 | 0 |
| **Sep 2024** | 2 | 0 | 0 | 0 | 2 | 0 | 0 |
| **Oct 2024** | 1 | 0 | 0 | 1 | 0 | 0 | 0 |
| **Nov 2024** | 0 | 0 | 0 | 2 | 0 | 0 | 0 |
| **Dec 2024** | 0 | 0 | 0 | 3 | 0 | 0 | 0 |
| **Jan 2025** | 0 | 0 | 0 | 2 | 0 | 0 | 0 |
| **Feb 2025** | 0 | 0 | 0 | 0 | 3 | 0 | 0 |
| **Mar 2025** | 0 | 0 | 0 | 3 | 1 | 0 | 0 |
| **Apr 2025** | | | | | | | |
| **May 2025** | | | | | | | |
| **Jun 2025** | | | | | | | |
| **Total** | **6** | **0** | **0** | **12** | **8** | **0** | **1** |

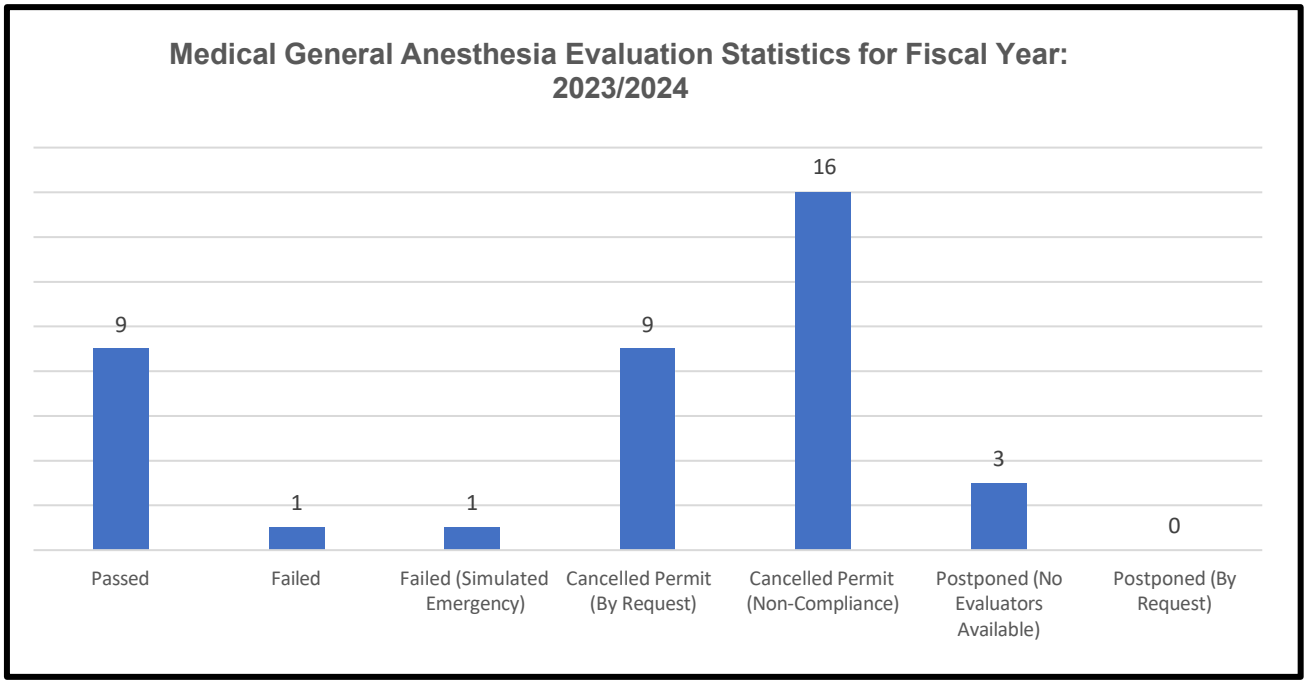
## Medical General Anesthesia Evaluation Statistics for Fiscal Years 2020–21, 2021–22, 2022–23, 2023–24, and 2024–25

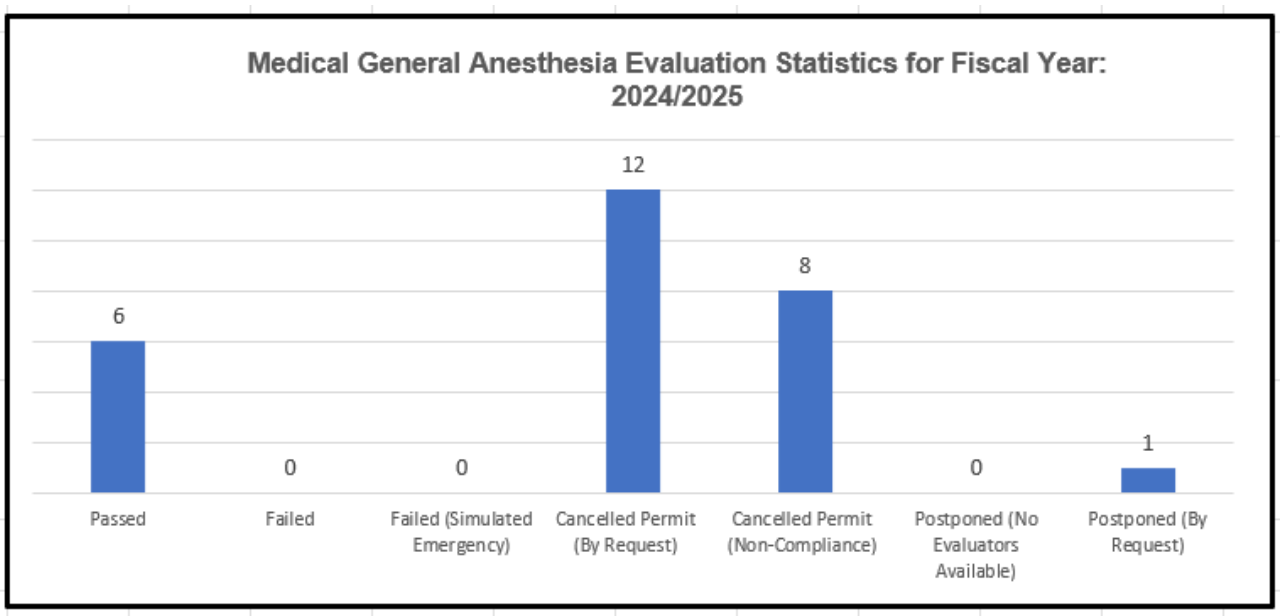
| | 20–21 | 21–22 | 22–23 | 23–24 | 24–25 |
|---|---|---|---|---|---|
| **Passed Evaluation** – Permitholder met all required components of the onsite evaluation. | 1 | 3 | 5 | 9 | 6 |
| **Failed Evaluation** – Permitholder failed due to multiple deficient components that were required for the onsite evaluation. | 0 | 0 | 1 | 1 | 0 |
| **Failed Simulated Emergency** – Permitholder failed one or more simulated emergency scenarios required for the onsite evaluation. | 0 | 0 | 0 | 1 | 0 |
| **Cancelled Permit by Request** – Permitholder no longer wanted permit. | 3 | 2 | 11 | 9 | 12 |
| **Cancelled Permit for Non-Compliance** – Permitholder did not complete required onsite evaluation. | 0 | 15 | 9 | 16 | 8 |
| **Postponed (No Evaluators Available)** – Permitholder evaluation was postponed due to no available evaluators. | 5 | 11 | 3 | 3 | 0 |
| **Postponed (By Request)** – Permitholder requested postponement due to scheduling conflict, emergencies, or COVID-related issues. | 3 | 4 | 1 | 0 | 1 |


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2020/2021
1
0
0
3
0
5
3
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2021/2022
3
0
0
2
15
11
4
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2022/2023
8
0
2
0
1
5
2
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Medical General Anesthesia Evaluation Statistics for Fiscal Year: 2023/2024
9
1
1
9
16
3
0
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

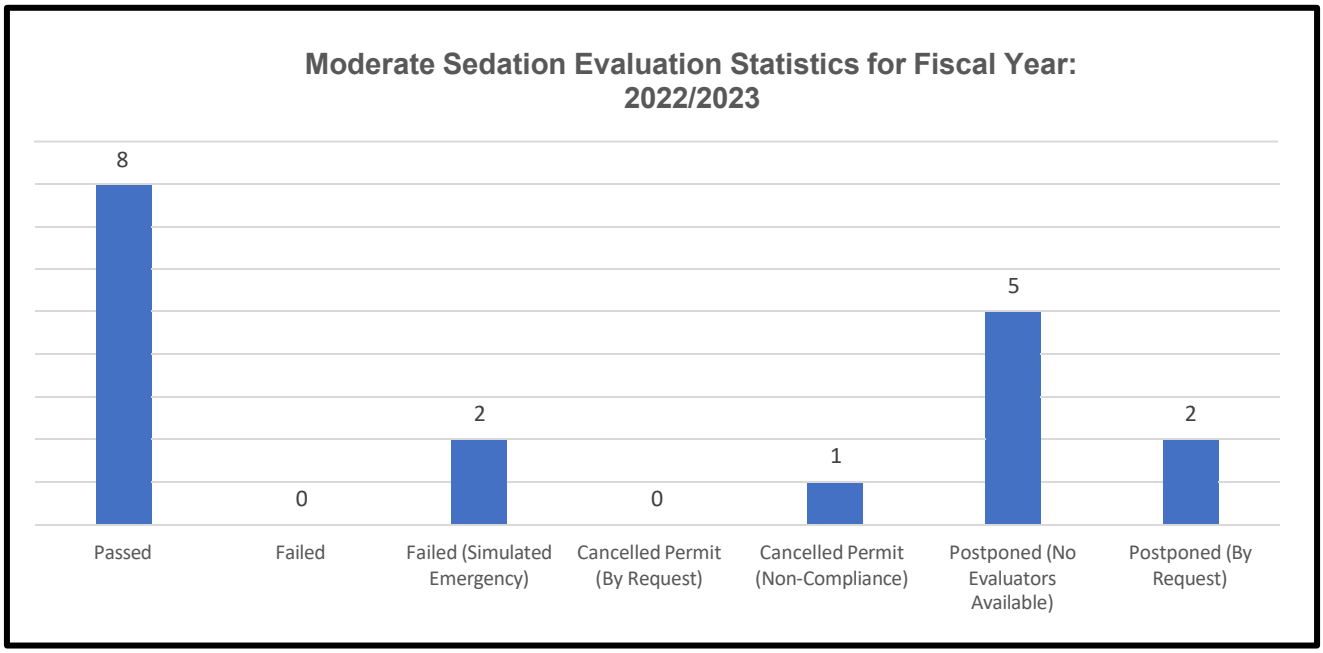


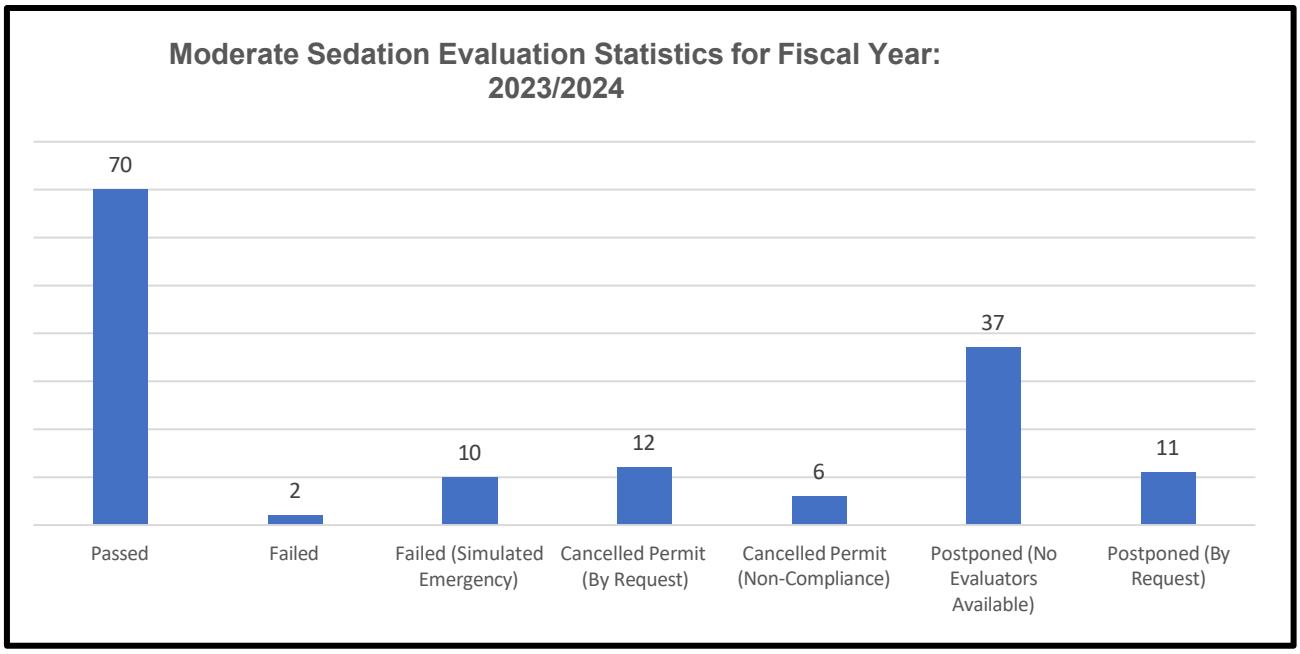

## Moderate Sedation Evaluation Statistics for Fiscal Year 2024–25

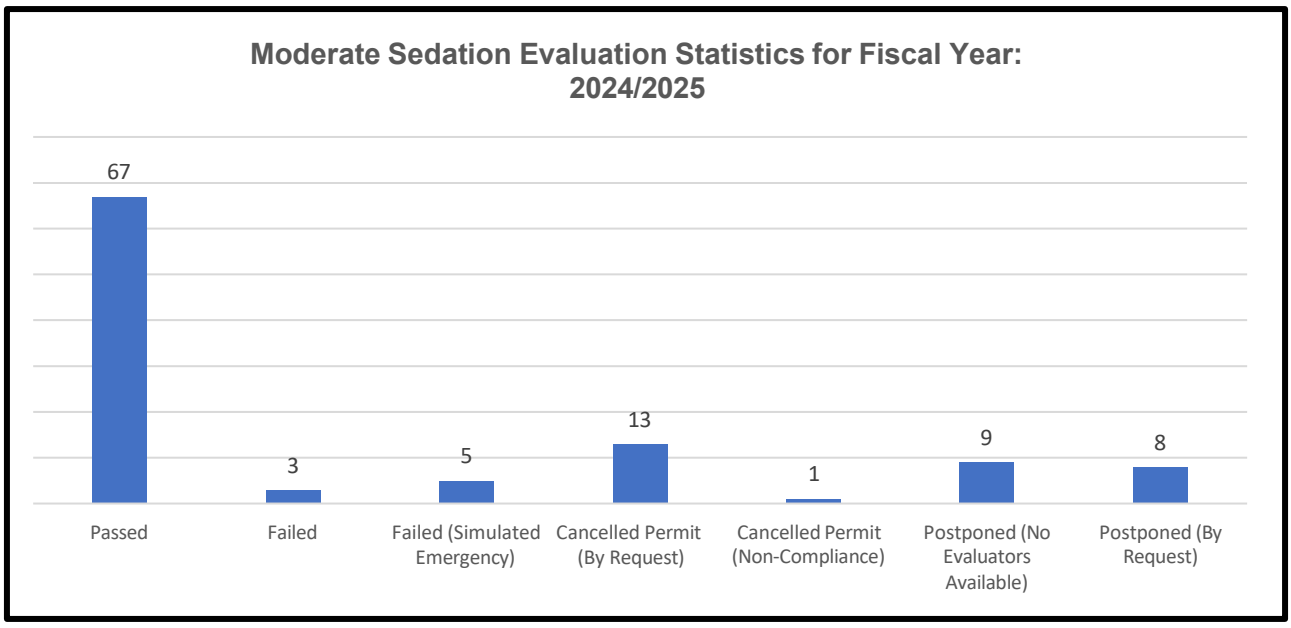
| | Passed Evaluation | Failed Evaluation | Failed Simulated Emergency | Cancelled Permit by Request | Cancelled Permit for Non-compliance | Postponed (No Evaluators Available) | Postponed (By Request) |
|---|---|---|---|---|---|---|---|
| **Jul 2024** | 5 | 0 | 1 | 0 | 0 | 1 | 2 |
| **Aug 2024** | 7 | 0 | 0 | 2 | 0 | 3 | 0 |
| **Sep 2024** | 6 | 1 | 1 | 2 | 0 | 0 | 0 |
| **Oct 2024** | 7 | 0 | 2 | 0 | 0 | 1 | 1 |
| **Nov 2024** | 12 | 0 | 0 | 1 | 0 | 0 | 0 |
| **Dec 2024** | 9 | 0 | 0 | 1 | 0 | 0 | 1 |
| **Jan 2025** | 8 | 0 | 1 | 1 | 0 | 0 | 2 |
| **Feb 2025** | 5 | 1 | 0 | 2 | 1 | 2 | 2 |
| **Mar 2025** | 8 | 1 | 0 | 4 | 0 | 2 | 0 |
| **Apr 2025** | | | | | | | |
| **May 2025** | | | | | | | |
| **Jun 2025** | | | | | | | |
| **Total** | **67** | **3** | **5** | **13** | **1** | **9** | **8** |

## Moderate Sedation Evaluation Statistics for Fiscal Year 2022–23, 2023–24, and 2024–25

| | 22–23 | 23–24 | 24–25 | | |
|---|---|---|---|---|---|
| **Passed Evaluation** – Permitholder met all required components of the onsite evaluation. | 8 | 70 | 67 | | |
| **Failed Evaluation** – Permitholder failed due to multiple deficient components that were required for the onsite evaluation. | 0 | 2 | 3 | | |
| **Failed Simulated Emergency** – Permitholder failed one or more simulated emergency scenarios required for the onsite evaluation. | 2 | 10 | 5 | | |
| **Cancelled Permit by Request** – Permitholder no longer wanted permit. | 0 | 12 | 13 | | |
| **Cancelled Permit for Non-Compliance** – Permitholder did not complete required onsite evaluation. | 1 | 6 | 1 | | |
| **Postponed (No Evaluators Available)** – Permitholder evaluation was postponed due to no available evaluators. | 5 | 37 | 9 | | |
| **Postponed (By Request)** – Permitholder requested postponement due to scheduling conflict, emergencies, or COVID-related issues. | 2 | 11 | 8 | | |




Moderate Sedation Evaluation Statistics for Fiscal Year: 2023/2024
70
2
10
12
6
37
11
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)


Moderate Sedation Evaluation Statistics for Fiscal Year: 2024/2025
67
3
5
13
1
9
8
Passed
Failed
Failed (Simulated Emergency)
Cancelled Permit (By Request)
Cancelled Permit (Non-Compliance)
Postponed (No Evaluators Available)
Postponed (By Request)

**Current Evaluators per Region**

| Region | GA | MGA | MS |
|---|---|---|---|
| Northern California | 118 | 17 | 44 |
| Southern California | 154 | 17 | 42 |

## Action Requested

No action is requested.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 7, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Jessica Olney, Staff Services Manager I<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 14.b.:** Discussion and Possible Action on Recommendation from the Board's Anesthesia Committee Regarding Renewal of Moderate Sedation Permit Following Failure of Onsite Inspection and Evaluation |

On April 4, 2025, the Anesthesia Committee (Committee), comprised of Committee Chair, Alan Felsenfeld, DDS, MA, and Steven Chan, DDS, met to discuss two failed onsite inspections and evaluations of permitholder E.P., who holds a Moderate Sedation (MS) Permit.

## Background

To administer or order the administration of moderate sedation on an outpatient basis for a dental patient, a dentist must possess either a general anesthesia permit or moderate sedation permit issued by the Dental Board of California (Board). (Business and Professions Code (BPC), § 1647.2, subd. (a).) Prior to issuance or renewal of a moderate sedation permit, the Board may, at its discretion, require an onsite inspection and evaluation of the licensee and the facility, equipment, personnel, and procedures utilized by the licensee. (BPC, § 1647.7, subd. (a).) 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. (BPC, § 1647.7, subd. (a); California Code of Regulations (CCR), tit. 16, § 1043.6, subs. (c).) Every dentist issued a moderate sedation permit is required to have an onsite inspection and evaluation at least once in every six years. (BPC, § 1647.7, subd. (a).)

Board inspections and evaluations are conducted by a team of one or more evaluators, who are contracted by the Board as subject matter experts (SMEs). At the conclusion of the evaluations, the SMEs each provide an independent evaluation and recommend a grade using the following pass/fail system pursuant to CCR, title 16, section 1043.6, subsection (b):

a. Passed Evaluation. Permit holder or applicant met all required components of the onsite inspection and evaluation, as provided in CCR, title 16, sections 1043.3 and 1043.4; or

b. Conditional Approval for failing to have appropriate equipment, proper documentation of controlled substances, or proper recordkeeping as provided in CCR, title, section 1043.3, subsection (b); or

c. Failed Simulated Emergency. Permit holder or applicant failed one or more simulated emergency scenario(s) described in CCR, title 16, section 1043.4, subsection (c); or

d. Failed Evaluation. Permit holder or applicant failed due to multiple deficient components required for the on-site inspection and evaluation or failed to comply with the conditions for issuance of a conditional approval, as provided in subsection (b)(2) of this section.

An applicant or permitholder who has failed the inspection and evaluation solely on the basis of a failure to demonstrate knowledge and ability in recognition and treatment of any or all of the simulated emergencies may be reevaluated only on the simulated emergencies provided the reevaluation is within 30 days. (CCR, tit. 16, § 1043.6, subs. (d).)

**Inspection and Evaluation of Permitholder E.P.**

E.P. was issued an MS Permit on October 4, 2022. An onsite inspection and evaluation of E.P. was conducted on December 12, 2024, and the SMEs recommended a failure. A notice of the failed onsite inspection and evaluation was mailed to the permitholder on December 30, 2024. A second onsite inspection and evaluation was conducted on February 4, 2025. The SMEs recommended a failure. A notice of the second failed onsite inspection and evaluation and suspension of the MS permit was mailed to the permitholder on February 24, 2025, citing failure to maintain equipment required by CCR, title 16, section 1043.3, subsection (a), failure to monitor the patient by at least two required methods as specified in CCR, title 16, section 1043.3, subsection (a)(7)(K), failure to maintain anticholinergic drugs as required by CCR, title 16, section 1043.3, subsection (c)(8), and failure to physically demonstrate knowledge of and a method of treatment of the simulated emergencies as required by CCR, title 16, section 1043.4, subsection (c). The notice further advised the permitholder that pursuant to CCR, title 16, section 1043.6, subsection (c), the Board will decide the matter and may grant or deny a permit or request further evaluation of the appellant with a Board member or other Board-appointed representative being present.

## Discussion of Permit Recommendation

Board staff met with the Committee to consider renewal of the MS Permit per CCR, title 16, section 1043.6, subsection (c), which provides:

- If a permitholder or applicant has failed two evaluations, the Board will decide the matter and may grant or deny a permit or request further evaluation of the appellant with a Board member or other Board-appointed representative being present.

- The permitholder or applicant must successfully complete remedial education in a subject within the scope of the onsite inspection and evaluation as determined by the Board prior to being reevaluated if a third onsite inspection and evaluation is granted or prior to the issuance of a new permit.

The Committed recommended to deny renewal of the MS permit due to patient safety concerns during the administration of moderate sedation on an outpatient basis; if permitholder E.P. seeks to apply for a new Moderate Sedation Permit, the permitholder shall submit for prior Board approval and successfully complete, prior to applying for a new Moderate Sedation Permit, remedial education of 24 hours in the administration of moderate sedation including recognition and management of medical emergencies in the administration of moderate sedation to dental patients in an outpatient setting and submit to and pass an onsite inspection and evaluation.

## Action Requested:

If the Board agrees with the Committee's recommendation, the Board is asked to move to approve the Committee recommendation to deny renewal of E.P.'s MS Permit.

Potential Motions:

1. Move to grant renewal of E.P.'s Moderate Sedation Permit.

2. Move to adopt the Committee recommendation to deny renewal of E.P.'s MS Permit; if E.P. seeks to apply for a new Moderate Sedation Permit, E.P. shall submit for prior Board approval and successfully complete, prior to applying for a new Moderate Sedation Permit, remedial education of 24 hours in the administration of moderate sedation including recognition and management of medical emergencies in the administration of moderate sedation to dental patients in an outpatient setting, and submit to and pass an onsite inspection and evaluation.

3. Move to further evaluate permitholder E.P. through a third onsite inspection and evaluation of the permitholder; prior to scheduling the third onsite inspection and evaluation, permitholder E.P. shall submit for prior Board approval and

successfully complete remedial education of 24 hours in the administration of moderate sedation including recognition and management of medical emergencies in the administration of moderate sedation to dental patients in an outpatient setting.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 20.:** Board President's Report on Closed Session Items |

## Background

Dr. Steven Chan, President of the Dental Board of California, will provide a verbal report on closed session items.

## Action Requested

No action requested.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 29, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Brant Nelson, Legislative and Regulatory Specialist<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 21.a.:** Legislative Proposal to Amend Business and Professions Code (BPC) Section 1724(a) to Remove Dentist Licensure Fee for Repealed Portfolio Pathway |

## Background

Prior to January 1, 2025, a dentist license applicant could utilize the portfolio examination under Business and Professions Code (BPC) section 1632, subdivision (c)(1), as a pathway for dentist licensure. As of January 1, 2025, the Dental Board of California's (Board) Sunset bill, Senate Bill (SB) 1453 (Ashby, Chapter 483, Statutes of 2024), amended BPC section 1632 to strike subdivision (c)(1)(A) and (B), thereby eliminating the portfolio examination pathway. Subdivision (c) was restructured so that the clinical and written examinations administered by the Western Regional Examining Board (WREB) and American Board of Dental Examiners, Inc. (ADEX), previously listed under subdivision (c)(2)(A) and (B), were renumbered as subdivision (c)(1) and (2).

## Discussion

Although the portfolio examination pathway for dentist licensure in BPC section 1632, subdivision (c)(1), was repealed and the WREB and ADEX examination requirements were restructured and renumbered as new subdivision (c)(1) and (2), BPC section 1724, which sets forth dentist license fees, still references the $1,500 application fee associated with the portfolio examination pathway in subdivision (a). As that pathway has been repealed and the WREB and ADEX examinations are now referenced as paragraphs (1) and (2) under subdivision (c) of BPC section 1632, BPC section 1724, subdivision (a), should be amended to reflect repeal of the portfolio examination pathway and new examination structure under BPC section 1632. Attached hereto is a legislative proposal to make this amendment.

## Action Requested

Board staff request the Board discuss the information presented in this memo and the attached legislative proposal.

Suggested Motions

Option 1 (submit legislative proposal): Move to approve for submission to the California State Legislature the legislative proposal to amend Business and Professions Code section 1724, subdivision (a), to remove the dentist licensure fee for the repealed portfolio pathway.

Option 2 (submit the legislative proposal as revised during this meeting): Move to approve for submission to the California State Legislature the legislative proposal, as revised during this meeting, to amend Business and Professions Code section 1724, subdivision (a), to remove the dentist licensure fee for the repealed portfolio pathway.

Option 3 (no action): If the Board does not wish to act on the recommendation, no motion is needed.

**Attachment:** Legislative Proposal to Amend Business and Professions Code Section 1724 to Remove Dentist Licensure Fee for the Repealed Portfolio Pathway

## DENTAL BOARD OF CALIFORNIA

## LEGISLATIVE PROPOSAL TO AMEND BUSINESS AND PROFESSIONS CODE SECTION 1724 TO REMOVE DENTIST LICENSURE FEE FOR REPEALED PORTFOLIO PATHWAY

Proposed amendments are indicated in underline for new text and ~~strikethrough~~ for deleted text.

Amend Section 1724 of Article 6 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

**1724.** The amount of charges and fees for dentists licensed pursuant to this chapter shall be established by the board as is necessary for the purpose of carrying out the responsibilities required by this chapter as it relates to dentists, subject to the following limitations:

(a) ~~The fee for an application for licensure qualifying pursuant to paragraph (1) of subdivision (c) of Section 1632 shall not exceed one thousand five hundred dollars ($1,500).~~ The fee for an application for licensure qualifying pursuant to paragraph (1) or (2) of subdivision (c) of Section 1632 shall not exceed one thousand dollars ($1,000).

(b) The fee for an application for licensure qualifying pursuant to Section 1634.1 shall not exceed one thousand dollars ($1,000).

(c) The fee for an application for licensure qualifying pursuant to Section 1635.5 shall not exceed one thousand dollars ($1,000).

(d) The fee for an initial license and for the renewal of a license is five hundred twenty-five dollars ($525). On and after January 1, 2016, the fee for an initial license shall not exceed six hundred fifty dollars ($650), and the fee for the renewal of a license shall not exceed six hundred fifty dollars ($650). On and after January 1, 2018, the fee for an initial license shall not exceed eight hundred dollars ($800), and the fee for the renewal of a license shall not exceed eight hundred dollars ($800).

(e) The fee for an application for a special permit shall not exceed one thousand dollars ($1,000), and the renewal fee for a special permit shall not exceed six hundred dollars ($600).

(f) The delinquency fee shall be 50 percent of the renewal fee for such a license or permit in effect on the date of the renewal of the license or permit.

(g) The penalty for late registration of change of place of practice shall not exceed seventy-five dollars ($75).

(h) The fee for an application for an additional office permit shall not exceed seven hundred fifty dollars ($750), and the fee for the renewal of an additional office permit shall not exceed three hundred seventy-five dollars ($375).

(i) The fee for issuance of a replacement pocket license, replacement wall certificate, or replacement engraved certificate shall not exceed one hundred twenty-five dollars ($125).

(j) The fee for a provider of continuing education shall not exceed five hundred dollars ($500) per year.

(k) The fee for application for a referral service permit and for renewal of that permit shall not exceed twenty-five dollars ($25).

(l) The fee for application for an extramural facility permit and for the renewal of a permit shall not exceed twenty-five dollars ($25).

(m) The fee for an application for an elective facial cosmetic surgery permit shall not exceed four thousand dollars ($4,000), and the fee for the renewal of an elective facial cosmetic surgery permit shall not exceed eight hundred dollars ($800).

(n) The fee for an application for an oral and maxillofacial surgery permit shall not exceed one thousand dollars ($1,000), and the fee for the renewal of an oral and maxillofacial surgery permit shall not exceed one thousand two hundred dollars ($1,200).

(o) The fee for an application for a general anesthesia permit shall not exceed one thousand dollars ($1,000), and the fee for the renewal of a general anesthesia permit shall not exceed six hundred dollars ($600).

(p) The fee for an onsite inspection and evaluation related to a general anesthesia or moderate sedation permit shall not exceed four thousand five hundred dollars ($4,500).

(q) The fee for an application for a moderate sedation permit shall not exceed one thousand dollars ($1,000), and the fee for the renewal of a conscious sedation permit shall not exceed six hundred dollars ($600).

(r) The fee for an application for an oral conscious sedation permit shall not exceed one thousand dollars ($1,000), and the fee for the renewal of an oral conscious sedation permit shall not exceed six hundred dollars ($600).

(s) The fee for an application for a pediatric minimal sedation permit shall not exceed one thousand dollars ($1,000), and the fee for the renewal of a pediatric minimal sedation permit shall not exceed six hundred dollars ($600).

(t) The fee for a certification of licensure shall not exceed one hundred twenty-five dollars ($125).

(u) The fee for an application for the law and ethics examination shall not exceed two hundred fifty dollars ($250).

(v) This section shall become operative on January 1, 2022.

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# MEMORANDUM

| | |
|---|---|
| **DATE** | April 29, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Working Group<br>Jeri Fowler, RDAEF, OA<br>Cara Miyasaki, RDA, RDHEF, MS |
| **SUBJECT** | **Agenda Item 21.b.:** Legislative Proposal to Add BPC Section 1778 Relating to Board Approval of Dental Assistant Educational Programs and Courses |

## Introduction

The Dental Board of California (Board) staff have identified inefficiencies in the regulations for approving, inspecting, and evaluating Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) educational programs and courses. Further, recent trends suggest a decline of licensed dental auxiliaries, which impacts consumer access to dental care. Board staff seek the Dental Assisting Council (Council) review of dental auxiliary education requirements to determine if legislative or regulatory amendments may improve dental auxiliary licensure, education, and/or licensure portability, and Board program/course approval. This memorandum discusses issues regarding continued Board approval of dental assistant educational programs and courses and a potential legislative solution to resolve the issues identified herein.

## Background

At the August 2022 Council meeting, the Council moved to create a two-member working group, consisting of Council Member Pacheco and a second Council Member, who was selected and announced later, to review issues regarding dental assistant certification and education requirements in other states, and review the applicable statutes and regulations regarding Board approval of the RDA and RDAEF programs and courses for potential amendments. (August 25, 2022 Council Meeting Minutes, Agenda Item 7.)

### License Requirements in Other States

At the Council's November 2022 meeting, the Working Group, consisting of Council Members Cara Miyasaki and Joanne Pacheco, provided an update on their research of

these issues. (November 17, 2022 Council Meeting Minutes, Agenda Item 7.) To determine if other states require dental assistant certification and licensure and/or educational requirements, eight questions were developed by the Working Group and sent to all dental boards in the United States inquiring whether the state boards certify or license dental assistants and/or require educational requirements. The Working Group received some responses back from approximately 17 states and was still waiting for more responses. Before the next Council meeting in February 2023, the data would be aggregated, and the report would be presented at that meeting.

CODA Approval of Educational Programs and License Reciprocity

At the November 2022 Council Meeting, Council Member Jeri Fowler noted her research on dental assistant certification and licensure and/or educational requirements in other states and noticed there were a substantial number of other states that required Commission on Dental Accreditation (CODA) approval of educational programs. She believed one of the reasons there are not that many CODA-approved dental assistant programs were due to the high cost to obtain CODA approval. She hoped the Council would work with the Dental Assisting National Board (DANB) to get reciprocity.

Council Member Miyasaki noted there tended to be license reciprocity between states using CODA-approved program education, but having a CODA-approved program was pricey. She raised concern that in California, having all dental assistant educational programs be CODA approved would wipe out many programs, such as ones that are taught in high schools. She stated that as there were many different types of dental assistant programs in California, it would not be possible for all dental assistant programs to be CODA-approved, and there was a nice balance of having CODA-approved programs and ones that were not approved that met the Board requirements for RDA licensure.

Council Member Fowler noted there were possibly 23 states that participate in license reciprocity, and 35 states had expanded function dental assistants. However, in some states, their idea of expanded function was coronal polishing and sealants, and 22 states had restorative functions in their allowable duties.

At the Council's February 2023 meeting, the Working Group presented the results of their national dental board survey and Board staff's additional research of common practices or requirements for dental assisting licensure across the states. (February 9, 2023 Council Meeting Materials, Agenda Item 9.) The Working Group noted that the Dental Practice Act limits how individuals can become qualified for examination and licensure in California and current graduates of California dental assistant programs would not be eligible for DANB Certified Dental Assistant (CDA) certification because they must graduate from a CODA-approved program or meet the work experience pathway requirements. For California to be consistent with DANB and for the applicant to have transportability between other states, the educational program for RDA licensure would need to be a CODA-approved program. If the Board were to accept

CODA-approved educational programs, statutory and regulatory changes would be required, including courses completed as part of the CODA-approved educational program, such as Radiation Safety, Pit and Fissure Sealants, Coronal Polishing, and Infection Control.

Proposed Amendments to Board Approval of Dental Assistant Educational Programs and Courses Regulations

Also at the Council's February 2023 meeting, the Working Group had several observations, including that there are multiple course approvals containing the same content for a course that has already been approved but it is only submitted due to the course being taught at a different clinical site. This multiplies the amount of work needed for the approval process and the amount of work by Board staff.

The Working Group proposed that once a course has been Board approved, it would be approved regardless of the clinical site the course is or will be taught at, and this would allow the courses, such as infection control, coronal polishing, and pit and fissure sealants, to be taught at the actual clinical site where the student or candidate was working. (February 9, 2023 Council Meeting Minutes, Agenda Item 9.) This would help ensure the student is familiar with the equipment, materials, and supplies that are available at their office. Equipment materials and supplies could be supplemented by the provider if anything was missing or needed. The Working Group proposed changing the language for a provider of a dental assistant continuing education course requiring lab, clinical, free clinical, and/or clerical requirements to omit the need to apply for a course that was already approved simply because the course was taught at a different location. This would minimize the number of applications received by Board staff. Since such changes would require regulatory amendments, the Working Group could bring forward a regulatory proposal to make those changes.

The Council requested an estimate on the number of programs applying for Board approval of multiple locations and inquired on the impact of submitting multiple applications for multiple locations. The Council also was made aware of the California Dental Association's (CDA) legislative proposal (Assembly Bill (AB) 481 (Wendy Carrillo, 2023)) to create a pathway, including DANB certification, for dental assistants from states outside of California to apply for licensure. CDA representatives noted that if AB 481 went into effect, it likely would impact the Board's RDA and RDAEF educational program and course approval regulations. Although AB 481 died in the Assembly Appropriations Committee, the most of the provisions of that bill were made effective in the Board's Sunset bill, Senate bill (SB) 1453 (Ashby, Chapter 483, Statutes of 2024).

Data on Applications for Board Approval of Dental Assistant Educational Programs/Courses

At the May 2023 Council meeting, Board staff presented data on dental assistant educational programs/courses application approvals and site visits and noted that due to the COVID-19 pandemic, there were no site visits conducted in 2022. (May 18, 2023

Council Meeting Materials, Agenda Item 7.) At that time, Board staff was preparing to streamline internal processes and preparing to conduct site visits. In addition, Council Members Pacheco and Miyasaki volunteered to research on what other accrediting bodies require to perform program site visits. (May 18, 2023 Council Meeting Minutes, Agenda Item 7.) Board staff continued to provide updated data on dental assistant educational programs/courses application approvals at the next several meetings.

At the November 2024 Council meeting, Board staff provided an overview of educational program and course re-evaluations and noted that Board staff began the preliminary stages of the re-evaluation process by sending a request for information to 173 approved Pit & Fissure course providers who obtained Board approval prior to 2023. (November 7, 2024 Council Meeting Materials, Agenda Item 7.a.)

Statutory Issues

In addition, following passage of the Board's Sunset bill, SB 1453, Board staff began reviewing the new infection control course requirements for Board approval in Business and Professions Code (BPC) section 1755 and identified several clarification and implementation problems, which were presented to the Board at its November 2024 meeting. (November 7-8, 2024 Meeting Materials, Agenda Item 27.e.) The Board referred the issues to the Council for review and recommendation by a Council Working Group. (November 7-8, 2024 Board Meeting Minutes, Agenda Item 27.e.)

In December 2024, the Infection Control Working Group, Council Members Pacheco and Miyasaki, who were simultaneously working on amendments to California Code of Regulations (CCR), title 16, 1005, Minimum Standards for Infection Control, began their review of the new statutory infection control course for solutions to the infection control statute and additional radiation safety statute issues identified by Board staff. The Infection Control Working Group, down to one member, Council Member Miyasaki following the terming out of Council Member Pacheco on January 1, 2025, presented the Working Group legislative proposal to amend BPC sections 1725, 1753.52, 1754.5, and 1755 at the Council's February 2025 meeting. (February 6, 2025 Meeting Materials and Supplement, Agenda Item 9.b.) The Board approved the legislative proposal at its February 6-7, 2025 meeting.

## Update

During the Working Group review of the infection control and radiation safety course statutes, concern was raised by Board staff and Board Counsel regarding the Board's ability to continue reviewing and approving dental assistant educational programs and courses. Board Counsel proposed changing the dental assistant educational program and course review and approval process to an accreditation process through a state or national accrediting body that regularly reviews educational programs. As the Board is a licensing and oversight body, the Board struggles to perform regular reviews of education requirements and advancements. Indeed, the Board's last substantive review

of the educational program and course requirements regulations, CCR, title 16, sections 1070 through 1071, was completed in July 2011, with the revised regulations going into effect on November 11, 2011.

Notably, in the 15 years since the last revisions to these regulation, significant advancements have been made in the electronic delivery of education. Further, the Board has struggled to review initial and renewal applications and perform site visits to ensure the educational program or course meets the minimum regulatory requirements. As such, it would appear important to relieve the Board and its staff from performing educational program and course applications review and site visits, but the task must be placed with an appropriate oversight entity, such as an existing entity that accredits educational programs or courses. These issues were presented to Council Member Miyasaki, who raised concerns with the ability of dental assisting course providers to obtain or afford accreditation and the resulting decrease in access by dental assistants and license and permit applicants to access these courses.

Data on Re-Evaluations of Board-Approved Dental Assistant Educational Programs and Courses

As shown under Agenda Item 7 for this meeting, during Fiscal Year 2024-2025, the Board has been conducting re-evaluations of dental assistant educational programs and courses. The re-evaluations have identified major compliance issues justifying withdrawal of Board approval of the programs and courses. The most common issues are as follows.

1. Board-approved RDA Programs Compliance Issues. During re-evaluations of RDA educational programs, Board staff have identified the following compliance issues:
   a. Failure to provide minimum required number of 265 hours of clinical instruction in extramural dental facilities per CCR, title 16, section 1070.2, subsection (d)(5).
   b. Failure of program director to maintain accurate and complete individual student records per CCR, title 16, section 1070, subsection (b)(1).
   c. For modular or open-entry programs, lack of documentation that students receive basic instruction in infection control and basic chairside skills prior to other program content and activities involving patients per CCR, title 16, section 1070.2, subsection (d)(8)(A).

2. Issues with Board-approved Stand-alone Courses. During re-evaluations of stand-alone dental assistant courses, Board staff have identified the following compliance issues:
   a. Failure to identify the location where students are receiving clinical instruction to ensure compliance with CCR, title 16, sections 1070, subsection (f), and 1070.3, subsection (c)(2)(C).

b. Failure to demonstrate that clinical instruction is planned and supervised per CCR, title 16, section 1070, subsection (j).
c. Failure to provide written contracts of affiliation with each extramural dental facility used for clinical instruction per CCR, title 16, section 1070, subsection (j)(4).
d. Lack of documentation of compliance with required instructor-student ratios per CCR, title 16, section 1070.1.
e. No data provided on number of students enrolled or simultaneously engaged in instruction to ensure compliance with CCR, title 16, sections 1070, subsection (f)(1), 1070.1, and as applicable, sections 1014.1, subsections (f) and (g), 1070.3, subsection (f), 1070.4, subsection (f), and 1070.5, subsection (f).
f. Infection control protocols required in CCR, title 16, section 1070, subsection (g), that are provided to students and faculty are incomplete and/or missing protocols required by CCR, title 16, section 1005, subsection (b).

3. Issue with both RDA Programs and stand-alone courses:
   a. Lack of documentation that students are provided with specific performance objectives and standards of performance for laboratory and clinical experiences per CCR, title 16, section 1070, subsection (i), and as applicable, sections 1014.1, subsection (e), 1070.3, subsection (g), 1070.4, subsection (g), and 1070.5, subsection (g). Some performance evaluation forms indicate merely “done” or “not done” rather than provide evaluations with specific standards.

Notably, as discussed under Agenda Item 7, between Fiscal Years 2021-2022 and 2024-2025, the Board only conducted six educational program site visits, four of which were performed in the last Fiscal Year. Yet, there are currently 92 Board approved educational programs that must be re-evaluated every seven years (CCR, tit. 16, § 1070, subs. (a)(2)). Further, out of 43 pit and fissure course standard re-evaluations conducted in the past year, only three courses have been issued continued Board approval. Six of those courses were reported closed, 10 courses had Board approval withdrawn, and 19 course re-evaluation course applications are pending.

Board Staffing and Costs

With so many dental assistant educational programs and stand-alone courses that must be monitored and re-evaluated, and Board staff’s inability to re-evaluate all the programs and courses on a regular basis, it appears Board oversight of dental assistant education is insufficient and inadequate, raising significant concerns of appropriate student education and licensee practice on patients.

Board staff also note the Assembly Appropriations Committee analysis of AB 873 (Alanis, 2025) indicated the $300 application fees proposed to be charged for Board review of the new interim therapeutic restoration and radiographic decisionmaking

(BPC, § 1753.52), radiation safety (BPC, § 1754.5), and infection control (BPC, § 1755) courses appears insufficient to cover staff costs. The proposed $300 application fee is based on the existing course application fees set in regulation (CCR, tit. 16, § 1022), which has not been updated since those fees were initially set, effective on August 24, 2017. Accordingly, the Board likely will need to perform a desk audit to determine whether the educational program and course application fees should be increased to cover staff costs.

Research on Alternatives to Board Approval

To resolve the issues raised above, Board staff researched whether Board approval of dental assistant educational programs and courses could be moved to education accrediting or approval entities. Board staff reached out to various education oversight entities to understand their accreditation/approval process and applicability to dental assistant educational programs and courses.

Specifically, Board staff inquired whether each entity accredits or approves programs or courses for dental assisting, and if so, whether the entity used the Board's regulations to determine dental assistant program compliance for accreditation. Board staff also requested information on average, how long accreditation or approval takes from program submission of the accreditation application to approval. Board staff received the following responses:

1. American Dental Association Commission on Dental Accreditation (CODA), Allied Dental Education Programs:

    - CODA accredits programs and courses for dental assisting.
      CODA does not use Board regulations to determine dental assistant education program compliance. CODA accredits dental assistant education programs utilizing the Commission's Accreditation Standards for Dental Assisting Education Programs (available online at https://coda.ada.org/standards), which are national in scope and represent the minimum requirements for accreditation; it is expected that institutions that voluntarily seek CODA accreditation will recognize the ethical obligation of complying with the spirit as well as the letter of these standards.

    - CODA accreditation process: Programs seeking accreditation must submit an application that addresses the Criteria for Consideration of an Application for Accreditation and the CODA Standards. Provided that the application is in order, the first opportunity for the Commission to consider the program is generally 12 to 18 months following the Commission's formal acknowledgment of receipt of the application, initiation of the review process, and following an initial site visit.

2. Bureau for Private Postsecondary Education (BPPE):
   - BPPE does not accredit dental assistant educational programs. BPPE grants approval to both unaccredited and accredited dental assistant programs to operate in California. BPPE noted that "accredited" means accreditation by an accrediting body recognized by the U.S. Department of Education (e.g., CODA). Dental assistant courses are exempt from BPPE approval if they do not offer a degree and charge students less than $2,500 in total fees per Education Code section 94874, subdivision (f).

   - For dental assistant programs that are accredited, BPPE verifies accreditation details, such as the institution's name, locations, ownership structure, and approved programs (CCR, tit. 5, § 71390). For unaccredited dental assistant programs that do not lead to licensure and are not approved by the Board, BPPE relies on its own regulations and minimum operating standards when granting approval. (See, CCR, tit. 5, §§71110-71340.) Among other things, BPPE reviews:
     - The program's primary administrative location and the physical address of each branch or satellite.
     - The type of business organization of the program or school.
     - The ownership structure of the program or school.
     - Student enrollment, fee payment, and financial aid policies, practices, and disclosures.
     - Advertising materials, public statements about the program, and a copy of the institution's catalog.
     - Degrees and educational programs offered.
     - Admissions requirements.
     - Financial resources and statements.
     - Faculty number and qualifications.
     - Facilities and equipment, including leases and rental agreements.
     - Copy of diploma or certificate of completion.

   - In approving unaccredited RDA programs that lead to licensure, BPPE relies on Board approval to ensure programmatic compliance. BPPE will not approve an unaccredited RDA program to operate unless it has been approved by the Board per CCR, title 5, section 71220, subsection (f). The Board sets specific requirements for RDA educational programs under BPC section 1614 and CCR, title 16, sections 1070, 1070.1, and 1070.2, including:
     - A minimum of 800 hours of instruction.
     - Adequate provision for the supervision and operation of the program.
     - Faculty qualifications and instructor-student ratios.
     - Facilities and equipment requirements.
     - Required areas of instruction in dental assistant and RDA duties, as well as specific duties related to infection control, radiation safety, coronal polishing, and pit and fissure sealants.

- BPPE's approval process for an unaccredited DA program typically takes three to six months for a complete application, but delays can extend this to six to 12 months if issues arise. However, exact timelines vary on a case-by-case basis. Institutions must submit a comprehensive application, which can range from 200 to 500 pages, including a recent audited financial statement, a $5,000 non-refundable fee, and documentation of program approvals (e.g., Board approval for RDA programs).

3. Western Association of Schools and Colleges, Senior College and University Commission (WSCUC):

   - Institutional accreditation involves a comprehensive review of all institutional functions. Institutional accrediting organizations, like WSCUC, accredit the institution rather than individual programs, although new programs are reviewed through the substantive change process.

   - Program review is a required element in the WSCUC accreditation process. While accreditation attests to the institution's capacity and effectiveness, it is not possible for WSCUC to review and evaluate every degree program in the course of an accreditation review. Instead, WSCUC expects institutions to have processes that assure program currency, quality and effectiveness. When implemented effectively and followed up deliberately, program review is a powerful means of engaging faculty in evaluating and improving programs in the organization.

   - The WSCUC internal review process for an academic program or institution typically takes one to 36 months from the start of self-study to final accreditation decision. Timelines vary based on institutional complexity and application completeness.

4. Accrediting Commission for Community and Junior Colleges (ACCJC)
   - ACCJC is an institutional accreditor recognized by the US Department of Education and Council for Higher Education Accreditation (CHEA). The accreditation process ensures that an institution is meeting its mission and delivering high-quality academic and learning support programs. The accreditation processes for the institutions are inclusive of the academic programs offered by the institution, regardless of location or modality.

   - ACCJC does not use the Board's regulations as it does not have separate program specific accreditation standards. ACCJC uses Standards of Accreditation and the federal requirements and recognition criteria set forth by the Department of Education under 34 CFR Part 602.

- Institutions must seek ACCJC approval when they make substantive changes to their academic offerings, such as the addition of a new program or a change in modality to deliver the program. In those instances, the institution would complete a substantive change application and provide information to demonstrate that the new program (or other changes) is in alignment with the institution's mission, is appropriately resourced, demonstrates expected rigor and academic quality, and supports attainment of equitable student outcomes. ACCJC reviews and makes decisions on substantive changes typically within a month of receiving an application (the committee meets on a schedule four to five times each semester).

## Working Group Discussion

In March 2025, Council Member Fowler joined Council Member Miyasaki on the Working Group. On March 28, 2025, Council Member Fowler, met with Board staff and Board Counsel to discuss the ability of the Board's continued review and approval of dental assistant educational programs and courses and the legislative proposal to add BPC section 1778 to move oversight of dental assistant education to accrediting bodies. On April 3, 2025, Council Members Fowler and Miyasaki met to discuss the legislative proposal and the submission of it as an agenda item for the May 14, 2025 Council meeting.

## Legislative Proposal to Add BPC Section 1788

Every course required to be completed for dental assisting practice must be Board approved as established in the relevant statutes. Further, various pathways to dental assisting licensure require the dental assistant education to be completed through a Board-approved educational program.

To address the inability of the Board to continue reviewing and visiting dental assistant educational programs and courses, Board staff and Board Counsel presented a proposal to the Working Group for their consideration. The Working Group reiterated the prior concerns with the high cost of obtaining accreditation and resulting decline of dental assistant and license and permit applicant access to such courses. As such, the Working Group does not recommend requiring the stand-alone dental assisting courses to be accredited.

However, the Working Group noted that dental assistant educational programs likely are both accredited and Board approved, resulting in duplicate applications and fees to the accrediting body and the Board. As such, Board staff drafted a legislative proposal to change Board approval of educational programs to accept accreditation from specified entities and reduce barriers to the educational programs in offering courses to dental

assisting students. Further, allowing DANB certificates to satisfy course requirements would increase license reciprocity and reduce dental assisting license barriers.

Board staff propose to add BPC section 1778 that would define, for purposes of the dental assisting statutes, the term “board approved” to mean accreditation by at least one of the following:

(1) CODA;
(2) BPPE;
(3) Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges; or
(4) Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges.

In addition, Board staff propose to add statutory provisions to authorize successful completion of DANB examinations in radiation safety, infection control, pit and fissure sealants, and coronal polishing to satisfy completion of a Board-approved course in those areas. To ensure that license and permit applicants would not immediately have to retake courses offered through educational programs that, going forward, would have to be accredited by one of the above-listed entities, the legislative proposal would provide that Board-approved educational programs and courses successfully completed prior to January 1, 2029 would qualify as completion of the required course, subject to the statutory requirements for completion of the program or course (i.e., BPC, §§ 1750.2, 1750.4, and 1752.1 contain timeframes within which the courses must be completed prior to application). In addition, to assure implementation of the new statute, the legislative proposal would include a delayed effective date of January 1, 2029.

Board staff note that the accrediting bodies may use the dental assistant course requirements set forth in the Board’s regulations, so the regulations are not proposed to be repealed.

## Action Requested

The Working Group asked the Council to discuss the legislative proposal, including the strengths and weaknesses, and consider stakeholder input and any viable alternatives to resolve the issues raised herein. If the Council determined the legislative proposal would resolve the concerns presented, the Council may wish to recommend to the Board for submission to the California State Legislature the legislative proposal to add BPC section 1778 relating to Board approval of dental assistant educational programs and courses. Board staff are asking the Board to discuss the Council recommendations.

**Attachment**: Legislative Proposal to Add Business and Professions Code Section 1778 Relating to Board Approval of Dental Assistant Educational Programs and Courses

## DENTAL BOARD OF CALIFORNIA

## LEGISLATIVE PROPOSAL TO ADD BUSINESS AND PROFESSIONS CODE SECTION 1778 RELATING TO BOARD APPROVAL OF DENTAL ASSISTANT EDUCATIONAL PROGRAMS AND COURSES

Proposed amendments are indicated in underline for new text and ~~strikethrough~~ for deleted text.

Add Section 1778 to Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

**1778.** Beginning on January 1, 2029, for purposes of this Article:

(a) An educational program that is board approved shall mean a program offered by a dental assisting educational program that is accredited by at least one of the following:

(1) American Dental Association Commission on Dental Accreditation (CODA).

(2) Bureau for Private Postsecondary Education.

(3) Accrediting Commission for Senior Colleges and Universities, Western Association of Schools and Colleges.

(4) Accrediting Commission for Community and Junior Colleges, Western Association of Schools and Colleges.

(b) Successful completion of a radiation health and safety examination administered by the Dental Assisting National Board (DANB) shall qualify as completion of a board-approved course in radiation safety.

(c) Successful completion of an infection control examination administered by the DANB shall qualify as completion of a board-approved course in infection control.

(d) Successful completion of a general chairside assisting examination administered by the DANB shall qualify as completion of board-approved courses in pit and fissure sealants and coronal polishing.

(e) Board-approved educational programs and courses successfully completed prior to January 1, 2029, shall qualify as completion of board-approved educational programs and courses for purposes of applying for a dental assisting license or permit, subject to the statutory requirements for completion of such program or course prior to receipt by the Board of the dental assisting license or permit application.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

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| **DATE** | April 28, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Dental Board of California |
| **SUBJECT** | **Agenda Item 21.c.:** Legislative Proposal to Amend BPC, Division 2, Chapter 4, Article 7 Title Regarding Dental Auxiliaries |

This item is being tabled until the August 2025 Dental Assisting Council and Board meetings.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
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DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

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| **DATE** | April 29, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Tina Vallery, Division Chief<br>License and Program Compliance and Dental Assisting<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 21.d.:** Legislative Proposal to Amend BPC Sections 1753 and 1753.5 Regarding Authorized Duties and Procedures of Registered Dental Assistants in Extended Functions |

This memorandum discusses concerns and a legislative proposal to resolve those concerns regarding the allowable duties of registered dental assistants in extended functions (RDAEFs) licensed on or after January 1, 2010 (Business and Professions Code (BPC), § 1753.5), and the licensing requirements for RDAEFs who were licensed prior to January 1, 2010 (BPC, § 1753).

## Background

Assembly Bill (AB) 2637 (Eng, Chapter 499, Statutes of 2008), among other things, repealed, revised, and recast RDAEF license education and examination requirements. Under that bill, RDAEFs licensed on or after January 1, 2010, were authorized to perform the following duties (BPC, § 1753.5, subd. (b)):

(1) Conduct preliminary evaluation of the patient's oral health, including, but not limited to, charting, intraoral and extra-oral evaluation of soft tissue, classifying occlusion, and myofunctional evaluation.
(2) Perform oral health assessments in school-based, community health project settings under the direction of a dentist, registered dental hygienist, or registered dental hygienist in alternative practice.
(3) Cord retraction of gingiva for impression procedures.
(4) Size and fit endodontic master points and accessory points.
(5) Cement endodontic master points and accessory points.
(6) Take final impressions for permanent indirect restorations.
(7) Take final impressions for tooth-borne removable prosthesis.
(8) Polish and contour existing amalgam restorations.
(9) Place, contour, finish, and adjust all direct restorations.
(10) Adjust and cement permanent indirect restorations.
(11) Other procedures authorized by regulations adopted by the board.

However, RDAEFs licensed prior to January 1, 2010, were limited to performing only registered dental assistant (RDA) duties and specified RDAEF duties, until the licensee completed a Board-approved course in, and examination of the following additional procedures specified in BPC section 1753.5, subdivision (b), paragraphs (1), (2), (5), and (7) through (11):

> (1) Conduct preliminary evaluation of the patient's oral health, including, but not limited to, charting, intraoral and extra-oral evaluation of soft tissue, classifying occlusion, and myofunctional evaluation.
> (2) Perform oral health assessments in school-based, community health project settings under the direction of a dentist, registered dental hygienist, or registered dental hygienist in alternative practice.
> (5) Cement endodontic master points and accessory points.
> (7) Take final impressions for tooth-borne removable prosthesis.
> (8) Polish and contour existing amalgam restorations.
> (9) Place, contour, finish, and adjust all direct restorations.
> (10) Adjust and cement permanent indirect restorations.
> (11) Other procedures authorized by regulations adopted by the board. (BPC, §§ 1753, 1753.4.)

As of January 1, 2022, SB 607 (Min, Chapter 367, Statutes of 2021) eliminated the clinical and practical examination requirement for RDAEFs and required those who were licensed on or after January 1, 2010, to take and pass a written examination. Those licensed prior to January 1, 2010, who completed a board-approved educational course in the additional procedures specified in paragraphs (1), (2), (5), (7) to (11) of Section 1753.5 were not required to take an examination.

**Discussion**

As of January 1, 2025, SB 1453 (Ashby, Chapter 483, Statutes of 2024) further revised the duties that can be performed by RDAEFs under BPC section 1753.5. Two of the major changes, were the removal of “polish and contour existing amalgam restorations” (prior RDAEF duty under BPC, §1753.5, subd. (b), para. (8)), and the addition of “perform post, core, and build-up procedures in conjunction with direct and indirect restorations” (new subd. (b), para. (6)). BPC section 1753.5, subdivision (b), now states:

> (b) A registered dental assistant in extended functions licensed on or after January 1, 2010, is authorized to perform the following additional procedures under direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist:
>
> > (1) Perform oral health assessments, including intraoral and extraoral soft tissue evaluations to identify oral lesions, classifying occlusion, performing

myofunctional evaluations, and oral cancer screenings as authorized by the supervising dentist.
(2) Perform oral health assessments in school-based, community health project settings under the direction of a dentist, registered dental hygienist, or registered dental hygienist in alternative practice.
(3) Gingival retraction for impression and restorative procedures.
(4) Size and fit endodontic master points and accessory points.
(5) Cement endodontic master points and accessory points.
(6) Perform post, core, and build-up procedures in conjunction with direct and indirect restorations.
(7) Take final impression for permanent indirect restorations.
(8) Take final impressions for tooth-borne removeable prosthesis.
(9) Place, contour, finish, and adjust all direct restorations.
(10) Adjust and adhere all permanent indirect restorations.
(11) Other procedures authorized by regulations adopted by the board.

Board staff believe "polish and contour existing amalgam restorations" under prior BPC section 1753.5, subdivision (b)(8), may have been erroneously omitted in the amendment process of SB 1453. Board staff note this is a specialized duty that requires specific training. As such, Board staff believe the RDAEF duty to "polish and contour existing amalgam restorations" should be reinserted on the list of allowable duties for RDAEFs licensed on and after January 1, 2010. Attachment 1 hereto is a legislative proposal to amend BPC section 1753.5 to add "polish and contour existing amalgam restorations" back into this section.

In addition, it appears the list of duties set forth in BPC section 1753 that may only be performed by RDAEFs licensed prior to January 1, 2010, after completion of a Board-approved course in those duties, was not updated to reflect the new RDAEF duties added and renumbered in the amendments to BPC section 1753.5 made by SB 1453. As such, Board staff recommend BPC section 1753, subdivision (a)(3)(B), be amended to require an RDAEF licensee licensed prior to January 1, 2010, to successfully complete a Board-approved course in the following updated RDAEF duties listed under BPC section 1753.5, subdivision (b), as proposed to be amended, to perform those duties:

- Perform oral health assessments, including intraoral and extraoral soft tissue evaluations to identify oral lesions, classifying occlusion, performing myofunctional evaluations, and oral cancer screenings as authorized by the supervising dentist (BPC, § 1753.5, subd. (b), para. (1)).
- Perform oral health assessments in school-based, community health project settings under the direction of a dentist, registered dental hygienist, or registered dental hygienist in alternative practice (BPC, § 1753.5, subd. (b), para. (2)).
- Cement endodontic master points and accessory points (BPC, § 1753.5, subd. (b), para. (5)).

- Perform post, core, and build-up procedures in conjunction with direct and indirect restorations (BPC, § 1753.5, subd. (b), para. (6) – new duty added by SB 1453).
- Take final impressions for tooth-borne removeable prosthesis (BPC, § 1753.5, subd. (b), para. (8)).
- Place, contour, finish, and adjust all direct restorations (BPC, § 1753.5, subd. (b), para. (9)).
- Polish and contour existing amalgam restorations (BPC, § 1753.5, subd. (b), new para. (10) – old para. (8)).
- Adjust and adhere all permanent indirect restorations (BPC, § 1753.5, subd. (b), renumbered para. (11)).
- Other procedures authorized by regulations adopted by the board (BPC, § 1753.5, subd. (b), renumbered para. (12)).

## Action Requested

The Board is asked to consider the proposed legislative amendments and Council recommendations. If the Board agrees with the recommendation to amend the RDAEF duties and education requirements discussed above, the Board is asked to make one of the following motions.

Option 1 (support the proposed recommendation): Move the legislative proposal in **Attachment 1** for submission to the California State Legislature to amend Business and Professions Code sections 1753 and 1753.5 regarding RDAEF duties and education requirements.

Option 2 (support the proposed recommendation as revised during this meeting): Move the legislative proposal in **Attachment 1**, as revised during this meeting, for submission to the California State Legislature to amend Business and Professions Code sections 1753 and 1753.5.

Option 3 (no action): If the Board does not wish to act on the recommendation, no motion is needed.

## Attachment

1. Legislative Proposal to Amend Business and Professions Code Sections 1753 and 1753.5 Regarding Authorized Duties and Procedures of Registered Dental Assistants in Extended Functions

## DENTAL BOARD OF CALIFORNIA

## LEGISLATIVE PROPOSAL TO AMEND BUSINESS AND PROFESSIONS CODE SECTIONS 1753 AND 1753.5 REGARDING AUTHORIZED DUTIES AND PROCEDURES OF REGISTERED DENTAL ASSISTANTS IN EXTENDED FUNCTIONS

Proposed amendments are indicated in underline for new text and ~~strikethrough~~ for deleted text.

Amend Section 1753 of Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

**1753.** (a) On and after January 1, 2010, the board may license as a registered dental assistant in extended functions a person who files a completed application, pays the applicable fee, and submits written evidence, satisfactory to the board, of all of the following eligibility requirements:

(1) Current, active, and valid licensure as a registered dental assistant.

(2) A full set of fingerprints for purposes of conducting a criminal history check.

(3) Successful completion of either of the following:

(A) An extended functions postsecondary program approved by the board in all of the procedures specified in Section 1753.5.

(B) An extended functions postsecondary program approved by the board to teach the duties that registered dental assistants in extended functions were allowed to perform pursuant to board regulations prior to January 1, 2010, and a course approved by the board in the procedures specified in paragraphs (1), (2), (5), (6), and (~~7~~8) to (~~11~~12), inclusive, of subdivision (b) of Section 1753.5.

(4) Current certification in basic life support issued by American Red Cross, American Heart Association, American Safety and Health Institute, American Dental Association's Continuing Education Provider Recognition Program, or Academy of General Dentistry's Program Approval for Continuing Education.

(5) Successful completion of a board-approved pit and fissure sealant course.

(6) Passage of a written examination administered by the board. The board shall designate whether the written examination shall be administered by the board.

(b) A registered dental assistant in extended functions with permits in either orthodontic assisting or dental sedation assisting shall be referred to as an "RDAEF with orthodontic assistant permit," or "RDAEF with dental sedation assistant permit," as applicable. These terms shall be used for reference purposes only and do not create additional categories of licensure.

(c) Completion of the continuing education requirements established by the board pursuant to Section 1645 by a registered dental assistant in extended functions who also holds a permit as an orthodontic assistant or dental sedation assistant shall fulfill the continuing education requirement for such permit or permits.

(d) The licensee shall be responsible for complying with all applicable licensure renewal requirements, including continuing education pursuant to Section 1645.

Amend Section 1753.5 of Article 7 of Chapter 4 of Division 2 of the Business and Professions Code as follows:

**1753.5.** (a) A registered dental assistant in extended functions licensed on or after January 1, 2010, is authorized to perform all duties and procedures that a registered dental assistant is authorized to perform as specified in and limited by Section 1752.4, and the duties in this section.

(b) A registered dental assistant in extended functions licensed on or after January 1, 2010, is authorized to perform the following additional procedures under direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist:

(1) Perform oral health assessments, including intraoral and extraoral soft tissue evaluations to identify oral lesions, classifying occlusion, performing myofunctional evaluations, and oral cancer screenings as authorized by the supervising dentist.

(2) Perform oral health assessments in school-based, community health project settings under the direction of a dentist, registered dental hygienist, or registered dental hygienist in alternative practice.

(3) Gingival retraction for impression and restorative procedures.

(4) Size and fit endodontic master points and accessory points.

(5) Cement endodontic master points and accessory points.

(6) Perform post, core, and build-up procedures in conjunction with direct and indirect restorations.

(7) Take final impression for permanent indirect restorations.

(8) Take final impressions for tooth-borne removeable prosthesis.

(9) Place, contour, finish, and adjust all direct restorations.

(10) <u>Polish and contour existing amalgam restorations.</u>

~~(10)~~(11) Adjust and adhere all permanent indirect restorations.

~~(11)~~(12) Other procedures authorized by regulations adopted by the board.

(c) A registered dental assistant in extended functions licensed on or after January 1, 2010, may perform a duty specified in this section using contemporary techniques and materials designed for use in the performance of that duty under the direct supervision and pursuant to the order, control, and full professional responsibility of a licensed dentist if the registered dental assistant in extended functions has completed the appropriate education and training, and whose skill, knowledge, and education in the use of such contemporary technique or material has been determined clinically competent by the supervising licensed dentist.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR

DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | April 16, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Brant Nelson, Legislative and Regulatory Specialist<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 22.a.:** 2025 Tentative Legislative Calendar – Information Only |

## Background

The 2025 Tentative Legislative Calendar is being provided for information only. The 2025 Tentative Calendar is compiled by the Office of the Assembly Chief Clerk and the Office of the Secretary of the Senate.

## Action Requested

No action requested.

# 2025 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE AND THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised October 16, 2024

| JANUARY | | | | | | |
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| FEBRUARY | | | | | | |
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| MARCH | | | | | | |
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| APRIL | | | | | | |
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## DEADLINES

**Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).

**Jan. 6** Legislature Reconvenes (J.R. 51(a)(1)).

**Jan. 10** Budget must be submitted by Governor (Art. IV, Sec. 12(a)).

**Jan. 20** Martin Luther King, Jr. Day.

**Jan. 24** Last day to submit **bill requests** to the Office of Legislative Counsel.

**Feb. 17** Presidents' Day.

**Feb. 21** Last day for bills to be **introduced** (J.R. 61(a)(1), (J.R. 54(a)).

**Mar. 31** Cesar Chavez Day

**Apr. 10** **Spring Recess** begins upon adjournment of this day's session (J.R. 51(a)(2)).

**Apr. 21** Legislature reconvenes from **Spring Recess** (J.R. 51(a)(2)).

**May 2** Last day for **policy committees** to hear and report to **fiscal committees** fiscal bills introduced in their house (J.R. 61(a)(2)).

**May 9** Last day for **policy committees** to hear and report to the Floor **nonfiscal** bills introduced in their house (J.R. 61(a)(3)).

**May 16** Last day for **policy committees** to meet prior to June 9 (J.R. 61(a)(4)).

**May 23** Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61(a)(5)). Last day for **fiscal committees** to meet prior to June 9 (J.R. 61 (a)(6)).

**May 26** Memorial Day.

*Holiday schedule subject to Senate Rules committee approval.

# 2025 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE AND THE OFFICE OF THE ASSEMBLY CHIEF CLERK

Revised October 16, 2024

| JUNE | | | | | | |
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**June 2 - 6 Floor Session Only.** No committees, other than conference or Rules committees, may meet for any purpose (J.R. 61(a)(7)).

**June 6** Last day for each house to pass bills introduced in that house (J.R. 61(a)(8)).

**June 9** Committee meetings may resume (J.R. 61(a)(9)).

**June 15** **Budget Bill** must be **passed** by **midnight** (Art. IV, Sec. 12(c)(3)).

| JULY | | | | | | |
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**July 4** Independence Day.

**July 18** Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)). **Summer Recess** begins upon adjournment of session provided Budget Bill has been passed (J.R. 51(a)(3)).

| AUGUST | | | | | | |
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**Aug. 18** Legislature reconvenes from **Summer Recess** (J.R. 51(a)(3)).

**Aug. 29** Last day for **fiscal committees** to meet and report bills to the Floor. (J.R. 61(a)(11)).

| SEPTEMBER | | | | | | |
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| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
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**Sept. 1** Labor Day.

**Sept. 2-12 Floor Session Only.** No committees, other than conference or Rules committees, may meet for any purpose (J.R. 61(a)(12)).

**Sept. 5** Last day to **amend** on the Floor (J.R. 61(a)(13)).

**Sept. 12** Last day for **each house to pass bills** (J.R. 61(a)(14)). **Interim Study Recess** begins at end of this day's session (J.R. 51(a)(4)).

*Holiday schedule subject to Senate Rules committee approval.

## IMPORTANT DATES OCCURRING DURING INTERIM STUDY RECESS

**2025**

Oct. 12 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 12 and in the Governor's possession after Sept. 12 (Art. IV, Sec.10(b)(1)).

**2026**

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 5 Legislature reconvenes (J.R. 51(a)(4)).

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P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | April 28, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Brant Nelson, Legislative and Regulatory Specialist<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 22.b.:** Legislation of Interest |

## Background

The Dental Board of California (Board) staff have been tracking bills that impact the Board, the Department of Consumer Affairs (DCA), healing arts boards and their respective licensees, and all licensing boards. This memorandum includes information regarding each bill's status, location, date of introduction, date of last amendment, and a summary. The bills are listed in numerical order, with the Assembly Bills (AB XXX) first, followed by the Senate Bills (SB XXX). Legislation is amended, statuses are updated, and analyses are added frequently; thus, hyperlinks, identified in blue, underlined text, are provided throughout this document to ensure Board members and the public have access to the most up-to-date information. The information below was based on legislation, statuses, and analyses (if any) publicly available on April 23, 2025.

## Discussion

Staff will present updates on the following bills that may have a direct impact on the Board for discussion and possible action at the May meeting:

Priority Legislation for Board Consideration
AB 485 (Ortega, 2025) Labor Commissioner: unsatisfied judgments: nonpayment of wages.
AB 489 (Bonta, 2025) Health care professions: deceptive terms or letters: artificial intelligence.
AB 667 (Solache, 2025) Professions and vocations: license examinations: interpreters.
AB 742 (Elhawary, 2025) Department of Consumer Affairs: licensing: applicants who are descendants of slaves.
AB 873 (Alanis, 2025) Dentistry: dental assistants: infection control course.
AB 966 (Carrillo, 2025) Dental Practice Act: foreign dental schools.
AB 1307 (Ávila Farías, 2025) Licensed Dentists from Mexico Pilot Program.
SB 351 (Cabaldon, 2025) Health facilities.
SB 470 (Laird, 2025) Bagley-Keene Open Meeting Act: teleconferencing.

SB 641 (Ashby, 2025) Department of Consumer Affairs and Department of Real Estate: states of emergency: waivers and exemptions.
SB 861 (Committee on Business, Professions and Economic Development, 2025) Consumer Affairs.

Other Board-Monitored Legislation
The following bills have been identified by staff as being of potential interest to Board but do not require discussion at this time. Staff will continue to watch these bills and report on their progression at a future Board meeting. Information regarding each of these bill's status, location, date of introduction, date of last amendment, and a summary has been included in this memorandum. Please note staff will not be presenting these bills; should a Board member desire to discuss one of these bills they may present the bill at the meeting and provide arguments for the Board to take a position.

AB 341 (Arambula, 2025) Oral Health for People with Disabilities Technical Assistance Center Program.
AB 350 (Bonta, 2025) Health care coverage: fluoride treatments.
AB 371 (Haney, 2025) Dental coverage.
AB 479 (Tangipa, 2025) Criminal procedure: vacatur relief.
AB 837 (Davies, 2025) Ketamine.
AB 872 (Blanca Rubio, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances.
AB 876 (Flora, 2025) Nurse anesthetists: scope of practice.
AB 1107 (Flora, 2025) Cigarette and Tobacco Products Licensing Act of 2003: nitrous oxide: licensure.
AB 1215 (Flora, 2025) Hospitals: medical staff membership.
AB 1298 (Harabedian, 2025) The Department of Consumer Affairs.
AB 1431 (Tangipa, 2025) Personal income taxes: credit: medical services: rural areas.
AB 1461 (Essayli, 2025) Department of Consumer Affairs: regulatory boards
SB 338 (Becker, 2025) Mobile Health for Rural Communities Pilot Program.
SB 386 (Limón, 2025) Dental providers: fee-based payments.
SB 497 (Wiener, 2025) Legally protected healthcare activity.
SB 682 (Allen, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances.
SB 730 (Hurtado, 2025) Product safety: consumer products: perfluoroalkyl and polyfluoroalkyl substances.
SB 806 (Dahle, 2025) Department of Consumer Affairs

## Action Requested

If desired, the Board may take one of the following actions regarding each bill:

Support
Support if amended
Oppose

Oppose unless amended

Alternatively, the Board may take no action and designate the Board's position on a bill as one of the following:

Watch
Neutral
No Action

**Legislation Tracked by Dental Board of California (Board) Staff – 2025-2026 Legislative Session**
**2025 Legislative Year**

## Priority Legislation for Board Consideration

AB 485 (Ortega, 2025) Labor Commissioner: unsatisfied judgments: nonpayment of wages.
**Introduced**: February 10, 2025
**Last Amended**: March 19, 2025
**Location**: Assembly Appropriations Committee
**Status**: Referred to suspense file

**Summary:** Existing law generally prohibits employers from continuing to conduct business in the California if they have an unsatisfied final judgment for nonpayment of wages, unless the employer has obtained a bond from a surety company and filed that bond with the Labor Commissioner, as prescribed.

This bill would require a state agency, if an employer in an industry that is also required to obtain a license or permit from that state agency is found to have violated the unsatisfied judgment provision, to deny a new license or permit or the renewal of an existing license or permit for that employer. The bill would require the Labor Commissioner, upon finding that an employer is conducting business in violation of that provision, to notify the applicable state agency with jurisdiction over that employee's license or permit.

**Staff Comments:** This bill would require the Board to deny a new license or permit, or the renewal of an existing license or permit, upon notice by the Labor Commissioner of its finding that an employer is conducting business in violation of the unsatisfied judgment requirements. If the Board is required to deny licenses and permits, it may impact the Board's revenue. It is difficult for Board staff to estimate how this bill could impact Board revenue because the Labor Commissioner does not consistently aggregate and publicly report this data in a centralized, easily accessible format. However, Board staff anticipate the impact to be minimal.

Staff notes there is no process in the bill for the Board to issue the initial or renewal license or permit if the employer subsequently comes into compliance with the unsatisfied judgment requirements. Further, the Board does not provide lists of license or permit applicants to the Labor Commissioner, so it is unclear how the Labor Commission would know whether the employer had applied for a Board-issued license or permit. The Board may wish to communicate these issues to the author for clarification.

**Recommended Board Position:** Oppose unless amended to clarify Board action on the initial or renewal license or permit following subsequent compliance by the employer

and resolve the issue of Labor Commissioner awareness of license or permit applications submitted to the Board.

AB 489 (Bonta, 2025) Health care professions: deceptive terms or letters: artificial intelligence.
**Introduced**: February 10, 2025
**Last Amended**: April 10, 2025
**Location**: Assembly Privacy and Consumer Protection Committee
**Status**: Set for hearing on April 22, 2025

**Summary:** This bill would make provisions of law that prohibit the use of specified terms, letters, or phrases to falsely indicate or imply possession of a license or certificate to practice a health care profession, as defined, enforceable against an entity who develops or deploys artificial intelligence (AI) or generative artificial intelligence (GenAI) technology that uses one or more of those terms, letters, or phrases in its advertising or functionality. The bill would prohibit the use by AI or GenAI technology of certain terms, letters, or phrases that indicate or imply that the advice or care advice, care, reports, or assessments being provided through AI or GenAI is being provided by a natural person with the appropriated health care license or certificate. This bill would make a violation of these provisions subject to the jurisdiction of the appropriate health care profession board, and would make each use of a prohibited term, letter, or phrase punishable as a separate violation.

**Staff Comments:** The Board anticipates a small increase in complaints and enforcement cases.

**Recommended Board Position:** Watch

AB 667 (Solache, 2025) Professions and vocations: license examinations: interpreters.
**Introduced**: February 14, 2025
**Last Amended**: Revised April 9, 2025
**Location**: Assembly Appropriations Committee
**Status**: Unknown

**Summary:** This bill would, beginning July 1, 2026, require certain boards under the jurisdiction of the Department of Consumer Affairs to permit an applicant who cannot read, speak, or write in English to use an interpreter to interpret the English written and oral portions of the license examination, as applicable, examination if the applicant meets all other requirements for licensure, as specified.

This bill would require an interpreter to satisfy specified requirements, including not having the license for which the applicant is taking the examination, and would prohibit the assistance of an interpreter under certain circumstances, including when English language proficiency is required for the license. The bill would also require those boards to post on their internet websites that an applicant may use an interpreter if they

cannot read, speak, or write in English, the examination is not offered in their preferred language, and they meet all other requirements for licensure.

**Staff Comments:** The bill was amended to remove DCA Division 2 (healing arts) boards. However, Board staff recommend monitoring to ensure the language is not added back due to examination security concerns.

**Recommended Board Position:** Watch

AB 742 (Elhawary, 2025) Department of Consumer Affairs: licensing: applicants who are descendants of slaves.
**Introduced**: February 18, 2025
**Last Amended**: Revised April 8, 2025
**Location**: Assembly Judiciary Committee
**Status**: Unknown

**Summary:** This bill, once a process to certify descendants of American slaves is established by the Bureau for Descendants of American Slavery pursuant to SB 518 (Weber Pierson, 2025), would require state licensing boards to prioritize applicants seeking licensure who are descendants of American slaves. The bill would make those provisions operative when the certification process is established by the Bureau for Descendants of American Slavery and would repeal those provisions four years from the date on which the provisions become operative or on January 1, 2032, whichever is earlier.

**Staff Comments:** This bill is similar to AB 2862 (Gipson, 2024), which the Board opposed unless amended to resolve implementation, fiscal, and clarity concerns with that bill. Like AB 2862, AB 742 raises implementation, fiscal, and clarity concerns. First, the Business and Professions Code (BPC) currently requires that four applicant populations receive expedited review for licensure from the Board: (1) members of the Armed Forces who have served on active duty and were honorably discharged, (2) members of the Armed Forces enrolled in the US Department of Defense Skillbridge program; (3) spouses or domestic partners of active duty members of the Armed Forces who are currently assigned to a duty station in California under official active duty military orders, and (4) refugees who have been granted asylum by the Secretary of Homeland Security or the Attorney General of the United States or those with a special immigrant visa. (BPC, §§ 115.4, 115.5, 135.4.) Further, the Board is required to process an application within 30 days to register a military spouse or domestic partner licensed in another state. (BPC, § 115.10.) AB 742 is unclear whether it would require the Board to expedite license applications from descendants of American slaves ahead of military members and their spouses or domestic partners.

Second, the bill is unclear on what prioritize and whether that means the Board just must expedite license applications from descendants of American slaves, or whether the bill require the Board to do something more, such as outreach to communities and schools to encourage descendants of American slaves to apply for Board licensure.

Third, Government Code section 12944 prohibits any licensing board to establish any qualification for licensing that has an adverse impact on any class by virtue of its race, unless the practice can be demonstrated to be job related. Further, Government Code section 11135 prohibits a state agency from denying full and equal access to the program or activity conducted by the state agency on the basis of race. Depending upon whether implementation of the bill would favor any particular race of descendants of American slaves, the Board may face constitutional challenges from applicants of other races, resulting in costly litigation for the Board to defend its implementation of this bill. So that the Board can properly implement the bill, it may be appropriate to seek additional clarification of these issues from the author or legislative committees. The Board may wish to request clarification as to what is meant by prioritizing these applications, request clarity of numerical priority as to what type of applicant population would get expedited processing, and require the state, not the Board or its licensees, to cover all costs associated with litigating claims brought against the Board due to its implementation of the bill.

**Recommended Board Position:** Oppose unless amended to resolve the implementation, fiscal, and clarity concerns raised above.

AB 873 (Alanis, 2025) Dentistry: dental assistants: infection control course.
**Introduced**: February 19, 2025
**Last Amended**: April 9, 2025
**Location**: Assembly Appropriations Committee
**Status**: Referred to suspense file
**Summary:** This California Dental Association (CDA) sponsored bill would change the requirement that an unlicensed dental assistant complete a Board-approved 8-hour infection control course prior to providing specified services, to instead require completion of the infection control course within 90 days of first employment at the dental office. The bill also would include several Board-approved legislative proposals to resolve issues identified during implementation of the Board's Sunset bill, SB 1453 (Ashby, Chapter 483, Statutes of 2024).

Specifically, the bill would establish a statutory fee for Board review of each approval application or reevaluation for an interim therapeutic restoration (ITR) and radiographic decisionmaking, radiation safety, and dental assisting infection control course that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges. The bill also would clarify the new radiation safety and dental assistant infection control course statutes in accordance with the Board's legislative proposal approved at its February 2025 meeting. While the bill's sponsor, CDA, agreed to most of those amendments, CDA raised concern regarding limiting the use of an electronic infection control course with no in-person clinical instruction to only unlicensed dental assistants (prop. BPC, § 1755, subd. (g)). The Board sought to add new BPC section 1755, subdivision (g), to limit the use of the electronic infection control courses solely to unlicensed dental assistants, so that all registered dental assistant (RDA) license, orthodontic assistant, and dental sedation permit applicants, who would perform more duties involving blood and other potentially infection material, would

continue to take the eight-hour infection control course offered by an education program or infection control course provider under regulation for consumer protection.

The Board had communicated to the Assembly Business and Professions Committee staff that BPC section 1755, subdivision (g), in the Board's requested amendments was a concern for CDA, and the Board requested the Committee to resolve the issue, which it did by voting the bill out of Committee with this provision, discussed in the Committee analysis. The Board considers this issue resolved; however, the Board understands CDA may attempt to have this provision stricken as the bill moves through the process.

The Board approved several other legislative proposals at its November 2024 and February 2025 meetings to better clarify other SB 1453 implementation issues. Board staff have been in continued discussions with stakeholders on these issues, and CDA has expressed willingness to incorporate additional amendments to the bill, including:

- Amending BPC sections 1628 and 1633 regarding Dentist Licensure Requirements
- Amending BPC section 1635.5 regarding Licensure by Credential Pathway Requirements
- Amending BPC section 1638.1 regarding Elective Facial Cosmetic Surgery (EFCS) Permits

During the May 2025 Board meeting, the Board also will be asked to review three additional legislative proposals to amend BPC sections 1724, subdivision (a) (dentist license portfolio applicant fee repeal), and Article 7 (title regarding Dental Auxiliaries) for submission and inclusion in AB 873. Board staff also note the Board's requested amendment to BPC section 1725, new subdivision (l), that would have set the course application fee at $300 was changed in the final amendments to instead set the fee not to exceed $300. This is problematic as it will require the Board to pursue a rulemaking to set the ITR course application fee in regulation before the Board can begin processing applications for Board approval to offer the course.

**Staff Comments**: Board staff would need to implement evaluation and approval of the infection control course providers. Board staff anticipate that this would involve one new staff position at the Associate Governmental Program Analyst (AGPA) level and include two addition subject matter expert contracts to review infection control courses offered by providers.

**Recommended Board Position:** Support if amended to include the Board's additional legislative proposals to resolve SB 1453 issues.

AB 966 (Carrillo, 2025) Dental Practice Act: foreign dental schools.
**Introduced**: February 20, 2025
**Last Amended**: April 7, 2025
**Location**: Assembly Business and Profession Committee
**Status**: Unknown

**Summary:** Beginning January 1, 2024, existing law requires foreign dental schools seeking approval by the Board to complete the international consultative and accreditation process with the Commission on Dental Accreditation of the American Dental Association. Existing law maintained the approval of any foreign dental schools whose program was renewed by the board prior to January 1, 2020, through any date between January 1, 2024, and June 30, 2026, through that renewal date.

This bill would instead maintain the approval of any foreign dental school whose program was approved by the Board prior to January 1, 2024, until the school is denied accreditation by the Commission on Dental Accreditation of the American Dental Association (CODA) and the school does not appeal, the school has been issued a denial by CODA following the completion of the appeals process, or the school withdraws its application for CODA accreditation. The bill would require license applicants who graduated from a foreign dental school with extended Board approval to agree to practice dentistry in specified practice settings. The bill would require the Board, as part of the Board's first Sunset review report following January 1, 2032, to report specified information regarding workforce data of licensees and graduates of foreign dental schools with extended approval, as specified.

**Staff Comments:** This bill would require significant statutory and regulatory changes and staff time preparing the new workforce report required under the bill and increase staffing resource costs. This bill also may result in decreased consumer protection resulting from licensees, who graduated from a foreign dental school that had not been audited or otherwise reviewed for educational requirements compliance for many years. The bill also may result in a foreign dental school maintaining Board approval without Board oversight of compliance with existing regulatory requirements for a long time, as long as the school had applied for CODA approval.

**Recommended Board Position:** Oppose

AB 1307 (Ávila Farías, 2025) Licensed Dentists from Mexico Pilot Program.
**Introduced**: February 21, 2025
**Last Amended**: April 2, 2025
**Location**: Assembly Appropriations Committee
**Status**: Referred to suspense file

**Summary:** This bill would repeal and replace the existing Licensed Dentists from Mexico Pilot Program and instead requires the Board to issue a three-year nonrenewable permit to practice dentistry to an applicant who meets specified criteria and require participants in the program to comply with specified requirements. The bill would authorize participants to be employed only by federally qualified health centers that meet specified conditions and would impose requirements on those centers. The bill would require an evaluation of the program to be commenced beginning one year after the program has commenced, as specified, and would prescribe the information to be included in that evaluation. The bill would require the costs for the program to be fully paid for by funds provided by philanthropic foundations.

**Staff Comments:** The Board would be required to process a new license type with an expected number of 30 applications per year. Board staff determined there would be an increase in staffing and operational resources necessary to implement the bill, and such staffing and operational resources may not be available given the recent directives by the Governor to reduce costs and eliminate vacant positions.

**Recommended Board Position:** Oppose unless amended

AB 1434 (Michelle Rodriquez, 2025) Health care boards: workforce data collection.
**Introduced**: February 21, 2025
**Last Amended**: February 24, 2025
**Location**: Assembly
**Status**: Pending referral

**Summary:** Existing law requires specified boards, including the Board of Registered Nursing and the Respiratory Care Board of California, to collect certain workforce data from their respective licensees and registrants for future workforce planning at least biennially. This bill would make nonsubstantive changes to those provisions.

**Staff Comments:** Existing law but monitor for changes.

**Recommended Board Position:** Watch

SB 351 (Cabaldon, 2025) Health facilities.
**Introduced**: February 12, 2025
**Last Amended**: N/A
**Location**: Senate Judiciary Committee
**Status**: Set for hearing on April 29, 2025

**Summary:** This bill would prohibit hedge funds and private equity groups, as defined, involved in any manner with a physician or dental practice doing business in this state from making health care decisions or exercising power over specified actions, including making decisions regarding coding and billing procedures for patient care services. This bill would also render void and unenforceable specified types of contracts between a physician or dental practice and a private equity group or hedge fund that include any clause barring any provider in that practice from competing with that practice in the event of a termination or resignation, or from disparaging, opining, or commenting on that practice in any manner as to issues involving quality of care, utilization of care, ethical or professional challenges in the practice of medicine or dentistry, or revenue-increasing strategies employed by the private equity group or hedge fund.

**Staff Comments:** Board enforcement staff estimate 20 additional cases per year to investigate, which would potentially involve prohibited actions in connection with private equity or hedge fund ownership of dental practices.

**Recommended Board Position:** Watch

SB 470 (Laird, 2025) Bagley-Keene Open Meeting Act: teleconferencing.
**Introduced**: February 19, 2025
**Last Amended**: April 10, 2025
**Location**: Senate Appropriations Committee
**Status**: Set for hearing on April 28, 2025

**Summary:** The Bagley-Keene Open Meeting Act authorizes meetings through teleconference subject to specified requirements; those provisions will be repealed on January 1, 2026. This bill would instead repeal those provisions on January 1, 2030.

**Staff Comments:** The bill would allow the Board to continue with the current process of allowing teleconferencing providing cost savings and efficiencies for another four years.

**Recommended Board Position:** Support

SB 641 (Ashby, 2025) Department of Consumer Affairs and Department of Real Estate: states of emergency: waivers and exemptions.
**Introduced**: February 20, 2025
**Last Amended**: April 9, 2025
**Location**: Senate Public Safety Committee
**Status**: Set for hearing on April 29, 2025

**Summary:** This bill would authorize boards under the jurisdiction of DCA to waive the application of certain provisions of the licensure requirements, as specified, that the board or DCA is charged with enforcing for licensees and applicants impacted by a declared federal, state, or local emergency or whose home or business is in a declared disaster area.

**Staff Comments:** Board staff would need to coordinate with DCA to implement the bill in terms of initial set up, so fee waivers could be facilitated by way of BreEZe. Board staff, due to the inability to predict the extent of future disasters, are not certain as to the extent of fiscal impact this bill poses by allowing fee waivers (revenue loss).

**Recommended Board Position:** Watch

SB 861 (Committee on Business, Professions and Economic Development, 2025) Consumer affairs.
**Introduced**: March 13, 2025
**Last Amended**: N/A
**Location**: Senate Judiciary Committee
**Status**: Set for hearing on April 29, 2025

**Summary:** This bill, the Senate Business, Professions and Economic Development Committee Omnibus Bill, would amend various aspects of regulation and licensing across multiple boards and bureaus. The bill would reinstate BPC section 1616.5, which was repealed by the Board's Sunset bill, SB 1453, that requires DCA Director approval

for the Board to appoint its Executive Officer. The bill also includes the Board's legislative proposal to conform BPC sections 1602 and 1603, subdivisions (d) and (e), to change the references of the former registered dental hygienist Board member position to the new registered dental assistant position in accordance with recent amendments to BPC section 1601.1.

**Staff Comments:** The bill reinstates the requirement for the DCA Director to approve of the Board's candidate for Executive Officer prior to appointment. The Board did not to seek reinstate this requirement, and it is unclear why this provision is being reinstated and why the Director's oversight is necessary for the Board to appoint its Executive Officer.

**Recommended Board Position:** Support if the Board agrees with the reinstatement of DCA Director oversight over the Board's selection of its Executive Officer.

**Other Board-Monitored Legislation**

AB 341 (Arambula, 2025) Oral Health for People with Disabilities Technical Assistance Center Program.
**Introduced**: January 28, 2025
**Last Amended**: N/A
**Location**: Assembly Human Services Committee
**Status**: Unknown

**Summary:** This bill would require the State Department of Developmental Services (DDS) to contract with a public California dental school or college to administer the Oral Health for People with Disabilities Technical Assistance Center Program to improve dental care services for people with developmental and intellectual disabilities by reducing or eliminating the need for dental treatment using sedation and general anesthesia.

**Staff Comments:** None.

**Recommended Board Position:** Watch

AB 350 (Bonta, 2025) Health care coverage: fluoride treatments.
**Introduced**: January 29, 2025
**Last Amended**: April 23, 2025
**Location**: Assembly Appropriations Committee
**Status**: Unknown

**Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, to provide coverage for the application of fluoride varnish in the primary care setting for children under 21 years of age. This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the

Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified.

**Staff Comments:** None.

**Recommended Board Position:** Watch

AB 371 (Haney, 2025) Dental coverage.
**Introduced**: February 3, 2025
**Last Amended**: April 23, 2025
**Location**: Assembly Appropriations Committee
**Status**: Unknown

**Summary:** If a health care service plan or health insurer pays a contracting dental provider directly for covered services, this bill would require the plan or insurer to pay a noncontracting dental provider directly for covered services if the noncontracting provider submits to the plan or insurer a written assignment of benefits form signed by the enrollee or insured. The bill would require the plan or insurer to provide a predetermination or prior authorization to the dental provider and to reimburse the provider for not less than that amount, except as specified. The bill would require the plan or insurer to notify the enrollee or insured that the provider was paid and that the out-of-network cost may count towards their annual or lifetime maximum. The bill would require a noncontracting dental provider to make specified disclosures to an enrollee or insured before accepting an assignment of benefits.

This bill would require specified plans and insurers that cover dental services to offer urgent dental appointments within 48 hours of a request, nonurgent dental appointments within 18 business days of a request, and preventive dental care appointments within 20 business days of a request, as specified. The bill would require dentists to be available within 15 miles or 30 minutes from an enrollee's or insured's residence or workplace. The bill would require plans and insurers to report comprehensive information regarding the networks that each dental provider serves, including the plan's or insurer's self-insured network. The bill would require the Department of Managed Health Care or the Department of Insurance to review the adequacy of an entire dental provider network, including the portions of the network serving plans and insurers not regulated by the respective department.

**Staff Comments:** None.

**Recommended Board Position:** Watch

AB 479 (Tangipa, 2025) Criminal procedure: vacatur relief.
**Introduced**: February 10, 2025
**Last Amended**: N/A
**Location**: Assembly Public Safety Committee

**Status**: Hearing canceled at the request of author

**Summary:** Existing law allows a person who was arrested or convicted of a nonviolent offense while they were a victim of intimate partner violence, or sexual violence, to petition the court, under penalty of perjury, for vacatur relief. Existing law requires, to receive that relief, that the petitioner establish, by clear and convincing evidence, that the arrest or conviction was the direct result of being a victim of intimate partner violence or sexual violence that demonstrates the petitioner lacked the requisite intent. Existing law authorizes the court to vacate the conviction if it makes specified findings.

This bill would require the court, before it may vacate the conviction, to make findings regarding the impact on the public health, safety, and welfare, if the petitioner holds a license, as defined, and the offense is substantially related to the qualifications, functions, or duties of a licensee. The bill would require a petitioner who holds a license to serve the petition and supporting documentation on the applicable licensing entity and would give the licensing entity 45 days to respond to the petition for relief.

**Staff Comments:** None.

**Recommended Board Position:** No action

AB 837 (Davies, 2025) Ketamine.
**Introduced**: February 19, 2025
**Last Amended**: March 27, 2025
**Location**: Assembly Appropriations Committee
**Status**: Referred to suspense file

**Summary:** Existing law, the California Uniform Controlled Substances Act, categorizes controlled substances into five designated schedules, places the greatest restrictions on those substances contained in Schedule I, and generally places the least restrictive limitations on controlled substances classified in Schedule V. Existing law categorizes ketamine as a Schedule III controlled substance. Existing law, with a specified exception, makes it a crime to possess for sale or sell ketamine. Existing law makes a violation of that provision punishable by imprisonment in the county jail for a period of not more than one year or in the state prison.

This bill would instead make a violation of that provision punishable by imprisonment in the county jail for a period of not more than one year or for 3, 4, or 5 years. The bill would also make it a crime to transport, import, furnish, administer, or give away, offer to transport, import, furnish, administer, or give away, or attempt to import or transport ketamine into this state, except as specified. The bill would make a violation of these prohibitions punishable by imprisonment in the county jail for 3, 4, or 5 years.

**Staff Comments:** None.

**Recommended Board Position:** No action

AB 872 (Blanca Rubio, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances.
**Introduced**: February 19, 2025
**Last Amended**: April 10, 2025
**Location**: Assembly Environmental Safety and Toxic Materials Committee
**Status**: Unknown

**Summary:** This bill, along with other bills, seeks to address perfluoroalkyl substances (PFAS). This bill, beginning January 1, 2028, would prohibit a person from distributing, selling, or offering for sale a covered product, as defined, that contains intentionally added PFAS, as defined, unless the Department of Toxic Substances Control has issued a regulatory response for the covered product pursuant to the Green Chemistry program or the prohibition is preempted by federal law. The bill would authorize a manufacturer of a covered product to petition that department to evaluate a covered product and would require that department to evaluate and provide a regulatory response for a covered product under the Green Chemistry program, as specified. The bill would authorize that department to identify and categorize commercially active PFAS present in products distributed in California, as specified.

**Staff Comments:** None.

**Recommended Board Position:** No action

AB 876 (Flora, 2025) Nurse anesthetists: scope of practice
**Introduced**: February 19, 2025
**Last Amended**: April 23, 2025
**Location**: Assembly Appropriations Committee
**Status**: Unknown

**Summary:** Existing law provides that the utilization of a nurse anesthetist to provide anesthesia services in an acute care facility shall be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist or podiatrist. If a general anesthetic agent is administered in a dental office, the dentist shall hold a general anesthesia permit issued by the Board.

This bill would provide that, in an acute care facility, outpatient setting where the nurse anesthetist has been credentialed to provide anesthesia, or in a dental office where the dentist holds a general anesthesia permit, the anesthesia services would include preoperative, intraoperative, and postoperative care and pain management for patients receiving anesthesia ordered by a physician, dentist, or podiatrist that are provided within the scope of practice of the nurse anesthetist. The bill would authorize a nurse anesthetist to provide direct and indirect patient care services, including the administration of medications and therapeutic agents to implement a treatment, as specified.

The bill would provide that an order entered on the chart or medical record of a patient constitutes authorization for the nurse anesthetist to select the modality of anesthesia and to abort or modify the modality of anesthesia during the course of patient care. The bill would state that ordering and administering controlled substances and other drugs pursuant to those provisions does not constitute a prescription. The bill would also provide that, in an acute care facility or outpatient setting, anesthesia services may encompass services performed outside of the perioperative setting, as specified.

**Staff Comments:** None.

**Recommended Board Position:** Watch

AB 1107 (Flora, 2025) Cigarette and Tobacco Products Licensing Act of 2003: nitrous oxide: licensure.
**Introduced**: February 20, 2025
**Last Amended**: Revised April 8, 2025
**Location**: Assembly Public Safety Committee
**Status**: Unknown

**Summary:** Nitrous oxide is a colorless, odorless to sweet-smelling inorganic gas that was first used in surgical and dental anesthesia in the mid-1800s. Existing law, the Cigarette and Tobacco Products Licensing Act of 2003, requires the California Department of Tax and Fee Administration to issue a license to a retailer to engage in the sale of cigarettes or tobacco products upon receipt of a completed application and payment of certain fees unless any of certain exceptions apply. Existing law subjects licenses issued by the act to suspension or revocation for specified violations. Existing law prohibits a person from dispensing or distributing nitrous oxide to a person if the distributor knows or should know that the person is going to use the nitrous oxide for certain unlawful purposes and that person proximately causes great bodily injury or death to that person or another person. Existing law also requires a person who dispenses or distributes nitrous oxide to record each transaction involving the dispensing or distribution of nitrous oxide in a written or electronic document, as specified. Existing law makes a violation of either of these provisions a misdemeanor.

This bill would require a court to order the suspension, for up to one year, of the business license of a person who knowingly violates either of those provisions after having been previously convicted of a violation of the respective provision, except as specified. This bill would specify violations subjecting licenses to suspension or revocation include, among others, the crimes above, as specified. The bill would exempt from the license issuance requirement the issuance of a license to a retailer who has been convicted of specified crimes relating to the distribution of nitrous oxide, including the misdemeanors described above.

**Staff Comments:** None.

**Recommended Board Position:** Watch

AB 1215 (Flora, 2025) Hospitals: medical staff membership.
**Introduced**: February 21, 2025
**Last Amended**: N/A
**Location**: Assembly Business and Professions Committee
**Status**: Hearing canceled at the request of author

**Summary:** Existing law, enforced by the Medical Board of California, makes it unprofessional conduct in the regular practice of medicine in a specified licensed general or specialized hospital having five or more physicians and surgeons on the medical staff without required provisions governing the operation of the hospital, including, among other things, a provision that membership on the medical shall be restricted to physicians and surgeons and other licensed practitioners competent in their respective fields and worthy of professional ethics. Existing law also makes it unprofessional conduct in the regular practice of medicine in a licensed general or specialized hospital having less than five surgeons on the medical staff without required provisions governing the operation of the hospital, including, among other things, a provisions that membership on the medical staff shall be restricted to physicians and surgeons and other licensed practitioners competent in their respective fields and worthy of professional ethics.

This bill would clarify the membership restriction provisions of other licensees to specifically list dentists, podiatrists, clinical psychologists, nurse anesthetists, and nurse midwives.

**Staff Comments:** None.

**Recommended Board Position:** Watch

AB 1431 (Tangipa, 2025) Personal income taxes: credit: medical services: rural areas.
**Introduced**: February 21, 2025
**Last Amended**: N/A
**Location**: Assembly Revenue and Taxation Committee
**Status**: Referred to suspense file

**Summary:** The Personal Income Tax Law allows various credits against the taxes imposed by that law. This bill, for taxable years beginning on or after January 1, 2025, and before January 1, 2032, would allow a credit against the taxes imposed by that law to a qualified taxpayer in an amount equal to the qualified income earned by the qualified taxpayer for medical services performed in a rural area in the state, not to exceed $5,000 per taxable year, as specified.

**Staff Comments:** None.

**Recommended Board Position:** Watch

SB 338 (Becker, 2025) Mobile Health for Rural Communities Pilot Program.
**Introduced**: February 12, 2025
**Last Amended**: April 8, 2025
**Location**: Senate Health Committee
**Status**: Set for hearing on April 23, 2025

**Summary:** Existing law establishes various programs to address the needs of migrant agricultural families. Existing law also provides funding to enhance and maintain rural health services.

This bill would establish the "Mobile Health for Rural Communities Pilot Program" and require the State Department of Health Care Services (DHCS) to administer the program to expand access to health services for farmworkers in rural communities. The bill would authorize the department to work with a community organization, including Ayudando Latinos a Soñar or other community foundations, to assist in the administration of the program. The bill would require DHCS to deploy mobile units in two rural communities based on farmworker population and access to health care. The bill would define "mobile unit" to mean "a vehicle or portable facility that is equipped with, at a minimum, computers, Wi-Fi, cubicles for virtual visits, and exam rooms for telemedicine." The bill would require the DHCS, on or before January 1, 2027, to report the outcomes of the program to the Legislature. The bill would create the Farmworkers Health Equity Fund and would condition implementation of these provisions on no General Fund moneys being used.

**Staff Comments:** None.

**Recommended Board Position:** Watch

SB 386 (Limón, 2025) Dental providers: fee-based payments.
**Introduced**: February 14, 2025
**Last Amended**: April 7, 2025
**Location**: Senate Floor
**Status**: Third reading

**Summary:** This bill would require a health care service plan contract or health insurance policy, issued, amended, or renewed on and after April 1, 2026, that provides payment directly or through a contracted vendor to a dental provider to have a non-fee-based default method of payment. The bill, beginning April 1, 2026, would require a health care service plan, health insurer, or contracted vendor to obtain affirmative consent from a dental provider who opts in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider and would authorize the dental provider to opt out of the fee-based payment method at any time by providing affirmative consent to the health care service plan, health insurer, or contracted vendor.

The bill would require a health care service plan, health insurer, or contracted vendor that obtains affirmative consent to opt in or opt out of fee-based payment to apply the decision to include both the dental provider's entire practice and all products or services covered pursuant to a contract with the dental provider. The bill would specify that its provisions do not apply if a health care service plan or health insurer has a direct contract with a provider that allows the provider to choose payment methods for services rendered.

**Staff Comments:** This bill, sponsored by CDA, responds to the Governor's veto of SB 1369 (Limón, 2024), which would have required dental plans to default to a non-fee-based method of payment to providers, and to remit with each payment the associated claims and claim details. The Governor vetoed that bill stating that the issue was a matter that should be addressed during contract negotiations between dental providers and the dental plan.

**Recommended Board Position:** Watch

SB 497 (Wiener, 2025) Legally protected healthcare activity.
**Introduced**: February 19, 2025
**Last Amended**: April 21, 2025
**Location**: Senate Public Safety Committee
**Status**: Set for hearing on April 29, 2025

**Summary:** This bill would prohibit a provider of health care, a health care service plan, or a contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care in response to a criminal or civil action, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care. The bill would prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with or providing medical information to an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care, as specified. The bill would prohibit these entities from releasing medical information related to sensitive services, as defined, in response to a foreign subpoena that is based on a violation of another state's laws authorizing a criminal action against a person or entity for provision or receipt of legally protected health care activity, as defined. The bill would generally prohibit the issuance of a subpoena based on a violation of another state's law that interferes with a person's right to seek or obtain gender-affirming health care or gender-affirming mental health care, as specified.

This bill would prohibit a state or local agency or employee, appointee, officer, contractor, or official or any other person acting on behalf of a public agency from providing any Controlled Substances Utilization Review and Evaluation System (CURES) data or expend any resources in furtherance of any interstate investigation or

proceeding seeking to impose civil, criminal, or disciplinary liability upon the provision or receipt of legally protected health care activity, as defined. The bill would prohibit out-of-state law enforcement from having access to CURES data through the interstate data sharing hub and would prohibit the department from sharing data with an out-of-state law enforcement agency without a warrant, subpoena, or court order, and would prohibit an out-of-state user from providing any data in furtherance of an investigation or proceeding to impose liability for the provision or receipt of legally protected health care activity.

**Staff Comments:** None.

**Recommended Board Position:** Watch

SB 682 (Allen, 2025) Environmental health: product safety: perfluoroalkyl and polyfluoroalkyl substances.
**Introduced**: February 21, 2025
**Last Amended**: April 22, 2025
**Location**: Senate Health Committee
**Status**: Set for hearing on April 30, 2025

**Summary:** Existing law requires the Department of Toxic Substances Control, on or before January 1, 2029, to adopt regulations to enforce specified covered perfluoroalkyl substances (PFAS) restrictions, which include prohibitions on the distribution, sale, or offering for sale of certain products that contain specified levels of PFAS. Existing law requires the Department of Toxic Substances Control, on and after July 1, 2030, to enforce and ensure compliance with those provisions and regulations, as provided.

Existing law requires manufacturers of these products, on or before July 1, 2029, to register with the department, to pay a registration fee to the department, and to provide a statement of compliance certifying compliance with the applicable prohibitions on the use of PFAS to the Department of Toxic Substances Control, as specified. Existing law requires the Department of Toxic Substances Control to issue a notice of violation for a product in violation of the prohibitions on the use of PFAS, as provided.

This bill would, beginning January 1, 2027, prohibit a person from distributing, selling, or offering for sale a covered product that contains intentionally added PFAS, as defined, except for previously used products and as otherwise preempted by federal law. The bill would define “covered product” to include dental floss, among other products.

This bill would, beginning January 1, 2040, prohibit a person from distributing, selling, or offering for sale certain products that contain intentionally added PFAS, including, but not limited to, refrigerants, solvents, propellants, and clean fire suppressants, as specified, unless the Department of Toxic Substances Control has determined that the use of PFAS in the product is a currently unavoidable use, the prohibition is preempted by federal law, or the product is previously used.

This bill would also, beginning January 1, 2035, prohibit a person from distributing, selling, or offering for sale any other product, as defined, that contains intentionally added PFAS unless the Department of Toxic Substances Control has determined that the use of PFAS in the product is a currently unavoidable use, the prohibition is preempted by federal law, or the product is previously used. The bill would require the Department of Toxic Substances Control to maintain on its internet website a list of each determination of currently unavoidable use, when each determination expires, and the products and uses that are exempt from the prohibition.

**Staff Comments:** None.

**Recommended Board Position:** No action

SB 730 (Hurtado, 2025) Product safety: consumer products: perfluoroalkyl and polyfluoroalkyl substances.
**Introduced**: February 21, 2025
**Last Amended**: March 26, 2025
**Location**: Senate Environment Quality Committee
**Status**: Hearing canceled at the request of author

**Summary:** This bill, among other similar bills, seeks to address perfluoroalkyl substances (PFAS). This bill would, beginning January 1, 2027, prohibit a person from distributing, selling, or offering for sale, dental floss, among other things that contain intentionally added PFAS, as defined. The bill would authorize the Department of Toxic Substances Control to adopt regulations to designate additional consumer product categories to prohibit the distribution, selling, or offering for sale of consumer products containing intentionally added PFAS within those consumer product categories, as specified. The bill would define "product" for purposes of these provisions to not include, among other things, used products offered for sale, federally approved drugs or medical devices, or products containing fluoropolymers, as specified.

**Staff Comments:** None.

**Recommended Board Position:** No action

**Department of Consumer Affairs Legislation**

AB 1298 (Harabedian, 2025) The Department of Consumer Affairs:An act to amend Section 100 of the Business and Professions Code, relating to professions and vocations.

AB 1461 (Essayli, 2025) Department of Consumer Affairs: regulatory boards: Existing law provides for the licensure and regulation of various professions and vocations by boards and other entities within the Department of Consumer Affairs. Existing law establishes procedures for removing from office a member of a board or other licensing entity in the department based on certain conduct by that member.

This bill would make nonsubstantive changes to those provisions.

SB 806 (Dahle, 2025) Department of Consumer Affairs: Existing law establishes the Department of Consumer Affairs, which is comprised of boards that license and regulate various professions and vocations. Under existing law, each board within the department exists as a separate unit with specified functions.

This bill would make a nonsubstantive change to these provisions.

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

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DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | April 30, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Tina Vallery, Division Chief<br>License and Program Compliance and Dental Assisting<br>Dental Board of California |
| **SUBJECT** | **Supplement to Agenda Item 22.b.xi.:** Update, Discussion, and Possible Recommendation to the Board on Legislation AB 873 (Alanis, 2025) Dentistry: dental assistants: infection control course |

This memorandum discusses concerns with the April 9, 2025 version of Assembly Bill (AB) 873 and the new fee to be charged in Business and Professions Code (BPC) section 1725, subdivision (l).

## Background

At the Dental Assisting Council's (Council) February 6, 2025 meeting, the Council approved a recommendation to the Dental Board of California (Board) for submission to the California State Legislature a legislative proposal to amend various BPC sections to resolve clarity and implementation issues with new statutes enacted by the Board's Sunset bill, Senate Bill (SB) 1453 (Ashby, Chapter 483, Statutes of 2024). (February 6, 2025 Council Meeting Materials, Agenda Item 9.b., and supplemental text.) The Board adopted the Council's recommendation at the Board's February 6-7, 2025 meeting. Notably, the legislative proposal sought to set application review fees for three new dental assistant courses established in SB 1453.

The Board collects fees to cover Board expenses in administering and enforcing the Dental Practice Act and supporting regulations. The three new dental assistant courses required application fees to be established in statute.

On February 19, 2025, AB 873 was introduced to resolve concerns of the California Dental Association's (CDA) concerns with the dental assistant infection control course requirements in BPC section 1750. That bill also would repeal BPC section 1755, the new infection control course to resolve the implementation issues raised by Board staff during the November 2024 Council and Board meetings. On April 9, 2025, AB 873 was amended in the Assembly Business and Professions Committee and, among other things, would add new fees in BPC section 1725, subdivision (l), for review of the

approval application or reevaluation to offer courses in interim therapeutic restorations and radiographic decisionmaking (ITR/RDM) (BPC, § 1753.52), radiation safety (BPC, § 1754.5), and infection control (BPC, § 1755). AB 873 currently is on the suspense file in the Assembly Appropriations Committee.

## Discussion

Board staff noted the BPC section 1725 amendments requested by the Board would have set the new dental assistant course fees at $300, which is the same fee set in California Code of Regulations (CCR), title 16, section 1022 for all other course application reviews. Notably, the $300 course fees were enacted in 2017 and have not increased since they were initially established.

Setting the course application fees in statute avoids significant delay otherwise experienced when the Board must set a fee in regulation through the rulemaking process. However, the April 9, 2025 amendments to BPC section 1725 authorized the course fees in an amount not to exceed $300, which would require the actual fees to be set in regulation, further delaying implementation of the new statutory courses.

In addition, the Assembly Appropriations Committee analysis for the April 23, 2025 hearing, on page 2, stated:

> The Board estimates it would receive 173 new applications for approval of infection control courses annually. The Board will need to review each course for compliance with the state's Dental Practice Act and related regulations, minimum standards for infection control such as those set forth by the federal Centers for Disease Control and Prevention, Occupational Safety and Health Administration (OSHA), and California OSHA. The Board estimates it will need one program analyst and an increase in subject matter expert workload of four hours per application, at a rate of $100 per hour in 2026-27 and ongoing. If the Board charged the maximum fee of $300 to review an application, the Board would experience a revenue increase of $52,000 per year, which will not cover the total yearly cost associated with the workload. Assuming the maximum fee, the Board estimates costs of $184,000 in 2026-27 and $176,000 in 2027-28 and ongoing (State Dentistry Fund). [Emphasis added.]

To resolve the fee concern raised in that analysis, Board staff met on April 30, 2025, to review the workload analysis for reviewing the new infection control course applications, as well as the new ITR/RDM and radiation safety courses. During this discussion, Board staff determined that to perform the application review and evaluation required under statute, the Board would need to charge $4,800 for ITR/RDM and radiation safety course applications, which require site visits, and $1,350 for electronic infection control course applications, to cover the Board's costs. Attached for the Board's consideration is a legislative proposal to amend AB 873 to resolve these issues. The legislative

proposal would need to be presented to Assembly Member Alanis and CDA for consideration. Board staff also notes the regulatory course fees will need to be reviewed for potential increases, as well.

## Action Requested

The Board is asked to consider the proposed legislative amendments and Council recommendation. The Board is then asked to make one of the following motions.

Option 1 (support the proposed recommendation): Move the legislative proposal in **Attachment 1** for submission to amend Business and Professions Code section 1725 regarding dental assistant course fees.

Option 2 (support the proposed recommendation as revised during this meeting): Move the legislative proposal in **Attachment 1**, as revised during this meeting, for submission to amend Business and Professions Code section 1725 regarding dental assistant course fees.

Option 3 (no action): If the Board does not wish to act on the recommendation, no motion is needed.

## Attachment

1. Legislative Proposal to Amend AB 873 (Alanis, 2025) Regarding Business and Professions Code Section 1725 and Dental Assistant Course Application Fees

**DENTAL BOARD OF CALIFORNIA**

**LEGISLATIVE PROPOSAL TO AMEND AB 873 (ALANIS, 2025) (as Amended April 9, 2025) REGARDING BUSINESS AND PROFESSIONS CODE SECTION 1725 AND DENTAL ASSISTANT COURSE APPLICATION FEES**

Proposed amendments are indicated in *blue italic* for new text and ~~red strikethrough~~ for deleted text.

Amend Business and Professions Code Section 1725 in AB 873 as follows:

**1725.** The amount of the fees prescribed by this chapter that relate to the licensing and permitting of dental assistants shall be established by regulation and subject to the following limitations:

(a) The application fee for an original license shall not exceed two hundred dollars ($200).

(b) The fee for examination for licensure as a registered dental assistant shall not exceed the actual cost of the examination.

(c) The fee for application and for the issuance of an orthodontic assistant permit or a dental sedation assistant permit shall not exceed two hundred dollars ($200).

(d) The fee for the written examination for an orthodontic assistant permit or a dental sedation assistant permit shall not exceed the actual cost of the examination.

(e) The fee for the Registered Dental Assistant Combined Written and Law and Ethics Examination for a registered dental assistant shall not exceed the actual cost of the examination.

(f) The fee for examination for licensure as a registered dental assistant in extended functions shall not exceed the actual cost of the examination.

(g) The biennial renewal fee for a registered dental assistant license, registered dental assistant in extended functions license, dental sedation assistant permit, or orthodontic assistant permit shall not exceed two hundred dollars ($200).

(h) The delinquency fee shall be 50 percent of the renewal fee for the license or permit in effect on the date of the renewal of the license or permit.

(i) The fee for issuance of a duplicate registration, license, permit, or certificate to replace one that is lost or destroyed, or in the event of a name change, shall not exceed one hundred dollars ($100).

(j) The fee for each curriculum review and site evaluation for educational programs for registered dental assistants that are not accredited by a board-approved agency, or the Chancellor's office of the California Community Colleges shall not exceed seven thousand five hundred dollars ($7,500).

(k) The fee for review of each approval application or reevaluation for a course that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall not exceed two thousand dollars ($2,000).

(l) The fee for review of each approval application or reevaluation for a course provided pursuant to Sections 1753.52~~,~~ *and* 1754.5~~, and 1755~~ that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall ~~not exceed three hundred dollars ($300)~~*be set at four thousand eight hundred dollars ($4,800)*.

*(m) The fee for review of each approval application or reevaluation for a course provided pursuant to Section 1755 that is not accredited by a board-approved agency or the Chancellor's office of the California Community Colleges shall be set at one thousand three hundred fifty dollars ($1,350).*

~~(m)~~*(n)* Fees collected pursuant to this section shall be deposited in the State Dentistry Fund.

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DENTAL BOARD OF CALIFORNIA
2005 Evergreen St., Suite 1550, Sacramento, CA 95815
P (916) 263-2300 | F (916) 263-2140 | www.dbc.ca.gov

# MEMORANDUM

| | |
|---|---|
| **DATE** | April 21, 2025 |
| **TO** | Members of the Dental Board of California |
| **FROM** | Mirela Taran, Administrative Analyst<br>Dental Board of California |
| **SUBJECT** | **Agenda Item 23.:** Public Comment on Future Agenda Items |

## Background

Stakeholders are encouraged to submit comments on future agenda items, including proposals, in writing to the Board before, during or after the meeting for possible consideration by the Board at a future Board meeting.

## Action Requested

No action requested.