



DENTAL BOARD OF CALIFORNIA

**FULL BOARD MEETING
February 27-28, 2014**



**Wyndham Bayside San Diego
1355 North Harbor Drive
San Diego, CA 92101**



BOARD MEETING AGENDA

Thursday, February 27, 2014

Wyndham Bayside San Diego
1355 North Harbor Drive, San Diego, CA, 92101
(619) 232-3861 or (916) 263-2300

Members of the Board

Fran Burton, MSW, Public Member, President

Bruce Whitcher, DDS, Vice President

Judith Forsythe, RDA, Secretary

Steven Afriat, Public Member

Stephen Casagrande, DDS

Yvette Chappell-Ingram, Public Member

Katie Dawson, RDH

Luis Dominicis, DDS

Kathleen King, Public Member

Ross Lai, DDS

Huong Le, DDS, MA

Meredith McKenzie, Public Member

Steven Morrow, DDS, MS

Thomas Stewart, DDS

Debra Woo, DDS

During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should items not be completed, it is possible that it could be carried over and be heard beginning at 8:00 a.m. on the following day. Anyone wishing to be present when the Board takes action on any item on this agenda must be prepared to attend the two-day meeting in its entirety.

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

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

Thursday, February 27, 2014

8:30 A.M. FULL BOARD MEETING – OPEN SESSION

1. Call to Order/Roll Call/Establishment of Quorum
2. Approval of the November 21-22, 2013 Board Meeting Minutes
3. President's Report
4. Presentation by Paul Glassman, DDS, Office of Statewide Health Planning and Development (OSHDP), Regarding Health Workforce Pilot Project (HWPP) #172 and Assembly Bill 1174 (Bocanegra)

RECESS

5. Joint Meeting of the Legislative and Regulatory Committee and the Dental Assisting Council for the Purpose of Discussion and Possible Action Relating to Assembly Bill 1174 (Bocanegra)

RECESS

FULL BOARD RECONVENES

6. Discussion and Possible Action Regarding Assembly Bill 1174 (Bocanegra)
7. **COMMITTEE/COUNCIL MEETINGS – SEE ATTACHED AGENDAS**

➤ DENTAL ASSISTING COUNCIL

See attached Dental Assisting Council agenda

➤ ENFORCEMENT COMMITTEE

See attached Enforcement Committee agenda

➤ LEGISLATIVE AND REGULATORY COMMITTEE

See attached Legislative and Regulatory Committee agenda

➤ EXAMINATION COMMITTEE

See attached Examination Committee agenda

➤ ACCESS TO CARE COMMITTEE

See attached Access to Care Committee agenda

➤ LICENSING, CERTIFICATION, AND PERMITS COMMITTEE

See attached Licensing, Certification, and Permits Committee agenda

8. Discussion and Possible Action Regarding:
 - A. Comments Received During the 45-Day Public Comment Period for the Board's Proposed Rulemaking to: Amend §§ 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036; Add §§ 1032.7, 1032.8, 1032.9, 1032.10; and Repeal §§ 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements
 - B. Adoption of Proposed Amendment of §§ 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036; Proposed Addition of §§ 1032.7, 1032.8, 1032.9, 1032.10; and Proposed Repeal of §§ 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements
9. Discussion and Possible Action Regarding a Special Teleconference Meeting in April to Consider Any Adverse Comments Received Regarding the Board's Modified Text Relative to the Portfolio Examination Requirements Rulemaking
10. Public Comment of Items Not on the Agenda
The Board may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
11. Recess



**DENTAL BOARD OF CALIFORNIA
MEETING MINUTES
November 21-22, 2013**
Sportsmen's Lodge Events Center
Regency Room
4234 Coldwater Canyon Avenue
Studio City, CA 91604

DRAFT

Members Present

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

Members Absent

Staff Present:

Karen Fischer, Executive Officer
Jennifer Thornburg, Assistant Executive Officer
Kim Trefry, Enforcement Chief
Sarah Wallace, Legislative and Regulatory Analyst
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel
Greg Salute, Deputy Attorney General

Thursday, November 21, 2013

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

Dr. Huong Le, President, called the meeting to order at 1:10 p.m. Dr. Steven Morrow, Secretary, called the roll and a quorum was established.

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

Motioned/Seconded/Carried (M/S/C) (Afriat/ King) to approve the August 26-27, 2013 Board Meeting minutes and the October 9, 2013 Teleconference minutes. The motion passed unanimously.

3. **President's Report**

Dr. Le, President provided a recap of the Board's accomplishments over the past year that she has been President. She thanked the public members and staff for their help and feedback. She recognized the guests in the audience; Dr. Alan Felsenfeld, Gail Mathe and Bill Lewis from the California Dental Association (CDA), from the Dental Hygiene Committee of California (DHCC), Lori Hubble and Donna Kantner, Dr. Paul Reggiardo, California Association of Pediatric Dentists (CAPD), Dr. Earl Johnson, California Association of Orthodontists (CAO), Dr. Charles Broadbent, Western Regional Examination Board (WREB), Corrine Fishman, Department of Consumer Affairs (DCA) Headquarters, Lisa Okamoto, RDH, California Hygienists Association (CDHA), Dr. Lori Gagliardi, California Association of Dental Assisting Teachers (CADAT), and Dr. Guy Acheson, California Association of General Dentists (CAGD).

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

Corrine Fishman, from the Department of Consumer Affairs (DCA) Executive Office provided an update of current events throughout DCA including the department's information technology project, BreZE, the conversion to the new travel reimbursement system, CalATERS Global and an overview of the mandatory training requirements for Board, Council and Committee members.

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

Lori Hubble, Executive Officer of the Dental Hygiene Committee of California read a letter from DHCC President Michele Hurlbutt to Board President Dr. Huong Le. Ms. Hubble reported that DHCC is working on legislation to change the law so that Registered Dental Hygienists in Alternative Practice (RDHAP) can continue to work in underserved areas even after a designation of no longer underserved. Ms. Hubble reported that they are working on raising their statutory cap, continued competency goals and Sunset Review. There was discussion about the DHCC's desire to become a Board.

Dr. Le, Board President provided a review of Senator Bill Emmerson's accomplishments and presented him with a plaque from the Dental Board expressing their gratitude for his service in the Legislature.

6. **Examinations**

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

Dr. Charles Broadbent provided a review of the history of WREB. He then provided a Powerpoint Presentation. There was discussion about why there isn't a national examination and the WREB examiners.

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

i. Portfolio Examination Audit Handbook

Dawn Dill, Licensing Manager, provided an overview of the material provided including an explanation of the Audit Process. There was discussion about the Portfolio processes.

ii. Portfolio Examiner Calibration/Standardization Training Material

Ms. Dill provided an overview of the materials provided. Dr. Alan Felsenfeld, CDA commented that CDA is supportive of the Portfolio process.

7. Enforcement

A. Enforcement Program Status

Kim Trefry, enforcement Chief provided a report on the status of the Enforcement Program. There was discussion about the merits versus cost of the task force operation.

B. Enforcement Program Statistics

Ms. Trefry provided an overview of the statistics provided.

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

Ms. Trefry provided an overview of information provided.

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

Ms. Trefry provided an overview of the report provided. Gail Mathey, CDA commented that they would like to partner with the Access to Care Committee.

8. Licensing, Certification, and Permits

A. Review of Dental Licensure and Permit Statistics

Dawn Dill, Licensing Manager reviewed the statistics provided. There was discussion about professional shortage areas and where community clinics are located.

B. Review of General Anesthesia/Conscious Sedation Evaluation Statistics

Ms. Dill reviewed the statistics provided.

C. Update on General Anesthesia/Conscious Sedation Calibration Webinar

Ms. Dill provided an update. Dr. Guy Acheson requested statistics to show the rate of population growth versus growth in the number of licensed dentists by county.

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

- i. **The American Association of Oral and Maxillofacial Surgeons' (AAOMS) Requirements, Effective January 1, 2014; and,**
Sarah Wallace, Legislative and Regulatory Analyst, provided an overview of the AAOMS new capnography requirements, effective January 2014.
- ii. **The Dental Board of California's Requirement (California Code of Regulations, Title 16, Section 1043.3(a)(7)(K))**
Ms. Wallace explained that the Dental Board does not have any new capnography requirements effective in 2014.

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

There was no public comment.

The Board went into Closed Session at 5:28 p.m.

10. **Recess**

The Board recessed at 6:28 p.m.

Friday, November 22, 2013

11. **Call to Order/Roll Call/Establishment of Quorum**
Dr. Huong Le, President, called the meeting to order at 8:37 a.m. Dr. Steven Morrow, Secretary, called the roll and a quorum was established. The Board immediately went into Closed Session. The Full Board reconvened at 10:07 a.m.
12. **Report from the Licensing, Certification and Permits Committee Regarding Closed Session**
Dr. Whitcher, Chair of the Licensing, Certification and Permits Committee, reported that the committee reviewed one application for a license to replace a cancelled license from applicant MLC. The committee recommends approval of this application. M/S/C (Afriat/Forsythe) to accept the committee's recommendation to approve applicant MLC's license to replace cancelled license. The motion passed unanimously.

Fran Burton, Vice President, presented a plaque to Dr. Huong Le in appreciation of her hard work the past year as Dental Board President.
13. **Executive Officer's Report**
Karen Fischer, Executive Officer of the Dental Board, provided an update on what has been happening at the Dental Board since the last meeting and all the events she attended on behalf of the Dental Board.
14. **Budget Report**
Karen Fischer, Executive Officer of the Dental Board, reviewed the statistics provided.

Kim Trefry, Enforcement Chief gave an overview of the cost recovery program. There was discussion surrounding the factors that prevent collection of 100% of the fees owed.
15. **Update and Revision of the Board Member Administrative Procedure Manual**
Ms. Fischer asked the Board members to review the changes provided and provide comments to staff by mid January. M/S/C (Afriat/Burton) to provide comments and bring back to review at the February 2014 Dental Board meeting. The motion passed unanimously.
16. **Diversion Program**
 - A. **Diversion Program Background**
Lori Reis, Diversion Program Manager, reviewed the memo provided.
 - B. **Presentation by Maximus Regarding the Dental Board of California**
Virginia (Ginny) L. Matthews, RN, BSN, MBA, and William (Bill) Frantz, RN, Project Managers from MAXIMUS provided an overview of MAXIMUS, Inc.

C. Presentation by the California Dental Association (CDA) of its Well-Being Program

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

D. Diversion Program Statistics

Ms. Reis reviewed the statistics provided.

17. **Legislation**

A. 2014 Tentative Legislative Calendar – Information Only

Sarah Wallace, Legislative and Regulatory Analyst, reviewed the calendar provided.

B. Discussion and Possible Action Regarding 2013 End-of-Year Legislative Summary Report

Ms. Wallace provided a summary of the bills that the Board and staff have tracked throughout the past year. Katie Dawson, RDH, requested a definitive answer as to whether or not SB 562 (Galgiani) Dentists: Mobile or Portable Units, applies to hygienists.

C. Update Regarding Previously Approved Legislative Proposal Regarding Delegation of Authority to Accept the Findings of any Commission or Accreditation Agency Approved by the Board and Adopt those Findings as its Own Relating to the Approval of Foreign Dental Schools

Ms. Wallace provided an overview of the material provided.

D. Discussion and Possible Action Regarding Legislative Proposals for 2014:

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

Karen Fischer, Executive Officer and Jennifer Thornburg, Assistant Executive Officer provided an overview of the information provided including an explanation of the study that justifies increasing the maximum fees. M/S/C (Burton/Afriat) to collect information and seek an author.

Dr. Alan Felsenfeld, California Dental Association (CDA), commented that he would suggest waiting a year or two to do this during Sunset Review. Ms. Fischer stated that raising the cap on the maximum fee does not necessarily mean that fees will be raised immediately. Mr. Afriat commented that it takes one to two years to complete a

regulatory change. He suggests going forward with this modest and prudent request. The motion passed unanimously.

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

Ms. Wallace gave an overview of the information provided.

E. **Discussion and Possible Action Regarding Future Proposal to Amend Business and Professions Code §§1646 to 1647.26 Relating to General Anesthesia, Conscious Sedation, and Oral Conscious Sedation**

Dr. Bruce Witcher gave an overview of the information provided. Dr. Le suggested that this discussion be continued in the Licensing, Certification and Permits Committee at the next Board meeting. Dr. Paul Reggiardo, California Society of Pediatric Dentistry (CSPD), commented that they are fully supportive of these amendments especially for minor dental patients. Dr. Dee Nishimine, California Society of Periodontists, requested that they be included as an interested party. M/S/C (Burton/Afriat) to move this item to the Licensing, Certification and permits committee for further discussion. There was no public comment. The motion passed unanimously.

F. **Prospective Legislative Proposals**

There were no legislative proposals.

G. **Update on Pending Regulatory Packages:**

i. **Uniform Standards for Substance Abusing Licensees (California Code of Regulations, Title 16, Sections 1018 and 1018.01);**

Ms. Wallace provided an update on the progress of this regulatory package as stated in the memo that was provided.

ii. **Dentistry Fee Increase (California Code of Regulations, Title 16, Section 1021);**

Ms. Wallace gave an overview of the information provided including possible dates that the regulation could become effective.

iii. **Portfolio Examination Requirements (California Code of Regulations, Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033, 1033.1, 1034, 1034.1, 1035, 1035.1, 1035.2, 1036, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039)**

Ms. Wallace gave an update on the progress of the Portfolio Examination Requirements regulations as provided in the memo.

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

Ms. Wallace gave an update on the status of the Abandonment of Applications regulations as provided in the memo.

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

Ms. Wallace gave an overview of the information provided. M/S/C (Morrow/Dominicis) to direct staff to file a “Section 100” to make a change without regulatory effect to amend California Code of Regulations, Title 16, Section 1065. There was discussion regarding the need for this change or not. Dr. Paul Reggiardo commented that he felt the change to “Notice” would be clearer. The motion passed with 13 ayes and one opposed.

18. **Report from the Dental Assisting Council**

Judy Forsythe, Chair, reported that the August 28, 2013 Dental Assisting Council (DAC) meeting minutes were tabled for further review at the request of Dr. Lori Gagliardi. The Council requests that the Board consider delegating approval of Dental Assisting Programs and Courses to the Council. Ms. Forsythe requested this be a future meeting agenda item. Ms Forsythe reported that the Council will be looking at examination processes and sites. The DAC will be meeting on December 12, 2013 to discuss Dental Assisting Program and Course requirements. Ms. Forsythe reported that the Council elected Teresa Lua as 2014 Chair and Anne Contreras as 2014 Vice Chair of the Dental Assisting Council.

19. **Election of Board Officers for 2014**

Steve Afriat nominated Fran Burton for President. Ms. Burton accepted the nomination. M/S/C (Morrow/Afriat) to elect Fran Burton President of the Dental Board. The motion passed unanimously.

Steve Afriat nominated Dr. Bruce Witcher for Vice President. Dr. Witcher accepted the nomination. M/S/C (Afriat/Forsythe) to elect Dr. Bruce Witcher as Vice President of the Dental Board. The motion passed unanimously.

Fran Burton nominated Judy Forsythe for Secretary of the Dental Board. Ms. Forsythe accepted the nomination. M/S/C (Burton/Chappell-Ingram) to elect Judy Forsythe as Secretary of the Dental Board. The motion passed unanimously.

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

There were no public comments.

21. **Future Agenda Items**

Kathleen King requested a report on the CDA program “Give Kids a Smile”.

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

There were no Board Member comments.

23. **Adjournment**

The meeting was adjourned at 2:38 p.m.



MEMORANDUM

DATE	February 13, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	Agenda Item 3: President's Report

The President of the Dental Board of California, Fran Burton, MSW, will provide a verbal report.



MEMORANDUM

DATE	February 19, 2014
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 4: Presentation by Paul Glassman, DDS, Office of Statewide Health Planning and Development (OSHDP), Regarding Health Workforce Pilot Project (HWPP) # 172 and Assembly Bill 1174

Dr. Paul Glassman will be presenting information regarding the OSHPD HWPP #172. The findings of HWPP #172 were used to develop Assembly Bill 1174. Dr. Glassman will be accompanied by Ms. Kathryn Scott, representing The Children's Partnership, who will be available to answer questions regarding Assembly Bill 1174.

Both Dr. Glassman and The Children's Partnership are supporters of AB 1174, which is sponsored by its author, Assembly Member Bocanegra.



MEMORANDUM

DATE	February 19, 2014
TO	Legislative and Regulatory Committee Dental Assisting Council
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 5: Joint Meeting of the Legislative and Regulatory Committee and the Dental Assisting Council for the Purpose of Discussion and Possible Action Relating to Assembly Bill 1174 (Bocanegra)

Background:

The Legislative and Regulatory Committee (Committee) and the Dental Assisting Council (Council) will be having a joint meeting for the purpose of discussing and possibly taking action to recommend a position on AB 1174 to full Board for consideration. Dr. Glassman and Ms. Scott will be available to answer any questions of the Committee and the Council.

Staff has included an analysis of AB 1174 and a copy of the most recently amended version of the bill in the meeting materials for the Committee's and the Council's review.

Action Requested:

The Committee and the Council may recommend one of the following positions to the full Board for consideration regarding AB 1174.

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

The staff recommendations regarding a position on AB 1174 is included in the bill analysis.

**DENTAL BOARD OF CALIFORNIA
BILL ANALYSIS
FEBRUARY 27-28 BOARD MEETING**

BILL NUMBER: Assembly Bill 1174

AUTHOR: Assembly Member Bocanegra **SPONSOR:**

VERSION: Amended 01/06/2014 **INTRODUCED:** 02/22/2013

BILL STATUS: 02/06/2014 – To Senate
Committee on Business,
Professions and Economic
Development **BILL LOCATION:** Senate Committee
on Business,
Professions and
Economic
Development

SUBJECT: Dental Professionals:
Teledentistry Under Medi-Cal **RELATED
BILLS:**

SUMMARY

This bill authorizes Medi-Cal payments for teledentistry services provided to individuals participating in the Medi-Cal program and expands duties of registered dental assistants (RDAs), RDAs in extended functions (RDAEF), registered dental hygienists (RDH), and registered dental hygienists in alternative practice (RDHAP).

Specifically, this bill:

1) Applies existing law applicable to teleophthalmology and teledermatology to teledentistry, as follows:

a) Provides, to the extent federal financial participation (FFP) is available, that face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teledentistry by store and forward. Subjects services appropriately provided through the store and forward process to billing and reimbursement policies developed by the Department of Health Care Services (DHCS);

b) Requires a patient receiving teledentistry by store and forward to be notified of their right to receive interactive communication with the distant dentist and to receive interactive communication with the distant dentist, upon request, which may occur either at the time of the consultation or within 30 days of the patient's notification of the results of the consultation; and,

c) Permits DHCS to implement, interpret, and make specific the provisions of this bill by means of all-county letters, provider bulletins, and similar instructions; On or before January 1, 2008, DHCS to report to the Legislature the number and type of services provided and the payments made related to the application of store and forward teledentistry provided as a Medi-Cal benefit.

2) Authorizes an RDA to determine which radiographs to perform if the RDA has completed an educational program in those duties approved by the Dental Board of California (Board), or if he or she has provided evidence satisfactory to the Board of having completed a Board-approved course in those duties.

3) Defines the following terms:

a) Clinical instruction means instruction in which students receive supervised experience in performing procedures in a clinical setting on patients. Requires clinical instruction to be performed only upon successful demonstration and evaluation of preclinical skills. Requires at least one instructor for every six students who are simultaneously engaged in clinical instruction;

b) Course means a Board-approved course preparing an RDAEF to perform the duties specified in 4) below;

c) Didactic instruction means lectures, demonstrations, and other instruction without active participation by students. Authorizes an approved provider or its designee to provide didactic instruction through electronic media, home study materials, or live lecture methodology if the provider has submitted that content to the Board for approval;

d) Interim therapeutic restoration (ITR) means a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment;

e) Laboratory instruction means instruction in which students receive supervised experience performing procedures using study models, mannequins, or other simulation methods; and,

f) Preclinical instruction means instruction in which students receive supervised experience performing procedures on students, faculty, or staff members. Requires at least one instructor for every six students who are simultaneously engaged in preclinical instruction.

4) Authorizes a RDAEF licensed on or after January 1, 2010, and pursuant to the order, control and full professional responsibility of a supervising dentist, a RDH, or a RDHAP to perform both of the following additional duties:

a) Choose radiographs without the supervising dentist having first examined the patient, following protocols established by the supervising dentist and, consistent with the use of as low as reasonably necessary radiation for the purpose of diagnosis and treatment planning by the dentist. Requires the radiographs to be taken only in either of the following settings:

i) In a dental office setting, under the direct or general supervision of a dentist as determined by the dentist; and for RDH and RDHAP, under the general supervision of a dentist; or,

ii) In public health settings, including but not limited to, schools, head start and preschool programs, and residential facilities and institutions, under the general supervision of a dentist.

b) Place protective restorations, which for this purpose are identified as ITRs, as defined, that compromise the removal of soft material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material, and only when local anesthesia is not necessary. The protective restorations are to be placed only in accordance with both of the following:

i) In either of the settings specified in 4) a) i) and ii) above; and,

ii) After a diagnosis and treatment plan by a dentist.

5) Authorizes the functions specified in 4) above to be performed by an RDAEF, RDH, and RDHAP only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the Board or Dental Hygiene Committee (Committee), of having completed a Board- or Committee-approved course in those functions.

6) Deems RDAEF, RDH, or RDHAP who has completed the prescribed training in the Health Workforce Pilot Project No. 172 (HWPP No. 172) established by the Office of Statewide Health Planning and Development (OSHPD), as specified, to have satisfied the requirement for completion of a course of instruction approved by the Board or Committee.

7) Requires, in addition to the instructional components described in 8) and 9) below, a program to contain both of the following instructional components:

a) The course to be established at the postsecondary educational level; and,

b) All faculty responsible for clinical evaluation shall have completed a one-hour methodology course in clinical evaluation or have a faculty appointment at an accredited dental education program prior to conducting evaluations of students.

8) Requires a program or course to perform the duties specified in 4) a) above (choose radiographs) to contain all of the following additional instructional components:

a) The program must be of sufficient duration for the student to develop minimum competency making decisions about which radiographs to take to facilitate an evaluation by a dentist, but in no event be less than six hours, including at least two hours of didactic training, at least two hours of guided laboratory simulation training, and at least two hours of examination using simulated cases;

b) Didactic instruction must consist of instruction on both the following topics:

i) Guidelines for radiographic decisionmaking prepared by the American Dental Association and other professional dental associations; and,

ii) Specific decisionmaking protocols that incorporate information about the patient's health and radiographic history, the time span since previous radiographs were taken, the availability of previous radiographs, the general condition of the mouth including the extent of dental restorations present, and visible signs of abnormalities, including broken teeth, dark areas, and holes in teeth.

c) Laboratory instruction must consist of simulated decisionmaking using case studies containing the elements specified in 8) b) above. Requires at least one instructor for every 14 students who are simultaneously engaged in laboratory instruction; and,

d) Examinations to consist of decisionmaking where students make decisions and demonstrate competency to faculty on case studies containing the elements described in b) above.

9) Requires a program or course to perform the duties described in 4) b) above (place protective restorations) to contain all of the following additional instructional components:

a) The program must be of sufficient duration for the student to develop minimum competency in the application of protective restorations, including ITRs, but in no event be less than 16 clock hours, including at least four hours of didactic training, at least four hours of laboratory training, and at least eight hours of clinical training;

b) Didactic instruction to consist of instruction on specified topics, including: i) pulpal anatomy; ii) theory of adhesive restorative materials used in the placement of adhesive protective restorations related to mechanisms of bonding to tooth

structure, handling characteristics of the materials, preparation of the tooth prior to material placement, and placement techniques; iii) criteria that dentists use to make decisions about placement of adhesive protective restorations, as specified, including patient factors, as specified, and, tooth factors, as specified; iv) criteria for evaluating successful completion of adhesive protective restorations, as specified; v) protocols for handling sensitivity, complications, or unsuccessful completion of adhesive protective restorations including situations requiring immediate referral to a dentist; and vi) protocols for follow-up of adhesive protective restorations, as specified;

c) Laboratory instruction must consist of placement of adhesive protective restorations where students demonstrate competency in this technique on typodont teeth; and,

d) Clinical instruction must consist of experiences where students demonstrate placement of adhesive protective restorations under direct supervision of faculty.

10) The education requirements for the courses would be repealed as of January 1, 2018 with the expectation that the Board or the Committee would implement such requirements via the regulatory process.

11) Defines teledentistry consistent with existing law's definition of teleophthalmology and teledermatology.

12) Makes other conforming changes.

Existing law:

1) Establishes the Medi-Cal program under which qualified low-income persons receive health care benefits.

2) Provides, to the extent FFP is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Indicates that services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by DHCS.

3) Defines, "teleophthalmology and teledermatology by store and forward" as an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by a licensed optometrist where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time.

4) Prohibits in-person contact between a health care provider and a patient from being required under the Medi-Cal program for services appropriately provided through

telehealth, subject to reimbursement policies adopted by DHCS to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed pursuant to the Medi-Cal program.

5) Prohibits DHCS from requiring a health care provider to document a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.

6) Prohibits DHCS, for the purposes of payment for covered treatment or services provided through telehealth, from limiting the type of setting where services are provided for the patient or by the health care provider.

7) Establishes the Dental Practice Act, administered by the Board, to regulate the practice of dentistry. Requires the Board to review and evaluate all applications for licensure in all dental assisting categories. Requires the Board at least every seven years to review the allowable duties for dental assistants, RDAs, and RDAEFs. Establishes the Dental Assisting Council of the Board to consider all matters relating to dental assistants.

8) Defines a dental assistant as someone who is without a license and may perform basic supportive dental procedures. Requires the Board to license RDAs and RDAEFs upon completion of specified education, work requirements, passage of a written examination and a clinical or practical examination.

9) Establishes the Committee within the jurisdiction of the Board to, among other functions, evaluate all RDH educational programs, determine the appropriate type of licensure examination, and deny, suspend, or revoke a license of a RDH.

10) Defines direct supervision as supervision of dental procedures based on instructions given by a licensed dentist who must be physically present in the treatment facility during the performance of these procedures. Defines general supervision as supervision of dental procedure based on instructions given by a licensed dentist but not requiring the physical presence of the supervising dentist during the performance of those procedures.

PURPOSE OF THIS BILL:

The author believes existing law does not allow Medi-Cal to pay for the use of teledentistry services, especially store and forward dental care. The author is also concerned about the shortage of dental services in rural areas. The author cites a 2008 University of California, Los Angeles study that found that California has about 14% of the dentists in the nation (about 3.5 dentists for every 5,000), slightly higher than the national average, however, according to the author, California has 233 dental shortage areas. The author indicates that dentists cluster around urban communities which leave many rural and urban underserved communities without dentists. The author says Yuba County has less than one dentist for every 5,000 people, and counties such as Colusa, Imperial, Mariposa, Mono, and San Benito have less than 1.5 dentists for every 5,000 people. The author states that every dentist in these counties needs to be utilized to the

full extent of their ability. According to the author, the report found that California could soon be facing a dentist shortage since there will soon be more dentists retiring (19% have been licensed for 30+ years) compared to coming into the system (15% have been licensed for less than five years).

BACKGROUND:

a) Virtual Dental Home. According to an article published in July 2012 in the *Journal of the California Dental Association (CDA Journal)*, “The Virtual Dental Home: Bringing Oral Health to Vulnerable and Underserved Populations,” the traditional office and clinic-based oral health delivery system is failing to reach a large and increasing segment of the population. The *CDA Journal* article says that in California, oral health disparities are more severe than the national average, particularly among low-income and disabled populations. Just 25% of Medi-Cal beneficiaries reported a dental visit in 2007 and among pregnant women with Medi-Cal coverage only one in seven received dental services. Almost one-quarter of all children in California have never seen a dentist and about 40% of California’s black, Latino, and Asian preschoolers and approximately 65% of elementary school children in these groups need dental care. In 2011, only 22% of the total number of people eligible for Medi-Cal dental services received any service, a decrease of 8% from 2009. A decrease was expected for adults since most adult dental benefits were eliminated in 2009; however there was also a decrease for children. In 2011, only 27% of eligible children received any dental service compared to 34% in 2009. In California, approximately 6.3 million children, or two-thirds of all children in the state, suffer needlessly from poor oral health by the time they reach the third grade. Approximately 7% of California children missed school due to a dental problem in 2007, excluding time for cleaning or routine check-up. In 2007, there were more than 83,000 visits to California hospital emergency departments for preventable dental conditions.

b) Institute of Medicine (IOM) Report on Oral Health (2011). In 2011 the IOM published a report titled, “Improving Access to Oral Health Care for Vulnerable and Underserved Populations.” Various factors create barriers, preventing access to care for vulnerable and underserved populations, such as children and Medicaid beneficiaries. The Health Resources and Services Administration and the California HealthCare Foundation (CHCF) asked the IOM and the National Research Council to assess the current oral health care system, to develop a vision for how to improve oral health care for these populations, and to recommend ways to achieve this vision. According to the IOM report, access to oral health care across the life cycle is critical to overall health, and it will take flexibility and ingenuity among multiple stakeholders—including government leaders, oral health professionals, and others—to make this access available. The IOM report says to improve provider participation in public programs, states should increase Medicaid and Children’s Health Insurance Program reimbursement rates. In addition, with proper training, nondental health care professionals can acquire the skills to perform oral disease screenings and provide other preventive services. The IOM report calls on dental schools to expand opportunities for dental students to care for patients with complex oral health care needs in community-based settings in order to improve the students’ comfort levels in caring for vulnerable and underserved populations.

Finally, according to the IOM report, states should examine and amend state practice laws to allow healthcare professionals to practice to their highest level of competence. The IOM's recommendations provide a roadmap for the important and necessary next steps to improve access to oral health care, reduce oral health disparities, and improve the oral health of the nation's vulnerable and underserved populations.

c) HWPP No. 172. The HWPP at OSHPD permits temporary legal waivers of certain practice restrictions or educational requirements to test expanded roles and accelerated training programs for health care professionals. In December 2010, OSHPD approved HWPP No. 172 that allowed RDAs and RDHS to perform an expanded scope of practice. Specifically, the HWPP involved RDAs making decisions on which radiographs to take, if any, to facilitate an initial oral evaluation by a dentist. Secondly, RDAs, RDHs, and RDHs in alternative practice will be permitted to place ITRs. The long-term objective of the project is to facilitate the development of new models of care designed to improve the oral health status of underserved populations. The project has been extended twice, with the second extension running from December 1, 2012 to December 1, 2013. Funding for HWPP No. 172 comes from various sources including CHCF, American Dental Hygiene Association, American Dental Association, Paradise Foundation, and Verizon Foundation. Evaluation of the project is also funded by CHCF. HWPP No. 172 is a project at the University of Pacific, School of Dentistry which creates a virtual dental home and is testing a concept where patients interact with RDAs and RDHs after a telehealth consultation with a collaborating dentist who makes diagnostic and treatment decisions and determines the best location for treatment, thus creating a true community-based dental home. There are nine sites currently operating this model of care in California. Preventive and early intervention care is being provided in the community (two elementary schools in Sacramento and San Diego counties, a consortium of Head Start centers in San Francisco and San Diego, residential facilities associated with three regional centers for persons with developmental disabilities, four long-term care facilities, and one community clinic). Patients with advanced disease requiring the service of a dentist are being referred to dental offices and clinics. A policy brief describing the model and the results of the current project indicates that under HWPP No. 172, allied dental personnel completed the following types of procedures: collect patient information (including medical and dental history, consent forms, and caries risk assessment); chart pre-existing conditions; take digital radiographs; take digital intra and extra-oral photographs; prophylaxis; fluoride varnish; sealants; ITRs; patient, parent, and staff oral health education; nutritional counseling; oral hygiene instructions; case management; referrals; and, communication with collaborating dentists. As of March 31, 2013, a total of 1,494 patients have been seen: Head Start centers (797); elementary schools (212); long-term care facilities (176); multifunction community centers (197); and, regional centers (112). The policy brief also indicates that 110 ITRs were placed during the training phase of the program in addition to the 295 placed in the utilization phase for a total of 405.

d) ITR. According to the American Academy of Pediatric Dentistry, an ITR may be used to restore and prevent further decalcification and caries in young patients, uncooperative patients, or patients with special health care needs or when traditional

cavity preparation and/or placement of traditional dental restorations are not feasible and need to be postponed. Additionally, ITR may be used for step-wise excavation in children with multiple open carious lesions prior to definitive restoration of the teeth. The use of ITR has been shown to reduce the levels of cariogenic oral bacteria (e.g., mutans streptococci, lactobacilli) in the oral cavity. The ITR procedure involves removal of caries using hand or slow speed rotary instruments with caution not to expose the pulp. Leakage of the restoration can be minimized with maximum caries removal from the periphery of the lesion. Following preparation, the tooth is restored with an adhesive restorative material such as self-setting or resin-modified glass ionomer cement. ITR has the greatest success when applied to single surface or small two surface restorations. Inadequate cavity preparation with subsequent lack of retention and insufficient bulk can lead to failure. Follow-up care with topical fluorides and oral hygiene instruction may improve the treatment outcome in high caries-risk dental populations.

e) Regulation of RDAs, RDAEFs, and RDHs in California. In 2008, AB 2637 (Eng), Chapter 499, Statutes of 2008, established the current practice structures for RDAs, RDAEFs, and other dental assisting categories. AB 2637 contains a consensus language that was a product of several years of negotiation. The California Dental Association, the Dental Assisting Alliance which represents dental assisting schools and dental assistants, the California Association of Oral and Maxillofacial Surgeons, the California Society of Periodontists, and the California Association of Orthodontists all participated in a process of evaluating a more feasible and effective dental assisting structure, the result of which are the provisions adopted in AB 2637. Current law authorizes an RDA to, among various functions, apply and activate bleaching agents, obtain intraoral images for computer-aided design, chemically prepare teeth for bonding, place, adjust, and finish direct provisional restorations, place periodontal dressing, and place ligature ties and archwires. On the other hand, RDAEFs can perform all the functions of an RDA, and under direct supervision, and pursuant to the order of, control, and full professional responsibility of a licensed dentist: conduct preliminary evaluation of the patient's oral health; perform oral health assessments in school-based community health projects settings, as specified; size and fit endodontic master points and accessory points; and, adjust and cement permanent indirect restorations. These additional procedures could only be performed by a RDAEF upon evidence of having completed Board-approved courses in the additional procedures. Additionally, a RDAEF must also successfully complete an examination consisting of the additional procedures that would be performed. This examination is administered by the Board. Unlike for RDAs and RDAEFs, the Committee exists to license, regulate, and discipline RDHs. RDHs can perform soft tissue curettage, administer local anesthesia or nitrous oxide and oxygen, whether administered alone or in combination with each other, but only under the direct supervision (the dentist is physically present in the treatment facility). Under general supervision, RDHs are authorized to perform preventive and therapeutic interventions (including oral prophylaxis, scaling, and root planing), application of topical, therapeutic, and subgingival agents used for the control of caries and periodontal disease, and the taking of impressions for bleaching trays, as

specified. The law also authorizes RDHs licensed as of December 31, 2005, to perform the duties of an RDA.

BOARD STAFF ANALYSIS:

Board staff has concerns regarding the language's impact on the existing RDA licensure program and the implementation of these provisions.

Specifically, staff has the following concerns.

- Amendment of Business and Professions Code (BPC) § 1752.4(b): RDAs must complete Board-approved educational requirements in order to perform the duties contained in subdivision (b), the Board currently has existing regulatory requirements for the approval of ultrasonic scaling courses, orthodontic assistant permit courses, and dental sedation assistant permit courses. Pursuant to BPC 1752.1, applicants for RDA licensure on or after January 1, 2002 are required to successfully complete a Board-approved course in radiation safety and a Board-approved course in coronal polishing as a condition of licensure. Since the proposed provisions relating to the course an RDAEF would have to take to be able to choose radiographs does not apply to the RDA licensure category, the Board would need clarification as to what course requirements would need to be satisfied for an RDA to be able to determine which radiographs to perform.
- Addition of BPC § 1753.55: Staff has several concerns regarding this section. Specifically, staff has identified the following issues:
 - The definitions contained in this section seem to be derived from existing Board regulations pertaining to dental assisting educational programs and courses. Since the Board and the Dental Assisting Council are in the process of updating the requirements, staff will need to evaluate how these new definitions may impact existing law and the proposal that is being developed.
 - Since the educational component of this bill has a repeal date of January 1, 2018, the Board will need to promulgate a regulation to implement the course approval requirements to amend the current requirements for RDAEF programs and implement the requirements for the Board-approved courses in the additional duties.
 - There does not appear to be a Board examination requirement, and the authorization to perform these additional duties seems to rely entirely on completion of a program or course that includes training in performing these additional duties. Applicants for RDAEF licensure are required to pass a written examination and a clinical and practical examination in specified procedures. Additionally, RDAEFs that were licensed prior to January 1, 2010 are required to pass the practical portion of the exam to be able to perform the expanded duties allowed after January 1, 2010.

Staff believes the Board may want to discuss if an RDAEF should have to pass some sort of examination to ensure minimum competency for the purpose of promoting consumer protection.

- The Board will need to make changes to the licensing systems in order to provide a mechanism by which members of the public, licensees, and stakeholders may easily identify a RDAEFs authorization to perform the additional duties. This would require changes to the existing Legacy systems and BreEze.
- It should be noted that not all RDAEFs are authorized to perform the same duties. Those RDAEFs licensed prior to January 1, 2010 have had to complete additional education and examination requirements in order to perform the duties in BPC § 1753.5(1), (2), (5), and (7) – (11). The Board had developed a license type (RDAEF2) to distinguish those RDAEFs license prior to January 1, 2010 who have complied with the educational requirements and have successfully passed the examination to perform the new duties from those who have not. Board staff believes clarification may be needed as to whether an RDAEF2 would be able to be licensed in the proposed additional duties.
- The Board would need to develop a process to be able to verify a RDAEFs completion of the training in HWPP #172. The Board may want to discuss what requirements would be considered satisfactory.
- Amendments to BPC § 1753.6: The amendments to this section may adversely impact the provisions and how they apply to existing licensees. This section was applicable when AB 2637 expanded the scope of the RDAEF duties.
- Addition of BPC §1910.5: Staff believes the DHCC would initially need dentists to teach the course in ITR's since they have never been trained or licensed to perform the procedure. The Board may want to discuss whether there should be a requirement for work experience before allowing RDAEFs or RDHs to teach the course.
- Since the Board and the DHCC have separate rulemaking authority, there is potential for the course requirements to take separate directions if the regulations are promulgated separately.
- The Board may want to consider discussing requesting a delayed effective date of the bill if it enacted to ensure adequate implementation time and to make necessary modifications to the Board's licensing system.
- The number of licensees that would be interested in expanding their scope of practice as a result of this bill is unknown.

- The Board does not have existing staff resources to dedicate to the implementation and ongoing approval of the new programs and courses required by this bill. We anticipate needing to hire an additional staff person.
- In its current version, it is not clear the impact the bill will have on the dental assisting licensing staff that issue licenses to RDAs and RDAEFs; it is possible that the Board may need to hire an additional staff person.
- As currently written, changes to the Legacy and Breeze systems will be necessary to implement a license type so that the Board, licensees, and consumers will know if an RDAEF is permitted to perform the proposed duties.
- Staff anticipates that the Board will incur expenses to pursue disciplinary action on those licensees who may commit gross negligence as a result of the new scope of duties proposed. We estimate that the Board may see up to 10 additional cases annually that will require referral to the Attorney General's Office. The Board estimates that each case costs an average of \$5,000 (\$3,500 Attorney General's Office fees + \$750 Office of Administrative Hearing + \$750 evidence/witness expenses).

REGISTERED SUPPORT/OPPOSITION

Support

100% Campaign
 Alzheimer's Association
 Brighter Smiles for You Mobile Dental Hygiene Services
 California Academy of Physician Assistants
 California Coverage & Health Initiatives
 California Primary Care Association
 California School Health Centers Association
 California School-Based Health Alliance
 Children Now
 Children's Defense Fund California
 Children's Partnership
 Community Clinic Association of Los Angeles County
 Connecting to Care
 Golden Gate Regional Center
 La Maestro Community Health Centers
 Los Angeles Area Chamber of Commerce
 Los Angeles Trust for Children's Health
 Los Angeles Unified School District
 Maternal and Child Health Access
 Open Door Community Health Centers
 Oral Health Access Council
 PICO California
 United Ways California
 Venice Family Clinic

Western Dental Services Inc
Worksite Wellness LA
Several individuals

Support if Amended:

California Association of Oral and Maxillofacial Surgeons (CALAOMS)
California Dental Association (CDA)

Oppose Unless Amended:

California Dental Hygienists' Association (CDHA)

Opposition

None on File

STAFF RECOMMENDATION

Staff recommends a position of "Support if Amended" with amendments to the bill to address staff's concerns.

AMENDED IN ASSEMBLY JANUARY 6, 2014

AMENDED IN ASSEMBLY APRIL 9, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1174

Introduced by Assembly Members Bocanegra and Logue

February 22, 2013

An act to amend Sections 1752.4, ~~1753.5, 1753.6,~~ and 1910, and 1926 of, to amend, repeal, and add Section 1753.6 of, and to add, repeal, and add Sections 1753.55, 1910.5, and 1926.05 of, the Business and Professions Code, and to ~~add Section 14132.726 to amend Section 14132.725 of~~ the Welfare and ~~Institution~~ *Institutions* Code, relating to oral health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1174, as amended, Bocanegra. Dental professionals: teledentistry under Medi-Cal.

(1) Existing law, the Dental Practice Act, establishes the Dental Board of California. Existing law creates, within the jurisdiction of the board, a Dental Assisting Council that is responsible for the regulation of dental assistants, registered dental assistants, and registered dental assistants in extended functions and a Dental Hygiene Committee of California, that is responsible for the regulation of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions. Existing law governs the scope of practice for those professionals.

This bill would authorize a registered dental assistant *who has completed a specified educational program* to determine which

~~radiographs to perform if he or she has completed a specified educational program. The bill would authorize a registered dental assistant in extended functions licensed on or after January 1, 2010, to place interim therapeutic restorations, as defined, pursuant to the order, control, and full professional responsibility of a licensed dentist, as specified. The bill would authorize a registered dental hygienist to, after submitting to the committee evidence of satisfactory completion of a course of instruction approved by the committee, determine which a registered dental hygienist, and a registered dental hygienist in alternative practice to choose radiographs to perform and place interim therapeutic protective restorations upon the order of a licensed dentist., as specified.~~

(2) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including certain dental services, as specified. Existing law provides that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for “teleophthalmology and teledermatology by store and forward,” as defined to mean the asynchronous transmission of medical information to be reviewed at a later time by a licensed physician or optometrist, as specified, at a distant site.

~~This bill would enact similar provisions relating to the use of teledentistry, as defined, under the Medi-Cal program. The bill would provide that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for “teledentistry by store and forward.” The bill would define that term to mean an asynchronous transmission of dental information to be reviewed at a later time by a licensed dentist at a distant site, where the dentist at the distant site reviews the dental information without the patient being present in real time, as defined and as specified. The bill would also provide that dentist participation in services provided at an intermittent clinic, as defined, through the use of telehealth, as defined, shall be considered a billable encounter under Medi-Cal. The bill would also require, on or before January 1, 2017, the department to report to the Legislature the number and type of services provided, and the payments made related to the application of teledentistry, as specified.~~

This bill would additionally provide that face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for teledentistry by store and forward, as defined.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

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

- 1 SECTION 1. Section 1752.4 of the Business and Professions
2 Code is amended to read:
3 1752.4. (a) A registered dental assistant may perform all of
4 the following duties:
5 (1) All duties that a dental assistant is allowed to perform.
6 (2) Mouth-mirror inspections of the oral cavity, to include
7 charting of obvious lesions, existing restorations, and missing
8 teeth.
9 (3) Apply and activate bleaching agents using a nonlaser
10 light-curing device.
11 (4) Use of automated caries detection devices and materials to
12 gather information for diagnosis by the dentist.
13 (5) Obtain intraoral images for computer-aided design (CAD),
14 milled restorations.
15 (6) Pulp vitality testing and recording of findings.
16 (7) Place bases, liners, and bonding agents.
17 (8) Chemically prepare teeth for bonding.
18 (9) Place, adjust, and finish direct provisional restorations.
19 (10) Fabricate, adjust, cement, and remove indirect provisional
20 restorations, including stainless steel crowns when used as a
21 provisional restoration.
22 (11) Place postextraction dressings after inspection of the
23 surgical site by the supervising licensed dentist.
24 (12) Place periodontal dressings.
25 (13) Dry endodontically treated canals using absorbent paper
26 points.
27 (14) Adjust dentures extra-orally.
28 (15) Remove excess cement from surfaces of teeth with a hand
29 instrument.
30 (16) Polish coronal surfaces of the teeth.
31 (17) Place ligature ties and archwires.
32 (18) Remove orthodontic bands.

1 (19) All duties that the board may prescribe by regulation.

2 (b) A registered dental assistant may only perform the following
3 additional duties if he or she has completed a board-approved
4 registered dental assistant educational program in those duties, or
5 if he or she has provided evidence, satisfactory to the board, of
6 having completed a board-approved course in those ~~duties~~. *duties*:

7 (1) Remove excess cement with an ultrasonic scaler from
8 supragingival surfaces of teeth undergoing orthodontic treatment.

9 (2) The allowable duties of an orthodontic assistant permitholder
10 as specified in Section 1750.3. A registered dental assistant shall
11 not be required to complete further instruction in the duties of
12 placing ligature ties and archwires, removing orthodontic bands,
13 and removing excess cement from tooth surfaces with a hand
14 instrument.

15 (3) The allowable duties of a dental sedation assistant
16 permitholder as specified in Section 1750.5.

17 (4) The application of pit and fissure sealants.

18 (5) Determine which radiographs to perform.

19 (c) Except as provided in Section 1777, the supervising licensed
20 dentist shall be responsible for determining whether each
21 authorized procedure performed by a registered dental assistant
22 should be performed under general or direct supervision.

23 ~~SEC. 2.— Section 1753.5 of the Business and Professions Code~~
24 ~~is amended to read:~~

25 ~~1753.5.—(a) A registered dental assistant in extended functions~~
26 ~~licensed on or after January 1, 2010, is authorized to perform all~~
27 ~~duties and procedures that a registered dental assistant is authorized~~
28 ~~to perform as specified in and limited by Section 1752.4, and those~~
29 ~~duties that the board may prescribe by regulation.~~

30 ~~(b) A registered dental assistant in extended functions licensed~~
31 ~~on or after January 1, 2010, is authorized to perform the following~~
32 ~~additional procedures under direct supervision and pursuant to the~~
33 ~~order, control, and full professional responsibility of a licensed~~
34 ~~dentist:~~

35 ~~(1) Conduct preliminary evaluation of the patient’s oral health,~~
36 ~~including, but not limited to, charting, intraoral and extra-oral~~
37 ~~evaluation of soft tissue, classifying occlusion, and myofunctional~~
38 ~~evaluation.~~

39 ~~(2) Perform oral health assessments in school-based, community~~
40 ~~health project settings under the direction of a dentist, registered~~

1 ~~dental hygienist, or registered dental hygienist in alternative~~
2 ~~practice.~~

3 ~~(3) Cord retraction of gingiva for impression procedures.~~

4 ~~(4) Size and fit endodontic master points and accessory points.~~

5 ~~(5) Cement endodontic master points and accessory points.~~

6 ~~(6) Take final impressions for permanent indirect restorations.~~

7 ~~(7) Take final impressions for tooth-borne removable prosthesis.~~

8 ~~(8) Polish and contour existing amalgam restorations.~~

9 ~~(9) Place, contour, finish, and adjust all direct restorations.~~

10 ~~(10) Adjust and cement permanent indirect restorations.~~

11 ~~(11) Other procedures authorized by regulations adopted by the~~
12 ~~board.~~

13 ~~(e) All procedures required to be performed under direct~~
14 ~~supervision shall be checked and approved by the supervising~~
15 ~~licensed dentist prior to the patient's dismissal from the office.~~

16 ~~(d) (1) A registered dental assistant in extended functions~~
17 ~~licensed on or after January 1, 2010, is authorized to place interim~~
18 ~~therapeutic restorations, defined as the removal of caries using~~
19 ~~hand instruments and placement of an adhesive restorative material,~~
20 ~~upon the order of the supervising dentist under general supervision,~~
21 ~~except as authorized pursuant to paragraph (3), and pursuant to~~
22 ~~the order, control, and full professional responsibility of a licensed~~
23 ~~dentist.~~

24 ~~(2) A registered dental assistant in extended function may only~~
25 ~~perform the functions authorized pursuant to paragraph (1) if he~~
26 ~~or she has completed a board-approved registered dental assistant~~
27 ~~in extended function education program in performing those~~
28 ~~functions, or if he or she has provided evidence, satisfactory to the~~
29 ~~board, of having completed a board-approved course in those~~
30 ~~functions.~~

31 ~~(3) The supervising licensed dentist shall be responsible for~~
32 ~~determining whether the functions authorized pursuant to paragraph~~
33 ~~(1) may be performed under general or direct supervision.~~

34 *SEC. 2. Section 1753.55 is added to the Business and*
35 *Professions Code, to read:*

36 *1753.55. (a) For the purposes of this section, the following*
37 *definitions shall apply:*

38 *(1) "Clinical instruction" means instruction in which students*
39 *receive supervised experience in performing procedures in a*
40 *clinical setting on patients. Clinical instruction shall only be*

1 performed upon successful demonstration and evaluation of
2 preclinical skills. There shall be at least one instructor for every
3 six students who are simultaneously engaged in clinical instruction.

4 (2) “Course” means a board-approved course preparing a
5 registered dental assistant in extended functions to perform the
6 duties described in subdivision (b).

7 (3) “Didactic instruction” means lectures, demonstrations, and
8 other instruction without active participation by students. The
9 approved provider or its designee may provide didactic instruction
10 through electronic media, home study materials, or live lecture
11 methodology if the provider has submitted that content to the board
12 for approval.

13 (4) “Interim therapeutic restoration” means a direct provisional
14 restoration placed to stabilize the tooth until a licensed dentist
15 diagnoses the need for further definitive treatment.

16 (5) “Laboratory instruction” means instruction in which
17 students receive supervised experience performing procedures
18 using study models, mannequins, or other simulation methods.

19 (6) “Preclinical instruction” means instruction in which students
20 receive supervised experience performing procedures on students,
21 faculty, or staff members. There shall be at least one instructor
22 for every six students who are simultaneously engaged in
23 preclinical instruction.

24 (7) “Program” means a board-approved registered dental
25 assistant in extended functions educational program.

26 (b) In addition to the duties specified in Section 1753.5, a
27 registered dental assistant in extended functions licensed on or
28 after January 1, 2010, is authorized to perform both of the
29 following additional duties pursuant to the order, control, and full
30 professional responsibility of a supervising dentist:

31 (1) Choose radiographs without the supervising dentist having
32 first examined the patient, following protocols established by the
33 supervising dentist and, consistent with the use of as low as
34 reasonably necessary radiation, for the purpose of diagnosis and
35 treatment planning by the dentist. The radiographs shall be taken
36 only in either of the following settings:

37 (A) In a dental office setting, under the direct or general
38 supervision of a dentist as determined by the dentist.

39 (B) In public health settings, including, but not limited to,
40 schools, head start and preschool programs, and residential

1 facilities and institutions, under the general supervision of a
2 dentist.

3 (2) Place protective restorations, which for this purpose are
4 identified as interim therapeutic restorations, as defined by
5 paragraph (4) of subdivision (a), that compromise the removal of
6 soft material from the tooth using only hand instrumentation,
7 without the use of rotary instrumentation, and subsequent
8 placement of an adhesive restorative material. Local anesthesia
9 shall not be necessary. The protective restorations shall be placed
10 only in accordance with both of the following:

11 (A) In either of the following settings:

12 (i) In a dental office setting, under the direct or general
13 supervision of a dentist as determined by the dentist.

14 (ii) In public health settings, including, but not limited to,
15 schools, head start and preschool programs, and residential
16 facilities and institutions, under the general supervision of a
17 dentist.

18 (B) After a diagnosis and treatment plan by a dentist.

19 (c) The functions described in subdivision (b) may be performed
20 by a registered dental assistant in extended functions only after
21 completion of a program that includes training in performing those
22 functions, or after providing evidence, satisfactory to the board,
23 of having completed a board-approved course in those functions.

24 (1) A registered dental assistant in extended functions who has
25 completed the prescribed training in the Health Workforce Pilot
26 Project #172 established by the Office of Statewide Health
27 Planning and Development pursuant to Article 1 (commencing
28 with Section 128125) of Chapter 3 of Part 3 of Division 107 of the
29 Health and Safety Code shall be deemed to have satisfied the
30 requirement for completion of a course of instruction approved
31 by the board.

32 (2) In addition to the instructional components described in
33 subdivision (d) or (e), a program shall contain both of the
34 instructional components described in this paragraph:

35 (A) The course shall be established at the postsecondary
36 educational level.

37 (B) All faculty responsible for clinical evaluation shall have
38 completed a one-hour methodology course in clinical evaluation
39 or have a faculty appointment at an accredited dental education
40 program prior to conducting evaluations of students.

1 (d) A program or course to perform the duties described in
2 paragraph (1) of subdivision (b) shall contain all of the additional
3 instructional components described in this subdivision.

4 (1) The program shall be of sufficient duration for the student
5 to develop minimum competency making decisions about which
6 radiographs to take to facilitate an evaluation by a dentist, but
7 shall in no event be less than six hours, including at least two hours
8 of didactic training, at least two hours of guided laboratory
9 simulation training, and at least two hours of examination using
10 simulated cases.

11 (2) Didactic instruction shall consist of instruction on both of
12 the following topics:

13 (A) Guidelines for radiographic decisionmaking prepared by
14 the American Dental Association and other professional dental
15 associations.

16 (B) Specific decisionmaking protocols that incorporate
17 information about the patient's health and radiographic history,
18 the time span since previous radiographs were taken, the
19 availability of previous radiographs, the general condition of the
20 mouth including the extent of dental restorations present, and
21 visible signs of abnormalities, including broken teeth, dark areas,
22 and holes in teeth.

23 (3) Laboratory instruction shall consist of simulated
24 decisionmaking using case studies containing the elements
25 described in paragraph (2). There shall be at least one instructor
26 for every 14 students who are simultaneously engaged in
27 laboratory instruction.

28 (4) Examinations shall consist of decisionmaking where students
29 make decisions and demonstrate competency to faculty on case
30 studies containing the elements described in paragraph (2).

31 (e) A program or course to perform the duties described in
32 paragraph (2) of subdivision (b) shall contain all of the additional
33 instructional components described in this subdivision.

34 (1) The program shall be of sufficient duration for the student
35 to develop minimum competency in the application of protective
36 restorations, including interim therapeutic restorations, but shall
37 in no event be less than 16 clock hours, including at least four
38 hours of didactic training, at least four hours of laboratory
39 training, and at least eight hours of clinical training.

- 1 (2) *Didactic instruction shall consist of instruction on all of the*
2 *following topics:*
- 3 (A) *Pulpal anatomy.*
- 4 (B) *Theory of adhesive restorative materials used in the*
5 *placement of adhesive protective restorations related to*
6 *mechanisms of bonding to tooth structure, handling characteristics*
7 *of the materials, preparation of the tooth prior to material*
8 *placement, and placement techniques.*
- 9 (C) *Criteria that dentists use to make decisions about placement*
10 *of adhesive protective restorations including all of the following:*
- 11 (i) *Patient factors:*
- 12 (I) *The patient's American Society of Anesthesiologists Physical*
13 *Status Classification is Class III or less.*
- 14 (II) *The patient is cooperative enough to have the restoration*
15 *placed without the need for special protocols, including sedation*
16 *or physical support.*
- 17 (III) *The patient, or responsible party, has provided consent for*
18 *the procedure.*
- 19 (IV) *The patient reports that the tooth is asymptomatic, or if*
20 *there is mild sensitivity to sweet, hot, or cold that the sensation*
21 *stops within a few seconds of the stimulus being removed.*
- 22 (ii) *Tooth factors:*
- 23 (I) *The cavity is accessible without the need for creating access*
24 *using a dental handpiece.*
- 25 (II) *The margins of the cavity are accessible so that clean*
26 *noncarious margins can be obtained around the entire periphery*
27 *of the cavity with the use of hand instruments.*
- 28 (III) *The depth of the lesion is more than two millimeters from*
29 *the pulp on radiographic examination or is judged by the dentist*
30 *to be a shallow lesion such that the treatment does not endanger*
31 *the pulp or require the use of local anesthetic.*
- 32 (IV) *The tooth is restorable and does not have other significant*
33 *pathology.*
- 34 (D) *Criteria for evaluating successful completion of adhesive*
35 *protective restorations including all of the following:*
- 36 (i) *The restorative material is not in hyperocclusion.*
- 37 (ii) *There are no marginal voids.*
- 38 (iii) *There is minimal excess material.*

1 (E) Protocols for handling sensitivity, complications, or
2 unsuccessful completion of adhesive protective restorations
3 including situations requiring immediate referral to a dentist.

4 (F) Protocols for followup of adhesive protective restorations.

5 (3) Laboratory instruction shall consist of placement of adhesive
6 protective restorations where students demonstrate competency
7 in this technique on typodont teeth.

8 (4) Clinical instruction shall consist of experiences where
9 students demonstrate placement of adhesive protective restorations
10 under direct supervision of faculty.

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

14 SEC. 3. Section 1753.55 is added to the Business and
15 Professions Code, to read:

16 1753.55. (a) For the purposes of this section, “interim
17 therapeutic restoration” means a direct provisional restoration
18 placed to stabilize the tooth until a licensed dentist diagnoses the
19 need for further definitive treatment.

20 (b) In addition to the duties specified in Section 1753.5, a
21 registered dental assistant in extended functions licensed on or
22 after January 1, 2010, is authorized to perform both of the
23 following additional duties pursuant to the order, control, and full
24 professional responsibility of a supervising dentist:

25 (1) Choose radiographs without the supervising dentist having
26 first examined the patient, following protocols established by the
27 supervising dentist and, consistent with the use of as low as
28 reasonably necessary radiation, for the purpose of diagnosis and
29 treatment planning by the dentist. The radiographs shall be taken
30 only in either of the following settings:

31 (A) In a dental office setting, under the direct or general
32 supervision of a dentist as determined by the dentist.

33 (B) In public health settings, including, but not limited to,
34 schools, head start and preschool programs, and residential
35 facilities and institutions, under the general supervision of a
36 dentist.

37 (2) Place protective restorations through interim therapeutic
38 restorations that remove soft material from the tooth using only
39 hand instrumentation, without the use of rotary instrumentation,
40 and subsequent placement of an adhesive restorative material,

1 *without the use of local anesthesia. The protective restorations*
2 *shall only be placed subject to both of the following:*

3 *(A) In either of the following settings:*

4 *(i) In a dental office setting, under the direct or general*
5 *supervision of a dentist as determined by the dentist.*

6 *(ii) In public health settings, including, but not limited to,*
7 *schools, head start and preschool programs, and residential*
8 *facilities and institutions, under the general supervision of a*
9 *dentist.*

10 *(B) After a diagnosis and treatment plan by a dentist.*

11 *(c) This section shall become operative on January 1, 2018.*

12 ~~SEC. 3.~~

13 *SEC. 4. Section 1753.6 of the Business and Professions Code*
14 *is amended to read:*

15 1753.6. (a) Each person who holds a license as a registered
16 dental assistant in extended functions on the operative date of this
17 section may only perform those procedures that a registered dental
18 assistant is allowed to perform as specified in and limited by
19 Section 1752.4, and the procedures specified in paragraphs (1) to
20 (6), inclusive, until he or she provides evidence of having
21 completed a board-approved course in the additional procedures
22 specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of
23 subdivision (b), ~~and paragraph (1) of subdivision (d)~~, of Section
24 1753.5, and an examination as specified in Section 1753.4:

25 (1) Cord retraction of gingiva for impression procedures.

26 (2) Take final impressions for permanent indirect restorations.

27 (3) Formulate indirect patterns for endodontic post and core
28 castings.

29 (4) Fit trial endodontic filling points.

30 (5) Apply pit and fissure sealants.

31 (6) Remove excess cement from subgingival tooth surfaces with
32 a hand instrument.

33 ~~(b) This section shall become operative on January 1, 2010.~~

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

37 *SEC. 5. Section 1753.6 is added to the Business and Professions*
38 *Code, to read:*

39 1753.6. (a) Each person who holds a license as a registered
40 dental assistant in extended functions on the operative date of this

1 section may only perform those procedures that a registered dental
2 assistant is allowed to perform as specified in and limited by
3 Section 1752.4, and the procedures specified in paragraphs (1) to
4 (6), inclusive, until he or she provides evidence of having completed
5 a board-approved course in the additional procedures specified
6 in paragraphs (1), (2), (5), and (7) to (11), inclusive, of subdivision
7 (b) of Section 1753.5, procedures specified in Section 1753.55,
8 and an examination as specified in Section 1753.4:

9 (1) Cord retraction of gingiva for impression procedures.

10 (2) Take final impressions for permanent indirect restorations.

11 (3) Formulate indirect patterns for endodontic post and core
12 castings.

13 (4) Fit trial endodontic filling points.

14 (5) Apply pit and fissure sealants.

15 (6) Remove excess cement from subgingival tooth surfaces with
16 a hand instrument.

17 (b) This section shall become operative on January 1, 2018.

18 ~~SEC. 4.~~

19 SEC. 6. Section 1910 of the Business and Professions Code is
20 amended to read:

21 1910. A registered dental hygienist is authorized to perform
22 the following procedures under general supervision:

23 (a) Preventive and therapeutic interventions, including oral
24 prophylaxis, scaling, and root planing.

25 (b) Application of topical, therapeutic, and subgingival agents
26 used for the control of caries and periodontal disease.

27 (c) The taking of impressions for bleaching trays and application
28 and activation of agents with nonlaser, light-curing devices.

29 (d) The taking of impressions for bleaching trays and placements
30 of in-office, tooth-whitening devices.

31 (e) After submitting to the committee evidence of satisfactory
32 completion of a course of instruction approved by the committee,
33 the following:

34 (1) Determine which radiographs to perform.

35 (2) Place interim therapeutic restorations, defined as the removal
36 of caries using hand instruments and placement of an adhesive
37 restorative material, upon the order of a licensed dentist.

38 ~~SEC. 5. Section 14132.726 is added to the Welfare and~~
39 ~~Institutions Code, to read:~~

1 14132.726. (a) To the extent that federal financial participation
2 is available, face-to-face contact between a health care provider
3 and a patient shall not be required under the Medi-Cal program
4 for teledentistry by store and forward. Services appropriately
5 provided through the store and forward process are subject to
6 billing and reimbursement policies developed by the department.

7 (b) A patient receiving teledentistry by store and forward shall
8 be notified of the right to receive interactive communication with
9 the distant dentist, and shall receive an interactive communication
10 with the distant dentist, upon request. If requested, communication
11 with the distant dentist may occur either at the time of the
12 consultation, or within 30 days of the patient's notification of the
13 results of the consultation.

14 (c) Dentist participation in services provided at an intermittent
15 clinic, as defined in Section 1206 of the Health and Safety Code,
16 through the use of telehealth, as defined in Section 2290.5 of the
17 Business and Professions Code, shall be considered a billable
18 encounter under Medi-Cal.

19 (d) Notwithstanding Chapter 3.5 (commencing with Section
20 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
21 the department may implement, interpret, and make specific this
22 section by means of all-county letters, provider bulletins, and
23 similar instructions.

24 (e) On or before January 1, 2017, the department shall report
25 to the Legislature the number and type of services provided, and
26 the payments made related to the application of store and forward
27 teledentistry as provided, under this section as a Medi-Cal benefit.

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

29 (1) "Asynchronous store and forward" means the transmission
30 of a patient's dental information from an originating site to the
31 health care provider at a distant site without the presence of the
32 patient.

33 (2) "Distant site" means a site where a health care provider who
34 provides health care services is located while providing these
35 services via a telecommunications system.

36 (3) "Health care provider" means a person who is licensed under
37 Chapter 4 (commencing with Section 1600) of Division 2 of the
38 Business and Professions Code.

39 (4) "Originating site" means a site where a patient is located at
40 the time health care services are provided via a telecommunications

1 system or where the asynchronous store and forward service
2 originates:

3 (5) “Synchronous interaction” means a real-time interaction
4 between a patient and a health care provider located at a distant
5 site.

6 (6) “Teledentistry” means the mode of delivering dental health
7 care services and public dental health via information and
8 communication technologies to facilitate the diagnosis,
9 consultation, treatment, education, care management, and
10 self-management of a patient’s dental health care while the patient
11 is at the originating site and the dental health care provider is at a
12 distant site. Teledentistry includes synchronous interactions and
13 asynchronous store and forward transfers.

14 (7) “Teledentistry by store and forward” means an asynchronous
15 transmission of dental information to be reviewed at a later time
16 by a licensed dentist at a distant site, where the dentist at the distant
17 site reviews the dental information without the patient being present
18 in real time.

19 SEC. 7. Section 1910.5 is added to the Business and Professions
20 Code, to read:

21 1910.5. (a) For the purposes of this section, the following
22 definitions shall apply:

23 (1) “Clinical instruction” means instruction in which students
24 receive supervised experience in performing procedures in a
25 clinical setting on patients. Clinical instruction shall only be
26 performed upon successful demonstration and evaluation of
27 preclinical skills. There shall be at least one instructor for every
28 six students who are simultaneously engaged in clinical instruction.

29 (2) “Course” means a committee-approved course preparing
30 registered dental hygienist to perform the duties described in
31 subdivision (b).

32 (3) “Didactic instruction” means lectures, demonstrations, and
33 other instruction without active participation by students. The
34 approved provider or its designee may provide didactic instruction
35 through electronic media, home study materials, or live lecture
36 methodology if the provider has submitted that content to the
37 committee for approval.

38 (4) “Interim therapeutic restoration” means a direct provisional
39 restoration placed to stabilize the tooth until a licensed dentist
40 diagnoses the need for further definitive treatment.

1 (5) “Laboratory instruction” means instruction in which
2 students receive supervised experience performing procedures
3 using study models, mannequins, or other simulation methods.

4 (6) “Preclinical instruction” means instruction in which students
5 receive supervised experience performing procedures on students,
6 faculty, or staff members. There shall be at least one instructor
7 for every six students who are simultaneously engaged in
8 preclinical instruction.

9 (7) “Program” means a committee-approved registered dental
10 hygienist educational program.

11 (b) A registered dental hygienist may perform both of the
12 following duties:

13 (1) Choose radiographs without the supervising dentist having
14 first examined the patient, following protocols established by the
15 supervising dentist and, consistent with the use of as low as
16 reasonably necessary radiation, for the purpose of diagnosis and
17 treatment planning by the dentist. The radiographs shall be taken
18 only in either of the following settings:

19 (A) In a dental office setting, under the general supervision of
20 a dentist.

21 (B) In a public health setting, including, but not limited to,
22 schools, head start and preschool programs, and residential
23 facilities and institutions, under the general supervision of a
24 dentist.

25 (2) Place protective restorations, which for this purpose are
26 identified as interim therapeutic restorations, as defined by
27 paragraph (4) of subdivision (a), that compromise the removal of
28 soft material from the tooth using only hand instrumentation,
29 without the use of rotary instrumentation, and subsequent
30 placement of an adhesive restorative material. Local anesthesia
31 shall not be necessary. The protective restorations shall be placed
32 only in accordance with both of the following:

33 (A) In either of the following settings:

34 (i) In a dental office setting, under the general supervision of a
35 dentist.

36 (ii) In a public health setting, including, but not limited to,
37 schools, head start and preschool programs, and residential
38 facilities and institutions, under the general supervision of a
39 dentist.

40 (B) After a diagnosis and treatment plan by a dentist.

1 (c) *The functions described in subdivision (b) may be performed*
2 *by a registered dental hygienist only after completion of a program*
3 *that includes training in performing those functions, or after*
4 *providing evidence, satisfactory to the committee, of having*
5 *completed a committee-approved course in those functions.*

6 (1) *A registered dental hygienist who has completed the*
7 *prescribed training in the Health Workforce Pilot Project #172*
8 *established by the Office of Statewide Health Planning and*
9 *Development pursuant to Article 1 (commencing with Section*
10 *128125) of Chapter 3 of Part 3 of Division 107 of the Health and*
11 *Safety Code shall be deemed to have satisfied the requirement for*
12 *completion of a course of instruction approved by the committee.*

13 (2) *In addition to the instructional components described in*
14 *subdivision (d) or (e), a program shall contain both of the*
15 *instructional components described in this paragraph:*

16 (A) *The course shall be established at the postsecondary*
17 *educational level.*

18 (B) *All faculty responsible for clinical evaluation shall have*
19 *completed a one-hour methodology course in clinical evaluation*
20 *or have a faculty appointment at an accredited dental education*
21 *program prior to conducting evaluations of students.*

22 (d) *A program or course to perform the duties described in*
23 *paragraph (1) of subdivision (b) shall contain all of the additional*
24 *instructional components described in this subdivision.*

25 (1) *The program shall be of sufficient duration for the student*
26 *to develop minimum competency making decisions about which*
27 *radiographs to take to facilitate an evaluation by a dentist, but*
28 *shall in no event be less than six hours, including at least two hours*
29 *of didactic training, at least two hours of guided laboratory*
30 *simulation training, and at least two hours of examination using*
31 *simulated cases.*

32 (2) *Didactic instruction shall consist of instruction on both of*
33 *the following topics:*

34 (A) *Guidelines for radiographic decision making prepared by*
35 *the American Dental Association and other professional dental*
36 *associations.*

37 (B) *Specific decisionmaking protocols that incorporate*
38 *information about the patient's health and radiographic history,*
39 *the time span since previous radiographs were taken, the*
40 *availability of previous radiographs, the general condition of the*

1 *mouth including the extent of dental restorations present, and*
2 *visible signs of abnormalities, including broken teeth, dark areas,*
3 *and holes in teeth.*

4 *(3) Laboratory instruction shall consist of simulated decision*
5 *making using case studies containing the elements described in*
6 *paragraph (2). There shall be at least one instructor for every 14*
7 *students who are simultaneously engaged in laboratory instruction.*

8 *(4) Examination shall consist of decisionmaking where students*
9 *make decisions and demonstrate competency to faculty on case*
10 *studies containing the elements described in paragraph (2).*

11 *(e) A program or course to perform the duties described in*
12 *paragraph (2) of subdivision (b) shall contain all of the additional*
13 *instructional components described in this subdivision.*

14 *(1) The program shall be of sufficient duration for the student*
15 *to develop minimum competency in the application of protective*
16 *restorations, including interim therapeutic restorations, but shall*
17 *in no event be less than 16 clock hours, including at least four*
18 *hours of didactic training, at least four hours of laboratory*
19 *training, and at least eight hours of clinical training.*

20 *(2) Didactic instruction shall consist of instruction on all of the*
21 *following topics:*

22 *(A) Pulpal anatomy.*

23 *(B) Theory of adhesive restorative materials used in the*
24 *placement of adhesive protective restorations related to*
25 *mechanisms of bonding to tooth structure, handling characteristics*
26 *of the materials, preparation of the tooth prior to material*
27 *placement, and placement techniques.*

28 *(C) Criteria that dentists use to make decisions about placement*
29 *of adhesive protective restorations including all of the following:*

30 *(i) Patient factors:*

31 *(I) The patient's American Society of Anesthesiologists Physical*
32 *Status Classification is Class III or less.*

33 *(II) The patient is cooperative enough to have the restoration*
34 *placed without the need for special protocols, including sedation*
35 *or physical support.*

36 *(III) The patient, or responsible party, has provided consent for*
37 *the procedure.*

38 *(IV) The patient reports that the tooth is asymptomatic, or if*
39 *there is mild sensitivity to sweet, hot, or cold that the sensation*
40 *stops within a few seconds of the stimulus being removed.*

- 1 (ii) *Tooth factors:*
- 2 (I) *The cavity is accessible without the need for creating access*
- 3 *using a dental handpiece.*
- 4 (II) *The margins of the cavity are accessible so that clean*
- 5 *noncarious margins can be obtained around the entire periphery*
- 6 *of the cavity with the use of hand instruments.*
- 7 (III) *The depth of the lesion is more than two millimeters from*
- 8 *the pulp on radiographic examination or is judged by the dentist*
- 9 *to be a shallow lesion such that the treatment does not endanger*
- 10 *the pulp or require the use of local anesthetic.*
- 11 (IV) *The tooth is restorable and does not have other significant*
- 12 *pathology.*
- 13 (D) *Criteria for evaluating successful completion of adhesive*
- 14 *protective restorations including all of the following:*
- 15 (i) *The restorative material is not in hyperocclusion.*
- 16 (ii) *There are no marginal voids.*
- 17 (iii) *There is minimal excess material.*
- 18 (E) *Protocols for handling sensitivity, complications, or*
- 19 *unsuccessful completion of adhesive protective restorations*
- 20 *including situations requiring immediate referral to a dentist.*
- 21 (F) *Protocols for followup of adhesive protective restorations.*
- 22 (3) *Laboratory instruction shall consist of placement of adhesive*
- 23 *protective restorations where students demonstrate competency*
- 24 *in this technique on typodont teeth.*
- 25 (4) *Clinical instruction shall consist of experiences where*
- 26 *students demonstrate competency in placement of adhesive*
- 27 *protective restorations under direct supervision of faculty.*
- 28 (f) *This section shall remain in effect only until January 1, 2018,*
- 29 *and as of that date is repealed, unless a later enacted statute, that*
- 30 *is enacted before January 1, 2018, deletes or extends that date.*
- 31 SEC. 8. *Section 1910.5 is added to the Business and Professions*
- 32 *Code, to read:*
- 33 1910.5. (a) *For the purposes of this section, “interim*
- 34 *therapeutic restoration” means a direct provisional restoration*
- 35 *placed to stabilize the tooth until a licensed dentist diagnoses the*
- 36 *need for further definitive treatment.*
- 37 (b) *A registered dental hygienist may perform both of the*
- 38 *following duties:*
- 39 (1) *Choose radiographs without the supervising dentist having*
- 40 *first examined the patient, following protocols established by the*

1 *supervising dentist and, consistent with the use of as low as*
2 *reasonably necessary radiation, for the purpose of diagnosis and*
3 *treatment planning by the dentist. The radiographs shall be taken*
4 *only in either of the following settings:*

5 (A) *In a dental office setting, under the general supervision of*
6 *a dentist.*

7 (B) *In a public health setting, including, but not limited to,*
8 *schools, head start and preschool programs, and residential*
9 *facilities and institutions, under the general supervision of a*
10 *dentist.*

11 (2) *Place protective restorations, which for this purpose are*
12 *identified as interim therapeutic restorations, as defined by*
13 *subdivision (a), that comprise the removal of soft material from*
14 *the tooth using only hand instrumentation, without the use of rotary*
15 *instrumentation, and subsequent placement of an adhesive*
16 *restorative material. Local anesthesia shall not be necessary. The*
17 *protective restorations shall be placed only in accordance with*
18 *both of the following:*

19 (A) *In either of the following settings:*

20 (i) *In a dental office setting, under the general supervision of a*
21 *dentist.*

22 (ii) *In a public health setting, including, but not limited to,*
23 *schools, head start and preschool programs, and residential*
24 *facilities and institutions, under the general supervision of a*
25 *dentist.*

26 (B) *After a diagnosis and treatment plan by a dentist.*

27 (c) *The functions described in subdivision (b) may be performed*
28 *by a registered dental hygienist only after completion of a program*
29 *that includes training in performing those functions, or after*
30 *providing evidence, satisfactory to the committee, of having*
31 *completed a committee-approved course in those functions.*

32 (d) *This section shall become operative on January 1, 2018.*

33 *SEC. 9. Section 1926 of the Business and Professions Code is*
34 *amended to read:*

35 1926. A registered dental hygienist in alternative practice may
36 perform the duties authorized pursuant to subdivision (a) of Section
37 1907, subdivision (a) of Section 1908, ~~and~~ subdivisions (a) and
38 (b) of Section 1910, and Section 1926.05 in the following settings:

39 (a) Residences of the homebound.

40 (b) Schools.

1 (c) Residential facilities and other institutions.

2 (d) Dental health professional shortage areas, as certified by the
3 Office of Statewide Health Planning and Development in
4 accordance with existing office guidelines.

5 *SEC. 10. Section 1926.05 is added to the Business and
6 Professions Code, to read:*

7 *1926.05. (a) For the purposes of this section, the following
8 definitions shall apply:*

9 (1) *“Clinical instruction” means instruction in which students
10 receive supervised experience in performing procedures in a
11 clinical setting on patients. Clinical instruction shall only be
12 performed upon successful demonstration and evaluation of
13 preclinical skills. There shall be at least one instructor for every
14 six students who are simultaneously engaged in clinical instruction.*

15 (2) *“Course” means a committee-approved course preparing
16 registered dental hygienist in alternative practice to perform the
17 duties described in subdivision (b).*

18 (3) *“Didactic instruction” means lectures, demonstrations, and
19 other instruction without active participation by students. The
20 approved provider or its designee may provide didactic instruction
21 through electronic media, home study materials, or live lecture
22 methodology if the provider has submitted that content to the
23 committee for approval.*

24 (4) *“Interim therapeutic restoration” means a direct provisional
25 restoration placed to stabilize the tooth until a licensed dentist
26 diagnoses the need for further definitive treatment.*

27 (5) *“Laboratory instruction” means instruction in which
28 students receive supervised experience performing procedures
29 using study models, mannequins, or other simulation methods.*

30 (6) *“Preclinical instruction” means instruction in which students
31 receive supervised experience performing procedures on students,
32 faculty, or staff members. There shall be at least one instructor
33 for every six students who are simultaneously engaged in
34 preclinical instruction.*

35 (7) *“Program” means a committee-approved registered dental
36 hygienist in alternative practice educational program.*

37 (b) *A registered dental hygienist in alternative practice may
38 perform both of the following duties:*

39 (1) *Choose radiographs without the supervising dentist having
40 first examined the patient, following protocols established by the*

1 *supervising dentist and, consistent with the use of as low as*
2 *reasonably necessary radiation, for the purpose of diagnosis and*
3 *treatment planning by the dentist. The radiographs shall be taken*
4 *only in either of the following settings:*

5 (A) *In a dental office setting, under the general supervision of*
6 *a dentist.*

7 (B) *In a public health setting, including, but not limited to,*
8 *schools, head start and preschool programs, and residential*
9 *facilities and institutions, under the general supervision of a*
10 *dentist.*

11 (2) *Place protective restorations, which for this purpose are*
12 *identified as interim therapeutic restorations, as defined by*
13 *paragraph (4) of subdivision (a), that compromise the removal of*
14 *soft material from the tooth using only hand instrumentation,*
15 *without the use of rotary instrumentation, and subsequent*
16 *placement of an adhesive restorative material. Local anesthesia*
17 *shall not be necessary. The protective restorations shall be placed*
18 *only in accordance with both of the following:*

19 (A) *In either of the following settings:*

20 (i) *In a dental office setting, under the general supervision of a*
21 *dentist.*

22 (ii) *In a public health setting, including, but not limited to,*
23 *schools, head start and preschool programs, and residential*
24 *facilities and institutions, under the general supervision of a*
25 *dentist.*

26 (B) *After a diagnosis and treatment plan by a dentist.*

27 (c) *The functions described in subdivision (b) may be performed*
28 *by a registered dental hygienist in alternative practice only after*
29 *completion of a course or program that includes training in*
30 *performing those functions, or after providing evidence,*
31 *satisfactory to the committee, of having completed a*
32 *committee-approved course in those functions.*

33 (1) *A registered dental hygienist in alternative practice who*
34 *has completed the prescribed training in the Health Workforce*
35 *Pilot Project #172 established by the Office of Statewide Health*
36 *Planning and Development pursuant to Article 1 (commencing*
37 *with Section 128125) of Chapter 3 of Part 3 of Division 107 of the*
38 *Health and Safety Code shall be deemed to have satisfied the*
39 *requirement for completion of a course of instruction approved*
40 *by the committee.*

- 1 (2) *In addition to the instructional components described in*
2 *subdivision (d) or (e), a program shall contain both of the*
3 *instructional components described in this paragraph:*
- 4 (A) *The course shall be established at the postsecondary*
5 *educational level.*
- 6 (B) *All faculty responsible for clinical evaluation shall have*
7 *completed a one-hour methodology course in clinical evaluation*
8 *or have a faculty appointment at an accredited dental education*
9 *program prior to conducting evaluations of students.*
- 10 (d) *A program or course to perform the duties described in*
11 *paragraph (1) of subdivision (b) shall contain all of the additional*
12 *instructional components described in this subdivision.*
- 13 (1) *The program shall be of sufficient duration for the student*
14 *to develop minimum competency making decisions about which*
15 *radiographs to take to facilitate an evaluation by a dentist, but*
16 *shall in no event be less than six hours, including at least two hours*
17 *of didactic training, at least two hours of guided laboratory*
18 *simulation training, and at least two hours of examination using*
19 *simulated cases.*
- 20 (2) *Didactic instruction shall consist of instruction on both of*
21 *the following topics:*
- 22 (A) *Guidelines for radiographic decision making prepared by*
23 *the American Dental Association and other professional dental*
24 *associations.*
- 25 (B) *Specific decisionmaking protocols that incorporate*
26 *information about the patient’s health and radiographic history,*
27 *the time span since previous radiographs were taken, the*
28 *availability of previous radiographs, the general condition of the*
29 *mouth including the extent of dental restorations present, and*
30 *visible signs of abnormalities, including broken teeth, dark areas,*
31 *and holes in teeth.*
- 32 (3) *Laboratory instruction shall consist of simulated decision*
33 *making using case studies containing the elements described in*
34 *paragraph (2). There shall be at least one instructor for every 14*
35 *students who are simultaneously engaged in laboratory instruction.*
- 36 (4) *Examination shall consist of decisionmaking where students*
37 *make decisions and demonstrate competency to faculty on case*
38 *studies containing the elements described in paragraph (2).*

1 (e) A program or course to perform the duties described in
2 paragraph (2) of subdivision (b) shall contain all of the additional
3 instructional components described in this subdivision.

4 (1) The program shall be of sufficient duration for the student
5 to develop minimum competency in the application of protective
6 restorations, including interim therapeutic restorations, but shall
7 in no event be less than 16 clock hours, including at least four
8 hours of didactic training, at least four hours of laboratory
9 training, and at least eight hours of clinical training.

10 (2) Didactic instruction shall consist of instruction on all of the
11 following topics:

12 (A) Pulpal anatomy.

13 (B) Theory of adhesive restorative materials used in the
14 placement of adhesive protective restorations related to
15 mechanisms of bonding to tooth structure, handling characteristics
16 of the materials, preparation of the tooth prior to material
17 placement, and placement techniques.

18 (C) Criteria that dentists use to make decisions about placement
19 of adhesive protective restorations including all of the following:

20 (i) Patient factors:

21 (I) The patient's American Society of Anesthesiologists Physical
22 Status Classification is Class III or less.

23 (II) The patient is cooperative enough to have the restoration
24 placed without the need for special protocols, including sedation
25 or physical support.

26 (III) The patient, or responsible party, has provided consent for
27 the procedure.

28 (IV) The patient reports that the tooth is asymptomatic, or if
29 there is mild sensitivity to sweet, hot, or cold that the sensation
30 stops within a few seconds of the stimulus being removed.

31 (ii) Tooth factors:

32 (I) The cavity is accessible without the need for creating access
33 using a dental handpiece.

34 (II) The margins of the cavity are accessible so that clean
35 noncarious margins can be obtained around the entire periphery
36 of the cavity with the use of hand instruments.

37 (III) The depth of the lesion is more than two millimeters from
38 the pulp on radiographic examination or is judged by the dentist
39 to be a shallow lesion such that the treatment does not endanger
40 the pulp or require the use of local anesthetic.

1 (IV) The tooth is restorable and does not have other significant
2 pathology.

3 (D) Criteria for evaluating successful completion of adhesive
4 protective restorations including all of the following:

5 (i) The restorative material is not in hyperocclusion.

6 (ii) There are no marginal voids.

7 (iii) There is minimal excess material.

8 (E) Protocols for handling sensitivity, complications, or
9 unsuccessful completion of adhesive protective restorations
10 including situations requiring immediate referral to a dentist.

11 (F) Protocols for followup of adhesive protective restorations.

12 (3) Laboratory instruction shall consist of placement of adhesive
13 protective restorations where students demonstrate competency
14 in this technique on typodont teeth.

15 (4) Clinical instruction shall consist of experiences where
16 students demonstrate competency in placement of adhesive
17 protective restorations under direct supervision of faculty.

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

21 SEC. 11. Section 1926.05 is added to the Business and
22 Professions Code, to read:

23 1926.05. (a) For the purposes of this section, “interim
24 therapeutic restoration” means a direct provisional restoration
25 placed to stabilize the tooth until a licensed dentist diagnoses the
26 need for further definitive treatment.

27 (b) A registered dental hygienist in alternative practice may
28 perform both of the following duties:

29 (1) Choose radiographs without the supervising dentist having
30 first examined the patient, following protocols established by the
31 supervising dentist and, consistent with the use of as low as
32 reasonably necessary radiation, for the purpose of diagnosis and
33 treatment planning by the dentist. The radiographs shall be taken
34 only in either of the following settings:

35 (A) In a dental office setting, under the general supervision of
36 a dentist.

37 (B) In a public health setting, including, but not limited to,
38 schools, head start and preschool programs, and residential
39 facilities and institutions, under the general supervision of a
40 dentist.

1 (2) *Place protective restorations, which for this purpose are*
2 *identified as interim therapeutic restorations, as defined by*
3 *subdivision (a), that compromise the removal of soft material from*
4 *the tooth using only hand instrumentation, without the use of rotary*
5 *instrumentation, and subsequent placement of an adhesive*
6 *restorative material. Local anesthesia shall not be necessary. The*
7 *protective restorations shall be placed only in accordance with*
8 *both of the following:*

9 (A) *In either of the following settings:*

10 (i) *In a dental office setting, under the general supervision of a*
11 *dentist.*

12 (ii) *In a public health setting, including, but not limited to,*
13 *schools, head start and preschool programs, and residential*
14 *facilities and institutions, under the general supervision of a*
15 *dentist.*

16 (B) *After a diagnosis and treatment plan by a dentist.*

17 (c) *The functions described in subdivision (b) may be performed*
18 *by a registered dental hygienist in alternative practice only after*
19 *completion of a course or program that includes training in*
20 *performing those functions, or after providing evidence,*
21 *satisfactory to the committee, of having completed a*
22 *committee-approved course in those functions.*

23 (d) *This section shall become operative on January 1, 2018.*

24 SEC. 12. *Section 14132.725 of the Welfare and Institutions*
25 *Code is amended to read:*

26 14132.725. (a) ~~Commencing July 1, 2006, to~~ *To the extent*
27 *that federal financial participation is available, face-to-face contact*
28 *between a health care provider and a patient shall is not be required*
29 *under the Medi-Cal program for teleophthalmology—and,*
30 *teledermatology, and teledentistry by store and forward. Services*
31 *appropriately provided through the store and forward process are*
32 *subject to billing and reimbursement policies developed by the*
33 *department.*

34 (b) *For purposes of this section, “teleophthalmology—and,*
35 *teledermatology, and teledentistry by store and forward” means*
36 *an asynchronous transmission of medical or dental information to*
37 *be reviewed at a later time by a physician at a distant site who is*
38 *trained in ophthalmology or dermatology or, for teleophthalmology,*
39 *by an optometrist who is licensed pursuant to Chapter 7*
40 *(commencing with Section 3000) of Division 2 of the Business*

1 and Professions Code, *or a dentist*, where the physician—~~or~~,
2 optometrist, *or dentist* at the distant site reviews the medical *or*
3 *dental* information without the patient being present in real time.
4 A patient receiving teleophthalmology—~~or~~, teledermatology, *or*
5 *teledentistry* by store and forward shall be notified of the right to
6 receive interactive communication with the distant specialist
7 physician—~~or~~, optometrist, *or dentist* and shall receive an interactive
8 communication with the distant specialist physician—~~or~~, optometrist,
9 *or dentist*, upon request. If requested, communication with the
10 distant specialist physician—~~or~~, optometrist, *or dentist* may occur
11 either at the time of the consultation, or within 30 days of the
12 patient’s notification of the results of the consultation. If the
13 reviewing optometrist identifies a disease or condition requiring
14 consultation or referral pursuant to Section 3041 of the Business
15 and Professions Code, that consultation or referral shall be with
16 an ophthalmologist or other appropriate physician and surgeon, as
17 required.

18 (c) Notwithstanding Chapter 3.5 (commencing with Section
19 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
20 the department may implement, interpret, and make specific this
21 section by means of all-county letters, provider bulletins, and
22 similar instructions.

23 (d) On or before January 1, 2008, the department shall report
24 to the Legislature the number and type of services provided, and
25 the payments made related to the application of store and forward
26 telehealth as provided, under this section as a Medi-Cal benefit.



MEMORANDUM

DATE	February 19, 2014
TO	Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 6: Discussion and Possible Action Regarding Assembly Bill 1174 (Bocanegra)

Background:

Following the joint meeting of the Board's Legislative and Regulatory Committee (Committee) and the Dental Assisting Council (Council), the Board may consider the Committee's and the Council's position recommendation on Assembly Bill 1174. Dr. Glassman and Ms. Scott will be available to answer any questions of the Board.

Staff has included an analysis of AB 1174 and a copy of the most recently amended version of the bill in the meeting materials under Agenda Item 5.

Action Requested:

The Board may take action to take one of the following positions on AB 1174:

- Support
- Support if Amended
- Oppose
- Watch
- Neutral
- No Action

The staff recommendations regarding a position on AB 1174 is included in the bill analysis under Agenda Item 5.

**DENTAL ASSISTING
COUNCIL**



NOTICE OF DENTAL ASSISTING COUNCIL MEETING AGENDA

Thursday, February 27, 2014

Upon Conclusion of Board Meeting Agenda Item 6

Wyndham Bayside San Diego

1355 North Harbor Drive, San Diego, CA, 92101

(619) 232-3861 or (916) 263-2300

Members of the Dental Assisting Council

Chair - Teresa Lua, RDAEF,

Vice Chair - Anne Contreras, RDA,

Pamela Davis-Washington, RDA

Judith Forsythe, RDA

Michele Jawad, RDA

Emma Ramos, RDA

Bruce Whitcher, DDS

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

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

1. Call to Order/Roll Call/Establishment of Quorum
2. Approval of the August 26 and November 21, 2013 Dental Assisting Council Meeting Minutes
3. Status of Dental Assisting Program and Course Applications
4. Dental Assisting Program Licensure and Permit Statistics
5. Dental Assisting Program Examination Statistics

6. Discussion and Possible Action Regarding Appointing a Subcommittee to Work with Staff to Review the Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) Examination Process in Order to Identify Improvements
7. Update Regarding Dental Assisting Educational Program and Course Requirements Regulatory Proposal
8. Public Comment for Items Not on the Agenda
The Council may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
9. Future Agenda Items
Stakeholders are encouraged to propose items for possible consideration by the Council at a future meeting.
10. Council Member Comments for Items Not on the Agenda
The Council may not discuss or take action on any matter raised during the Council Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
11. Adjournment



**DENTAL ASSISTING COUNCIL
MEETING MINUTES**

August 26, 2013

Department of Consumer Affairs
Hearing Room, HQ2

1747 North Market Blvd., Sacramento, CA, 95834

DRAFT

Members Present

Judith Forsythe, RDA – Chair
Anne Contreras, RDA
Pamela Davis-Washington, RDA
Michele Jawad, RDA
Teresa Lua, RDAEF
Bruce Whitcher, DDS

Members Absent

Emma Ramos, RDA

Staff Present

Karen Fischer, Executive Officer
Jennifer Thornburg, Assistant Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Dental Assisting Unit and Investigative Analysis Unit Manager
Marla Rocha, Dental Assisting Program Examination Coordinator
Sharon Langness, Dental Assisting Educational Programs
Sarah Wallace, Legislative and Regulatory Analyst
Linda Byers, Executive Assistant
Spencer Walker, DCA Senior Staff Counsel

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

Judith Forsythe, Chair, called the Dental Assisting Council meeting to order at 9:17 a.m. Roll was called and a quorum established.

2. **Welcome and Introduction of New Dental Assisting Council Member Michele Jawad, RDA, and Administration of Oath of Office**

Dr. Le, Dental Board President administered the oath of office to Ms. Jawad. Judith Forsythe, Chair, welcomed her and gave a brief biography of her education and accomplishments.

3. **Welcome and Introduction of New Dental Assisting Program Analyst Marla Rocha**

Judith Forsythe, Chair, introduced Ms. Rocha and gave a brief biography of her education, accomplishments and responsibilities as a new staff member at the Dental Board.

4. **Approval of the February 28, 2013 Dental Assisting Council Meeting Minutes**
Moved/Seconded/Carried (M/S/C) (Lua/Davis-Washington) to approve the February 28, 2013 Dental Assisting Council minutes. The motion passed unanimously with Ms. Jawad abstaining.

5. **Chair Report**

Ms. Forsythe recognized Karen Fischer, Executive Officer of the Dental Board of California and thanked her for assembling such a great team. She commented that elections for Chair and Vice Chair of the Dental Assisting Council will be held at the November meeting.

6. **Update Regarding the Status of Dental Assisting Program and Course Applications**

Sharon Langness, analyst for programs and courses in the Dental Assisting Program, introduced herself and provided an update on the status of course and program applications currently being processed, as well as those that have received approval for 2013.

LaDonna Drury-Klein, Executive Director of the California Association of Dental Assisting Teachers (CADAT), expressed concern that the Dental Assisting Council (DAC) should know more about the Dental Assisting Programs and Courses application and approval process being conducted by staff. She shared historical information about how the review and approval process was conducted under COMDA and mentioned that CADAT would like to see that process brought back. Ms. Forsythe, the Council Chair, reminded everyone that it was a Board decision to authorize the Executive Officer to oversee that process and to approve the applications as appropriate which also expedited the process. Dr. Witcher commented that the DAC should set the standards for approvals, not do the approving.

Michele Jawad commented that a report of Program and Course approvals would be helpful. It was agreed that staff will provide the DAC with a list of Programs and Courses that are approved.

Ms. Drury-Klein further commented that CADAT would like to see the DAC take formal actions not just casual discussion. Legal Counsel commented that since this is report was intended as an update any formal action relating to this item should be mentioned under future agenda items.

7. **Dental Assisting Program Licensure and Permit Statistics**

Sharon Langness provided an update of the statistics. Teresa Lua asked for further clarification of the Statistics for Registered Dental Assistants in Extended Functions (RDAEF). There was a discussion regarding whether the statistics for the number of new RDAEF licenses was accurate. Karen Fischer, Dental Board Executive Officer, directed Dental Assisting staff to re-evaluate what/how information is gathered to produce the statistics. Joan Greenfield, Extended Functions Association, questioned the statistics for RDAEF's with enhanced duties.

8. **Dental Assisting Program Examination Statistics**
Sharon Langness provided an update of written and practical examination statistics for all dental assisting examinations. Teresa Lua commented that there is a large discrepancy in the Law and Ethics exam pass rates between the northern and southern regions. Michele Jawad, RDA, requested a comparison of the written exam pass rates between the northern and southern regions. Joan Greenfield, Director of Continuing Education for the Dental Health Department at Sacramento City College, requested that the RDAEF pass rates be broken down even further by northern and southern and provider. CADAT concurred with Ms. Greenfield regarding the RDAEF exams. LaDonna Drury-Klein suggested that the Council identify what types of data would be most useful in making recommendations to the Board regarding schools and examinations. She suggested comparing the pass rates with candidate preparedness and reviewing applications for more information.
9. **Update on Consultant Contracts Regarding Dental Assisting Examinations**
April Alameda, Interim Dental Assisting Manager, provided an update on the contracts for the re-evaluation of the Registered Dental Assistant Written examination, and the Dental Sedation Assistant (DSA) examination. She reported that the final reports on these examinations are due in April of 2014. LaDonna Drury-Klein expressed concern that the data shown for the DSA examination needs reviewing. She commented that there are only 10 approved DSA course providers, all private Dental offices, which do not offer the course to external candidates. She commented that CADAT is also concerned that the Subject Matter Experts (SME) being used to develop the DSA examination were employees from the same offices that were providing the examinations. There was discussion regarding whether re-evaluation of the DSA examination is premature considering there is such a small number of permit holders. Dr. Witcher commented that the examination is doing its job. Not every candidate will or should pass. An examination is meant to have a reasonable pass rate and then fall off markedly for second and third attempts.
10. **Report on a Plan for Registered Dental Assistant (RDA) Program Site Visits**
Sharon Langness reported on the plan for staff to begin re-evaluations of all RDA programs, which are required by regulation approximately every seven years. She reported that training has begun with new subject matter experts who will be assisting in the re-evaluation process. Additionally, she reported that staff will incorporate dental assisting courses into the re-evaluations in the future.
11. **Update on Amending California Code of Regulations, Title 16, Section 1004 Relative to the Abandonment of Applications to Split the Retake of the Registered Dental Assistant in Extended Functions (RDAEF) Examination**
Marla Rocha provided an update on the status and progress of the amendment. Sarah Wallace, Legislative Analyst for the Board, reported that the Board had already directed staff to move forward with this regulation and this was an update only. No action was required by the Council.
12. **Staff Update on the Proposed Regulatory Amendments to California Code of Regulations, Title 16, Sections 1014 and 1014.1, Relevant to Radiation Safety Course Requirements**

Marla Rocha provided an update on the status of the amendments. With the hiring of a new analyst in the dental assisting program, there are now the available staff resources to dedicate to the development of dental assisting regulatory proposals. Staff has been able to further review the need for radiation safety course amendments, as well as the need for other dental assisting education course and program amendments.

Staff recommended that the Council discontinue work on the individual regulatory proposal for radiation safety course requirements, and begin moving forward with the development of one regulatory proposal for needed amendments to all courses and programs, in addition to the radiation safety course requirements.

Staff thanked CADAT for their dedication and participation in discussions regarding the amendments to the radiation safety course requirements, and will consider all the work previously accomplished when developing the radiation safety course requirements as part of the larger regulatory package.

The Council discussed staff's recommendation to discontinue the work on the radiation safety course requirements.

M/S/C (Lua/Jawad) to direct staff to discontinue work on the individual regulatory proposal for radiation safety course requirements and begin moving forward with the development of one regulatory proposal pertaining to all dental assisting programs and courses in addition to the radiation safety course requirements once it is prioritized by the Council and the Board. LaDonna Drury-Klein, CADAT, commented that they support this and would like to see it move forward as quickly as possible. The motion passed unanimously.

13. **Discussion and Possible Action Regarding Recommendation to the Board for Dental Assisting Regulatory Priorities for Fiscal Year 2013/14**

Sharon Langness presented staff recommendations of regulatory priorities for the Council to consider and recommend to the Board its top priorities for FY 2013/14. There were three recommendations:

1. Dental Assisting Educational Programs and Courses
2. Dental Assisting Program Application and Examination Requirements
3. Dental Assisting Program Duties and Settings

Staff identified Dental Assisting Educational Programs and Courses as their top priority to be forwarded to the Board.

Staff suggested that a one-day 'working' meeting (workshop) be considered to facilitate stakeholders input to the proposal, if the Board approved this recommendation.

The Council discussed staff's recommendation to set the Dental Assisting Programs and Courses as its top priority and forward to the Board for its consideration.

M/S/C (Lua/Jawad) to recommend that the Board consider Dental Assisting Programs and Courses as its top priority when the Board develops its regulatory priorities for Fiscal Year 2013-14. There was no public comment. The motion passed unanimously.

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

There was no public comment.

15. **Future Agenda Items**

Joan Greenfield, Extended Functions Association requested considering promulgating regulations to add the administration of Local Anesthesia and Nitrous Oxide to the scope of practice for Registered Dental Assistants in Extended Functions 2.

LaDonna Drury-Klein, CADAT, requested that the manner in which examination statistics are managed and collected be an action item on a future agenda.

LaDonna Drury-Klein, CADAT, requested the Council's consideration and selection of examination sites and the frequency of Registered Dental Assistant (RDA) examinations in 2015-16 be placed on a future agenda as an action item.

LaDonna Drury-Klein, CADAT, requested that regulatory requirements for Dental Assisting (non-RDA) programs, such as ROP and private schools, be placed on a future agenda.

16. **Council Member Comments for Items Not on the Agenda**

There were no further Council member comments.

17. **Adjournment**

The meeting adjourned at 11:49 a.m.



DENTAL ASSISTING COUNCIL MEETING MINUTES
November 21, 2013

DRAFT

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

Members Present

Judith Forsythe, RDA, Chair
Anne Contreras, RDA
Pamela Davis-Washington, RDA
Michele Jawad, RDA
Teresa Lua, RDAEF
Emma Ramos, RDA
Bruce Witcher, DDS

Members Absent

Staff Present

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

1. **Call to Order/Roll Call/Establishment of Quorum**
Judith Forsythe, Chair, called the Dental Assisting Council meeting to order at 9:17 a.m. Roll was called and a quorum established.
2. **Approval of the August 26, 2013 Dental Assisting Council Meeting Minutes**
Lori Gagliardi, California Association of Dental Assisting Teachers (CADAT), asked that the minutes be tabled until the next meeting in order for staff to review the webcast for possible omissions. Ms. Forsythe, Chair of the Dental Assisting Council agreed to table the August 2013 minutes until the next meeting.
3. **Chair Report/Staff Report**
Judith Forsythe, Chair reported on her activities since the last meeting. Karen Fischer, Executive Officer provided an update on the Dental Assisting unit.
4. **Discussion and Possible Action Regarding the Staff Report on the Status of Dental Assisting Program and Course Applications**

A. Overview of Evaluation Process for Dental Assisting Program and Course Applications

Dawn Dill, Licensing Unit Manager, provided an overview of the process used to evaluate applications for Dental Assisting programs and courses. Lori Gagliardi, CADAT, asked if the approval of courses would be coming back to the Dental Assisting Council (DAC). Ms. Fischer stated no, the process was changed in order to streamline it. She stated that there are currently five Subject Matter Experts (SME) being trained to assist staff with the approvals. There was discussion about who has the authority to approve programs and courses. Spencer Walker, Senior Legal Counsel, stated that program and course approval is an Administrative function. Ms. Gagliardi requested that an item be placed on the next Dental Assisting Council agenda regarding changing back to the DAC approving Dental Assisting programs and courses.

B. Subject Matter Expert (SME) Qualifications

Ms. Dill provided an overview of the qualifications of a Subject Matter Expert (SME).

C. Number of Approved Programs and Courses

Ms. Dill reviewed the statistics provided.

D. Table of Programs/Courses Approved Since the Last Meeting

Ms. Dill reviewed the statistics provided.

5. **Discussion and Possible Action Relating to the Dental Assisting Licensure and Permit Program Statistics**

Ms. Dill provided an overview and explanation of the statistics provided and the process for correcting delinquencies.

6. **Discussion and Possible Action Relating to the Dental Assisting Examination Program Statistics**

A. Examination Statistics

Ms. Dill provided an overview of the statistics provided. There was discussion regarding the difference between the pass rates in the North and South. Ms. Jawad requested statistics regarding the trends of pass/fail rates between schools for each exam. Ms. Gagliardi requested numbers instead of percentages for each school for the practical exams. She also requested that staff provide an annual report on the total number of people who obtained a license during that year by school. Dr. Earl Johnson, California Orthodontists Association (COA) commented that the study materials for the Orthodontic Assistant exam are not good. He suggested that COA would provide their material for students to study.

B. 2014 Examination Dates

Ms. Dill reviewed the examination dates and sites for 2014. She noted that the November 2013 test was full and some candidates had to be rescheduled for the February 2014 exam. There was discussion regarding the need for more testing dates/sites versus the cost of providing the exam. Ms. Jawad requested more information on the process from

application to examination. Ms. Forsythe commented that her company's new building could accommodate the examination. She stated that she would research the possibility of holding examinations there.

C. Future Examination Dates and Locations

Lori Gagliardi, CADAT, made a request that staff conduct a survey of the number of graduates who do not take the Registered Dental Assistant examination(s) because of the location.

D. Examination Application Filing Periods

Ms. Dill provided an overview of the application filing process. Ms. Gagliardi asked if would be possible to rotate the dates that each site holds examinations. There was discussion about the application process.

7. **Report on Staff Recommendations for the Dental Assisting Educational Program and Course Requirements Regulatory Proposal**

Sarah Wallace, Legislative and Regulatory Analyst, reviewed the background information and draft proposed language provided.

8. **Election of Dental Assisting Council Chair and Vice-Chair**

Michele Jawad nominated Teresa Lua for Dental Assisting Council Chair. Ms. Lua accepted the nomination. The Council voted unanimously to elect Ms. Lua as Chair of the Dental Assisting Council.

Pamela Davis-Washington nominated Anne Contreras for Council Vice Chair. Ms. Contreras accepted the nomination

Teresa Lua nominated Michele Jawad for Council Vice Chair. Ms. Jawad accepted the nomination.

The Council voted to elect Anne Contreras as Vice Chair of the Dental Assisting Council.

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

There was no public comment for items not on the agenda.

10. **Future Agenda Items**

Lori Gagliardi, CADAT, requested an agenda item pertaining to approval of Dental Assisting Programs and Courses by the Dental Assisting Council.

Dr. Earl Johnson, COA, asked for a tally of the results of the new Orthodontic Assistant Permit examination.

11. **Council Member Comments for Items Not on the Agenda**

There were no comments.

12. **Adjournment**

The meeting adjourned at 10:38 a.m.



MEMORANDUM

DATE	February 13, 2014
TO	Dental Assisting Council Dental Board of California
FROM	Sharon Langness, Educational Programs Analyst Dental Assisting Program Dental Board of California
SUBJECT	DAC 3 : Status of Dental Assisting Program and Course Applications

The first table below identifies the number of applications which have received approval since the last Board meeting, and those that are currently moving through the approval process. The second table identifies the total number of applications which were approved for calendar year 2013. Attached is a list of names for the applicants who have received approval since the last Board meeting.

DA Program & Course Applications Approved and Received Since Last Board Meeting						
Program or Course Title	Approved	Denied	Withdrawn		Received	Currently Processing
			By Provider	By Board		
RDA Program/Prov	1				0	4
RDA Program/Full	1				n/a	n/a
Radiation Safety	1				1	4
Coronal Polish	1				2	5
Pit and Fissure	1				2	4
Ultrasonic Scaler	1				0	0
Infection Control	1				2	8
OA Permit	2				7	10
DSA Permit	0				2	6
Total Applications	9				16	41

Total DA Program and Course Applications Approved in 2013											
Course Totals	RDA Programs		RDAEF	Radiation Safety	Coronal Polish	Pit and Fissure Sealants	Ultrasonic Scaler	Infection Control	Orthodontic Assistant	Dental Sedation Assistant	Grand Total
	Provisional	Full									
	3	3	0	6	2	1	2	5	22	5	49

ATTACHMENT 1

Dental Assisting Programs/Courses Approved Since Last Board Meeting

Provider	Approval Date	RDA Program Provisional	RDA Program Full	X-Ray	CP	P/F	US	IC	DSA	OA
UEI College San Marcos	1/28/14	X								
UEI College El Monte	1/29/14		X							
The Super Dentists Chula Vista	12/30/13			X						
The Super Dentists Chula Vista	11/25/13				X					
The Super Dentists Chula Vista	12/2/13					X				
The Super Dentists Chula Vista	11/25/13						X			
The Super Dentists Chula Vista	12/30/13							X		
Cooke Orthodontics Napa	12/12/13									X
Keller Orthodontics Sunnyvale	12/30/13									X
INDIVIDUAL TOTALS		1	1	1	1	1	1	1	0	2
TOTAL APPROVALS = 9										

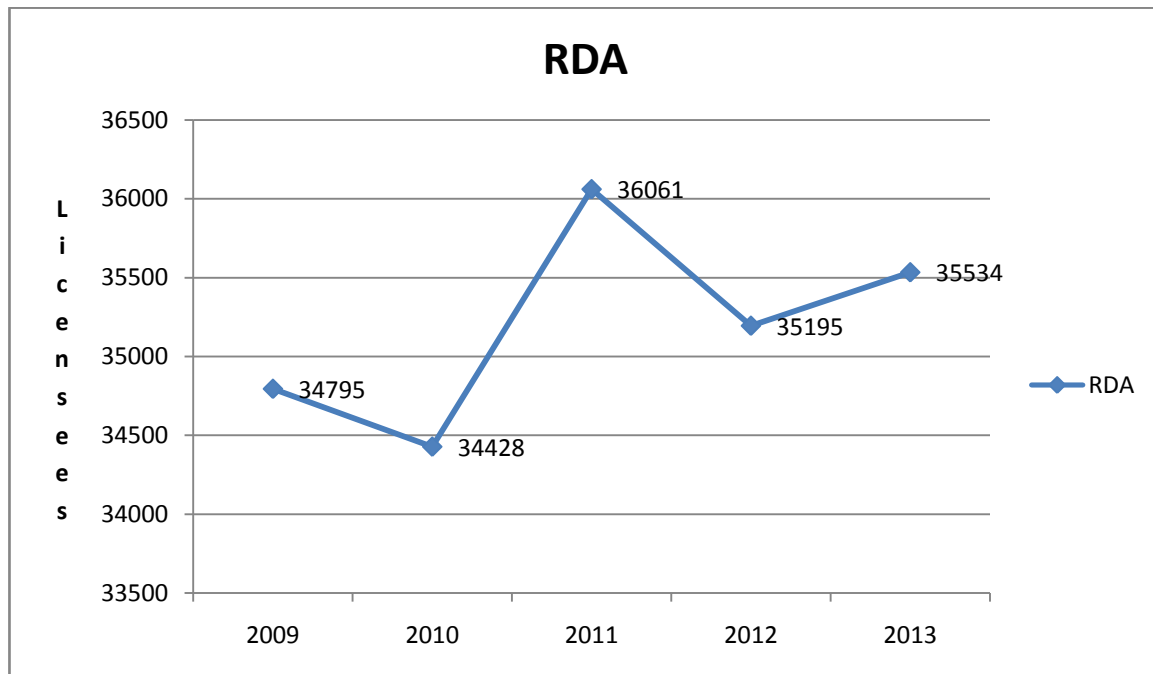


MEMORANDUM

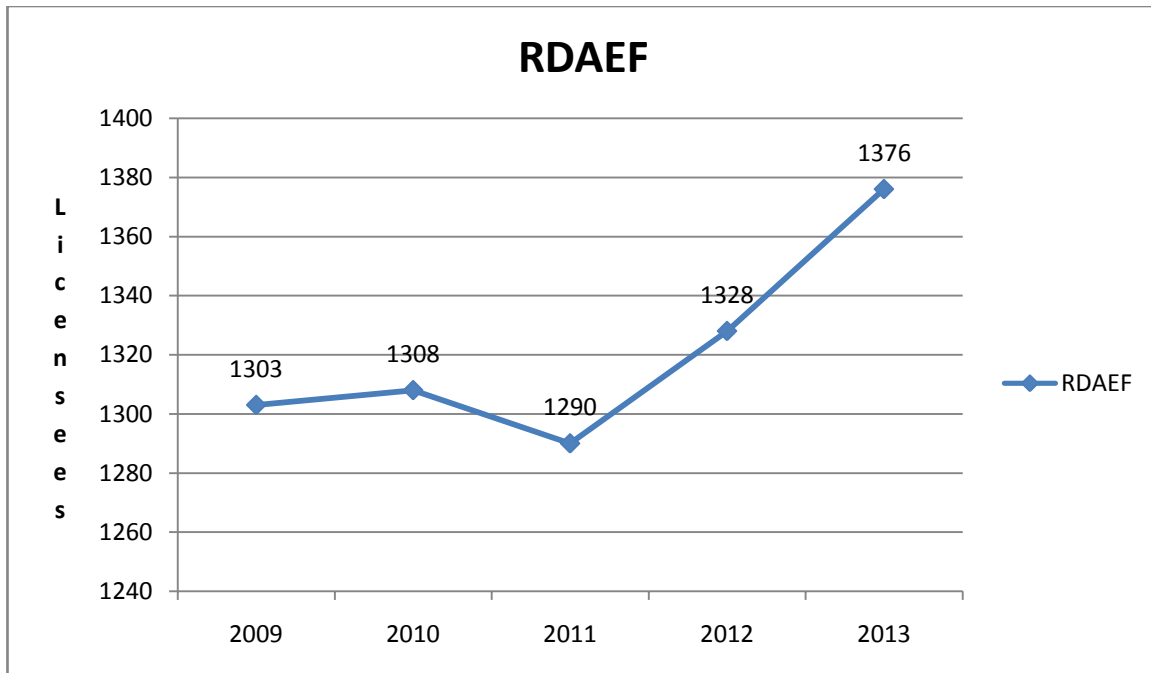
DATE	February 14, 2014
TO	Dental Board Members
FROM	Dawn Dill, Manager, Licensing and Examination Unit Dental Board of California
SUBJECT	Agenda Item DAC 4: Dental Assisting Program Licensure and Permit Statistics

Background

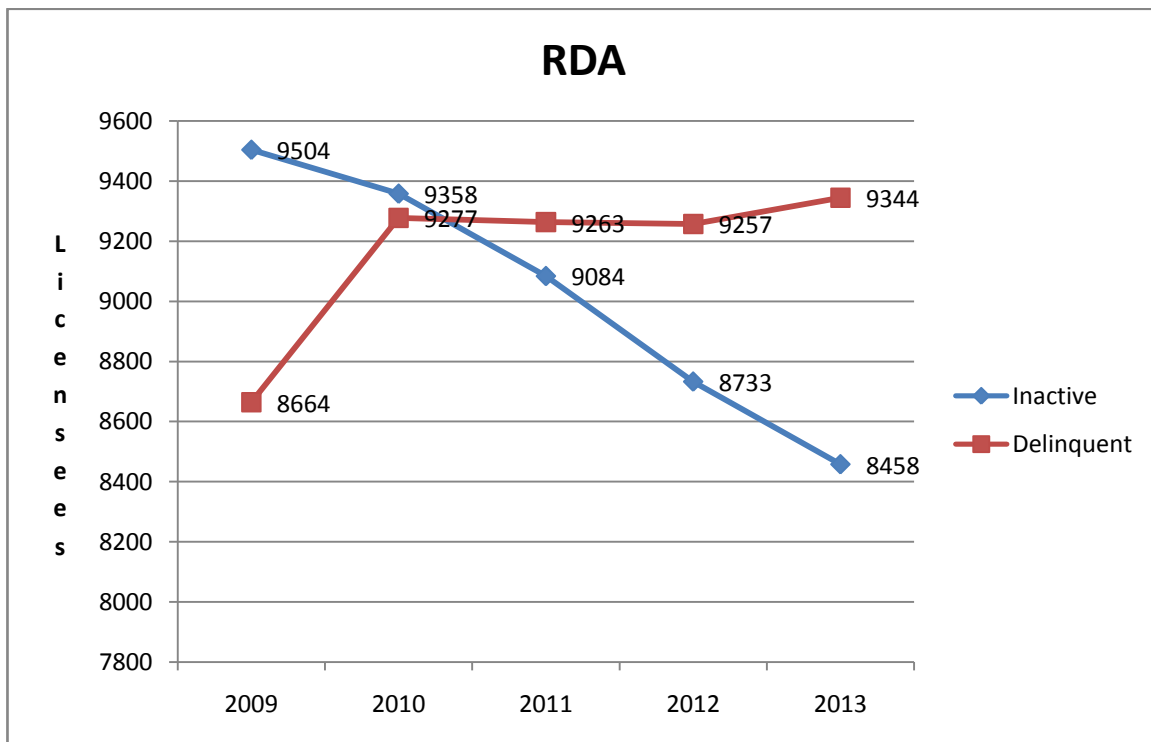
At the November 2013 Board Meeting there was a request for statistics showing trends. The graph below displays the number of active RDA licenses from 2009 to 2013. There was a 1% decrease in the number of licensees in 2010. In 2011 there was an increase of 5% in the number of active licensees. In 2012 the number of active licensees decreased 2.5% and increased 1% in 2013.



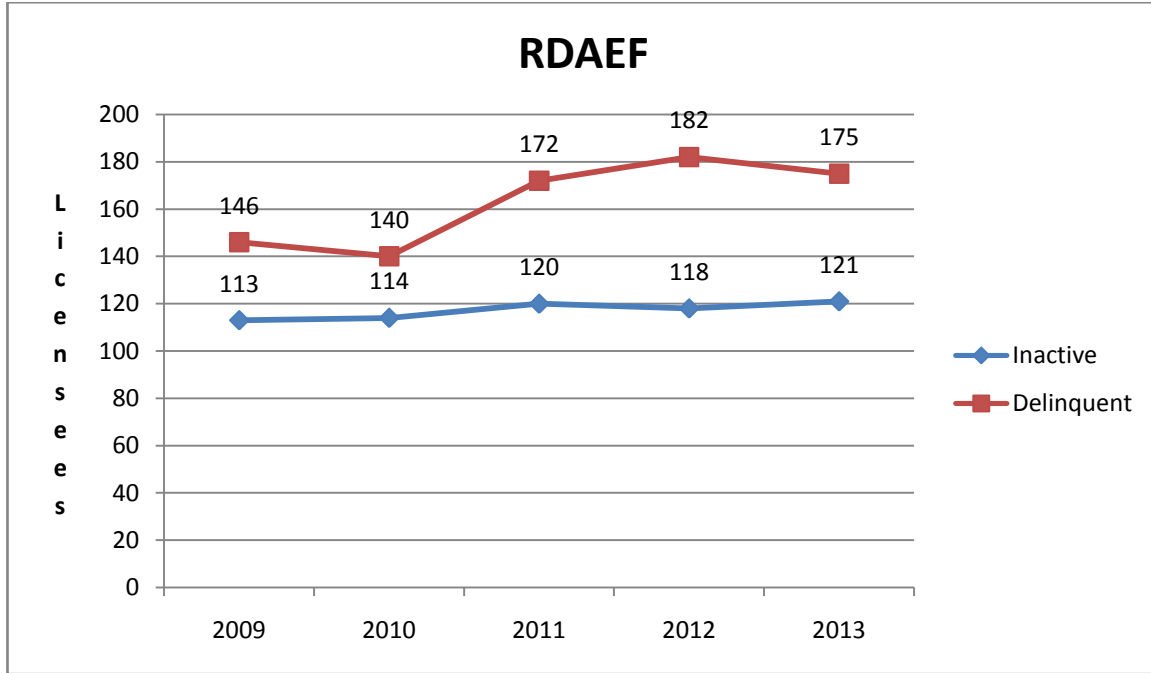
Below is a graph showing the number of active RDAEF licenses from 2009 to 2013. There has been an increase of 5% in the number of active licensees since 2009. This may be attributed to the enhancement of the allowable duties that went into effect on January 1, 2010.



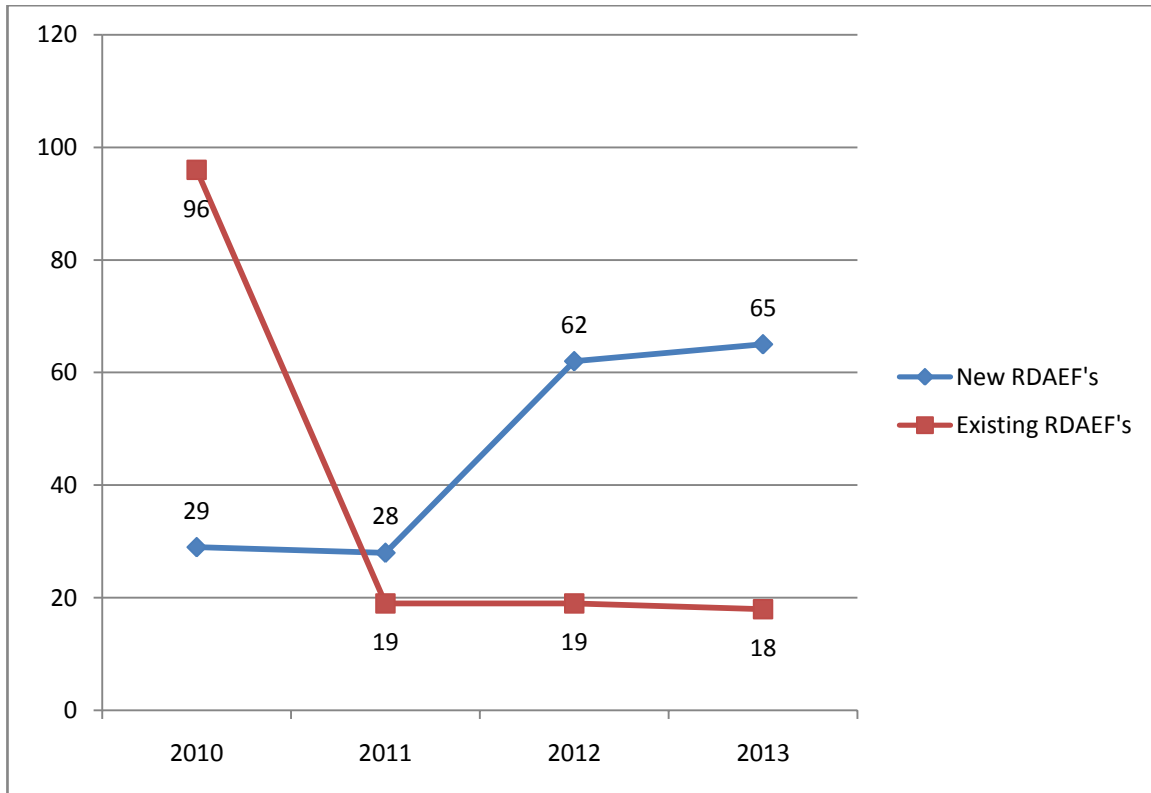
The graph below displays the number of inactive and delinquent licensees from 2009 to 2013. There was an increase of 7% for delinquent licenses between 2009 and 2010. In 2010 the number of inactive and delinquent licensees was very similar. Since 2010 the number of inactive licensees has decreased 10%, while the number of delinquent licensees as remained fairly consistent.



Below is a graph displaying the number of delinquent and inactive RDAEF licensees from 2009 to 2013. There was an increase of 19% in the number of delinquent licenses between 2010 and 2011. The number of inactive licensees has remained fairly consistent.



Below is a graph showing the number of new RDAEF licenses issued by year and the number of existing RDAEF licensees who were licensed to perform the enhanced RDAEF duties.



License/Permit /Certification/Registration Type	Current Active Permits	Delinquent	Total Cancelled Since Implemented
Dental Sedation Assistant Permit	23	0	0
Orthodontic Assistant Permit	118	2	0

Active Licensees by County as of February 2, 2014

County	DDS	RDA	RDAEF	Population
Alameda	1,455	1,378	48	1,554,720
Alpine	0	0	0	1,129
Amador	28	68	5	37,035
Butte	166	286	4	221,539
Calaveras	24	64	0	44,742
Colusa	3	22	2	21,411
Contra Costa	1,059	1,573	46	1,079,597
Del Norte	17	46	2	28,290
El Dorado	162	271	13	180,561
Fresno	560	793	17	947,895
Glenn	8	53	3	27,992
Humboldt	90	234	2	134,827
Imperial	40	79	2	176,948
Inyo	12	14	0	18,495
Kern	345	662	41	856,158
Kings	62	134	6	151,364
Lake	26	80	13	63,983
Lassen	28	62	2	33,658
Los Angeles	8,473	5,377	230	9,962,789
Madera	52	146	2	152,218
Marin	343	238	10	256,069
Mariposa	6	15	1	17,905
Mendocino	61	101	8	87,428
Merced	88	191	14	262,305
Modoc	4	8	0	9,327
Mono	2	8	0	14,348
Monterey	301	420	21	426,762
Napa	117	159	3	139,045
Nevada	95	134	4	98,292
Orange	3,761	2,226	69	3,090,132
Placer	447	635	32	361,682
Plumas	17	22	1	19,399
Riverside	1,098	2,019	68	2,268,783
Sacramento	1,095	1,847	92	1,450,121
San Benito	27	99	6	56,884
San Bernardino	1,330	1,711	61	2,081,313
San Diego	2,699	2,956	91	3,177,063

County	DDS	RDA	RDAEF	Population
San Francisco	1,233	500	17	825,863
San Joaquin	373	798	41	702,612
San Luis Obispo	240	302	3	274,804
San Mateo	867	847	27	739,311
Santa Barbara	345	352	6	431,249
Santa Clara	2,232	1,910	58	1,837,504
Santa Cruz	200	270	9	266,776
Shasta	132	303	8	178,586
Sierra	3	4	0	3,086
Siskiyou	30	41	1	44,154
Solano	297	672	33	420,757
Sonoma	418	815	35	491,829
Stanislaus	282	694	35	521,726
Sutter	59	132	12	95,022
Tehama	29	72	5	63,406
Trinity	4	7	0	13,526
Tulare	213	413	8	451,977
Tuolumne	57	91	0	54,008
Ventura	638	616	54	835,981
Yolo	117	243	8	204,118
Yuba	11	96	9	72,926

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



MEMORANDUM

DATE	February 13, 2014
TO	Dental Assisting Council
FROM	Marla Rocha, Examination Analyst
SUBJECT	DAC 5: Dental Assisting Program Examination Statistics

Written Examination Statistics for **2014** ALL CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	225	61%	39%
RDA Law & Ethics	202	66%	34%
RDAEF	5	20%	80%
Orthodontic Assistant	15	40%	60%
Dental Sedation Assistant	0	0%	0%

Written Examination Statistics for **2014** FIRST TIME CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	156	65%	35%
RDA Law & Ethics	146	73%	27%
RDAEF	1	100%	0%
Orthodontic Assistant	9	44%	56%
Dental Sedation Assistant	0	0%	0%

Written Examination Statistics for **2014** REPEAT CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	69	52%	48%
RDA Law & Ethics	56	48%	52%
RDAEF	4	0%	100%
Orthodontic Assistant	6	33%	67%
Dental Sedation Assistant	0	0%	0%

RDA Practical Examination Statistics for **2014 ALL CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	229	91%	9%
RDA – February South	271	78%	22%
RDA – April North			
RDA – April South			
RDA – August Central			
RDA – August North			
RDA – August South			
RDA – Nov – North			
RDA – Nov – South			
Total for Year			

RDA Practical Examination Statistics for **2014 FIRST TIME CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	172	92%	8%
RDA – February South	207	78%	22%
RDA – April North			
RDA – April South			
RDA – August Central			
RDA – August North			
RDA – August South			
RDA – Nov - North			
RDA – Nov - South			
Total for Year			

RDA Practical Examination Statistics for **2014 REPEAT CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	57	88%	12%
RDA – February South	64	80%	20%
RDA – April North			
RDA – April South			
RDA – August Central			
RDA – August North			
RDA – August South			
RDA – Nov - North			
RDA – Nov - South			
Total for Year			

RDAEF Clinical/Practical Examination Statistics for **2014 ALL CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – May North			
RDAEF – May South			
RDAEF – Sept South			
Total for Year			

RDAEF Clinical/Practical Examination Statistics for **2014** FIRST TIME CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – May North			
RDAEF – May South			
RDAEF – Sept South			
Total for Year			

RDAEF Clinical/Practical Examination Statistics for **2014** REPEAT CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – May North			
RDAEF – May South			
RDAEF – Sept South			
Total for Year			

Written Examination Statistics for **2013** ALL CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	3425	62%	38%
RDA Law & Ethics	3382	71%	29%
RDAEF	121	51%	49%
Orthodontic Assistant	145	52%	48%
Dental Sedation Assistant	10	90%	10%

Written Examination Statistics for **2013** FIRST TIME CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	2327	70%	30%
RDA Law & Ethics	2305	75%	25%
RDAEF	70	56%	44%
Orthodontic Assistant	108	56%	44%
Dental Sedation Assistant	7	86%	14%

Written Examination Statistics for **2013** REPEAT CANDIDATES

Written Exam	Total Candidates Tested	% Passed	% Failed
RDA	1098	45%	55%
RDA Law & Ethics	1077	62%	38%
RDAEF	51	45%	55%
Orthodontic Assistant	37	43%	57%
Dental Sedation Assistant	3	100%	0%

RDA Practical Examination Statistics for **2013 ALL CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	297	92%	8%
RDA – February South	314	82%	18%
RDA – April North	250	84%	16%
RDA – April South	304	77%	23%
RDA – August North	503	90%	10%
RDA – August Central	218	84%	16%
RDA – August South	462	83%	17%
RDA – Nov – North	402	89%	11%
RDA – Nov – South	492	77%	23%
Total for Year	3242	84%	16%

RDA Practical Examination Statistics for **2013 FIRST TIME CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	249	84%	16%
RDA – February South	253	81%	19%
RDA – April North	219	88%	12%
RDA – April South	258	78%	22%
RDA – August North	476	85%	15%
RDA – August Central	213	84%	16%
RDA – August South	415	75%	25%
RDA – Nov - North	352	93%	7%
RDA – Nov - South	428	77%	23%
Total for Year	2863	83%	17%

RDA Practical Examination Statistics for **2013 REPEAT CANDIDATE**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDA – February North	48	60%	40%
RDA – February South	61	85%	15%
RDA – April North	31	87%	13%
RDA – April South	46	76%	24%
RDA – August North	27	85%	15%
RDA – August Central	5	100%	0%
RDA – August South	47	77%	23%
RDA – Nov - North	50	58%	42%
RDA – Nov - South	64	78%	22%
Total for Year	379	78%	22%

RDAEF Clinical/Practical Examination Statistics for **2013 ALL CANDIDATES**

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – January North	21	86%	14%
RDAEF – June North	24	63%	37%
RDAEF – June South	34	26%	74%
RDAEF – Sep -North	30	70%	30%
RDAEF – Oct - South	33	61%	39%
RDAEF – Dec - North	15	67%	33%
Total for Year	157	62%	34%

RDAEF Clinical/Practical Examination Statistics for **2013** FIRST TIME CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – January North	18	94%	6%
RDAEF – June North	20	60%	40%
RDAEF – June South	30	30%	70%
RDAEF – Sep - North	20	80%	20%
RDAEF – Oct - South	9	67%	33%
RDAEF – Dec - North	0	0%	0%
Total for Year	97	66%	34%

RDAEF Clinical/Practical Examination Statistics for **2013** REPEAT CANDIDATES

Practical/Clinical Exam Type	Candidates Tested	% Passed	% Failed
RDAEF – January North	3	33%	67%
RDAEF – June North	4	75%	25%
RDAEF – June South	4	0%	100%
RDAEF – Sep - North	10	50%	50%
RDAEF – Oct - South	24	58%	42%
RDAEF – Dec - North	15	67%	33%
Total for Year	60	47%	53%



MEMORANDUM

DATE	February 19, 2014
TO	Dental Assisting Council
FROM	Teresa Lua, RDAEF
SUBJECT	DAC 6: Discussion and Possible Action Regarding Appointing a Subcommittee to Work with Staff to Review the Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) Examination Process in Order to Identify Improvements

Members of the Dental Assisting Council observed the examinations given at the University of San Francisco (UCSF) and in Pomona in February. The Chair of the Dental Assisting Council, Teresa Lua, RDAEF, is considering appointing a subcommittee to work with staff to review the Registered Dental Assistant (RDA) and Registered Dental Assistant in Extended Functions (RDAEF) examination process in order to identify improvements.



MEMORANDUM

DATE	February 19, 2014
TO	Dental Assisting Council
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item DAC 7: Update Regarding Dental Assisting Educational Program and Course Requirements Regulatory Proposal

Background:

The Dental Assisting Council had its first regulatory development workshop on December 12, 2013 in Sacramento. Members of the Council, staff, and stakeholders had the opportunity to openly discuss the necessary changes to the regulations. Staff will be working with assigned subcommittees to further develop the regulatory language to bring back to the next regulatory development workshop.

The subcommittee assigned to review the Radiation Safety Course Requirements (Cal. Code of Regs., Title 16, §§ 1014 and 1014.1) will be having a noticed subcommittee meeting within the next few months to openly discuss development of the regulations with stakeholders and staff.

The Council was originally scheduled to hold its next regulatory development workshop on March 7, 2014. This workshop date has been postponed until a later date due staff workload and the close proximity of the workshop to the Board and Council meetings at the end of February. Staff would not have had adequate time to prepare a substantive product for the Council's consideration and discussion on March 7th.

Additionally, staff is concerned that Assembly Bill 1174 (Bocanegra) will impact the requirements relating to dental assisting programs. Because of this, it would be prudent to postpone development of the regulatory language concerning programs until after the bill is enacted so that the Council and staff will have a better understanding of how the regulations should be further developed and avoid duplication of work effort. The Council would still be able to continue working on the individual course requirements while waiting for the bill to be enacted.

Action Requested:

No action necessary.

ENFORCEMENT COMMITTEE



NOTICE OF ENFORCEMENT COMMITTEE MEETING
Thursday, February 27, 2014

Upon Conclusion of the Dental Assisting Council meeting
Wyndham Bayside San Diego
1355 North Harbor Drive, San Diego, CA, 92101
(619) 232-3861 or (916) 263-2300

MEMBERS OF THE ENFORCEMENT COMMITTEE

Chair – Steven Afriat, Public Member
Vice Chair – Ross Lai, DDS
Katie Dawson, RDH
Luis Dominicis, DDS
Thomas Stewart, DDS

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

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

1. Call to Order/Roll Call/Establishment of Quorum
2. Approval of the February 28, 2013 Enforcement Committee Meeting Minutes
3. Define the 2014 Mission of the Enforcement Committee
4. Staff Update Regarding Enforcement Unit Status
5. Enforcement Program – Statistics and Trends
6. Review of Second Quarter Performance Measures from the Department of Consumer Affairs
7. Diversion Statistics

8. **Public Comment of Items Not on the Agenda**
The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
9. **Future Agenda Items**
Stakeholders are encouraged to propose items for possible consideration by the Committee at a future meeting.
10. **Committee Member Comments for Items Not on the Agenda**
The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
11. **Adjournment**



**ENFORCEMENT COMMITTEE
MEETING MINUTES
Thursday, February 28, 2013**
Holiday Inn on the Bay
1355 North Harbor Drive, San Diego, CA, 92101
DRAFT

Members Present

Steven Afriat, Public Member - Chair
Bruce Whitcher, DDS - Vice Chair
Fran Burton, Public Member
Luis Dominicus, DDS
Suzanne McCormick, DDS

Members Absent

Staff Present

Karen Fischer, Interim Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit and Dental Assisting Unit Manager
Lori Reis, Complaint and Compliance Unit Manager
Jocelyn Campos, Enforcement Coordinator
Linda Byers, Executive Assistant
Spencer Walker, Senior Legal Counsel
Greg Salute, Deputy Attorney General

ROLL CALL AND ESTABLISHMENT OF QUORUM

Steven Afriat, Chair, called the Enforcement Committee meeting to order at 11:08 a.m. Roll was called and a quorum established.

ENF 1 - Approval of the December 3, 2012 Enforcement Committee Meeting Minutes

M/S/C (McCormick/Dominicus) to approve the minutes of the December 3-4, 2012 meeting of the Enforcement Committee. The motion passed unanimously.

ENF 2 - Staff Update Regarding Enforcement Unit Projects and Improvements

Kim Trefry, Enforcement Chief, reported on the successful Enforcement efforts of the Southern California office in citing the suspect and seizing evidence for the case.

Ms. Trefry reported that the Vehicle Home Storage Permits were rescinded as of January 1, 2013. The Department of General Services has issued new criteria for the permits. Ms. Trefry believes that the Dental Board's sworn investigators meet the new criteria and she will be submitting a new request for consideration.

Ms. Trefry reported that the Board is requesting approval to purchase five (5) replacement vehicles for those with the highest mileage and/or highest repair costs in its aging fleet.

ENF 3 - Enforcement Program – Statistics and Status

Kim Trefry, Enforcement Chief, gave an overview of the statistics provided. Mr. Afriat noted that there are a significantly higher number of cases in the southern California office. Ms. Trefry commented that paperwork is being finalized to hire an additional investigator in the south and some of the cases that don't require travel or face-to-face interviews are being shifted to the north to relieve some of the burden in the south. Dr. Whitcher commented that it would be interesting to see the ratio of Investigative staff to licensees by region.

ENF 4 - Review of Second Quarter Performance Measures from the Department of Consumer Affairs

Ms. Trefry reviewed the Enforcement Units second quarter performance, compared to the Departments performance measures. She pointed out that most of our targets are being met.

ENF 5 - Diversion Statistics

Lori Reis, Complaint and Compliance Unit and Diversion Program Manager, reviewed the Diversion statistics provided noting that there two (2) intakes during the previous quarter ending December 31, 2012.

ENF 6 - Discussion and Possible Action Regarding Recommendations for the Appointment of a Northern California Diversion Evaluation Committee Member

Lori Reis, Complaint and Compliance Unit and Diversion Program Manager, reported that two candidates were interviewed by a Diversion Evaluation Committee (DEC) Panel. The Panel is recommending appointment of Gregory S. Pluckhan, D.D.S. to fill one of the dental vacancies on the Northern California DEC.

M/S/C (Morrow/Burton) to accept the DEC Panel's recommendation to appoint Gregory S. Pluckhan, DDS to fill one of the dental vacancies on the Northern California DEC and recommend that the full Board appoint Gregory S. Pluckhan, DDS to fill one of the dental vacancies on the Northern California DEC. The motion passed unanimously.

There was no public comment.

The committee adjourned at 11:27 a.m.



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	ENF 3: Define the 2014 Mission of the Enforcement Committee

This item is designed as an open forum to define any issues the Committee may want to explore during the year.



MEMORANDUM

DATE	February 12, 2014
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	Agenda Item ENF 4: Enforcement Program Status

Southern California Unlicensed Dentistry (SCUD) Task Force – Follow-up

At the November meeting, the Enforcement program reported on its initial effort to address the unlicensed dentistry problem identified in Southern California. Since that time, search warrants were served on seven (7) locations resulting in nine (9) arrests for unlicensed activity and associated charges.

Of the 109 cases originally identified, 59 have now been closed in this first effort.

In addition to the efforts of our sworn investigative staff, our non-sworn Special Investigators also participated in the task force. Staff contacted several offices for aiding and abetting unlicensed practice, working outside the scope of licensure, ownership issues, and allegations regarding working on an expired license. We anticipate repeating this effort later in 2014.

Staffing

The Sacramento office currently has two Investigator vacancies with two candidates in the background phase of the hiring process. In January, interviews were conducted for the vacant Inspector position, and a job offer was accepted. All other enforcement units are fully staffed.

Uniform Standards Implementation

The Uniform Standards Relating to Substance Abusing Licensees are scheduled to become effective April 1, 2014. Enforcement staff have met with the Diversion Program Liaison, Attorney General's Office, and our biological fluid testing contractor to identify internal policy and procedural changes in preparation for the upcoming implementation. The completed implementation plan will be presented at our May meeting date.

Patient Abandonment

Pursuant to Business and Professions Code section 1680(u), patient abandonment is described as, “the abandonment of the patient by the licensee without written notice to the patient that treatment is to be discontinued and before the patient has ample opportunity to secure the services of another dentist...” and is considered Unprofessional Conduct. During the past year, the enforcement program has begun to observe an increase in the number of *Patient Abandonment* complaints submitted. The data in the following table illustrates the complaint numbers received in this category over the past 5 years.

Calendar Year	Number of reported Patient Abandonment Cases
2009	37
2010	50
2011	46
2012	37
2013	98

There are a number of factors which appear to have contributed to the receipt of these complaint types. They include office closures attributed to tax liens, bankruptcies, or the unexpected death of the licensee. In some situations, substance abuse or a health issue has contributed to an unanticipated office closure.

Besides the consumer generated cases we've opened, staff have received calls from property managers at business locations and storage units who have come upon boxes of abandoned patient files left behind when a licensee vacated an office or could no longer pay storage fees. In another situation, records were left for garbage pickup. In these examples, the licensees not only failed to provide for continuity of patient care, but often left patient records unsecured and subject to destruction or disclosure by third parties.

Patient abandonment cases can be particularly frustrating for consumers whose care has been discontinued in this manner. They may not have access to their records to seek treatment elsewhere and may be required to pay for (and be exposed to) a second set of x-rays, before they can obtain continued care. In some instances, patients have paid for their treatment in advance and are unable to reach the dentist to request or receive a refund.

This report is informational at this time. We will continue to watch these complaint totals so that we may anticipate any need for redirected enforcement, education, or recommended changes to regulation.

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



MEMORANDUM

DATE	February 11, 2014
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	Agenda Item ENF 5: Enforcement Statistics and Trends (Complaints and Investigations)

Attached please find Complaint Intake and Investigation statistics for the previous five fiscal years, and the current fiscal year to date. Below is a summary of some of the program's trends (as of 12/31/2013):

Complaint & Compliance Unit

Complaints Received

The total number of complaint files received during the second quarter of the fiscal year was **725**, averaging **241** per month.

Pending Cases: 972

Average caseload per Consumer Services Analyst (CSA) = **269** complaint cases

Complaint Aging

# Months Open	# of Cases	% of Total Cases
0 – 3 Months	565	58%
4 – 6 Months	209	22%
7 – 9 Months	54	5%
10 – 12 Months	74	8%
1 – 3 Years	70	7%

Cases Closed:

The total number of complaint files closed between October 1, 2013 and December 31, 2013 was **745**, averaging **248** per month. The previous five-year average is 240 closures per month.

The average number of days a complaint took to close within the last year was **111** days (a 54% increase from last year's average of 72 days). Chart 2 displays the average complaint closure age over the previous five fiscal years.

Investigations

Current Open Caseload:

There are currently approximately **759** open investigative cases, **274** probation cases, and **84** open inspection cases.

Average caseload per full time Investigator = 38 (44 in North, 36 in South)

Average caseload per Special Investigator = 32

Average caseload per Analyst = 23

# Months Open	# of Cases	% of Total Cases
0 – 3 Months	192	26%
4 – 6 Months	126	18%
6 - 12 Months	177	23%
1 – 2 Years	173	23%
2 – 3 Years	72	9%
3+ Years	10	1%

Since our last report in November 2013, the number of cases over one year old has decreased from 48% to 33%. The number of cases in the oldest category (three years and older) has decreased from 20 to 10.

Case Closures:

The total number of investigation cases closed, filed with the AGO or filed with the District/City Attorney during the second quarter of the fiscal year is **262**, an average of **87** per month. The previous five-year average was 73 per month. Chart 2 displays the average closure age over the previous five fiscal years.

Of the closures, approximately 15% were referred for criminal action or administrative discipline.

The average number of days an investigation took to complete within the last three months was **396** days. The previous five-year average number of days to close a case is 436 days (refer to Chart 2).

Cases Referred for Discipline:

The total number of cases referred to the AGO's during the last three months was **25** (approximately eight referrals per month). The three-month average for a disciplinary case to be completed was **1226** days. Chart 2 displays the average closure age over the previous four fiscal years for cases referred for discipline.

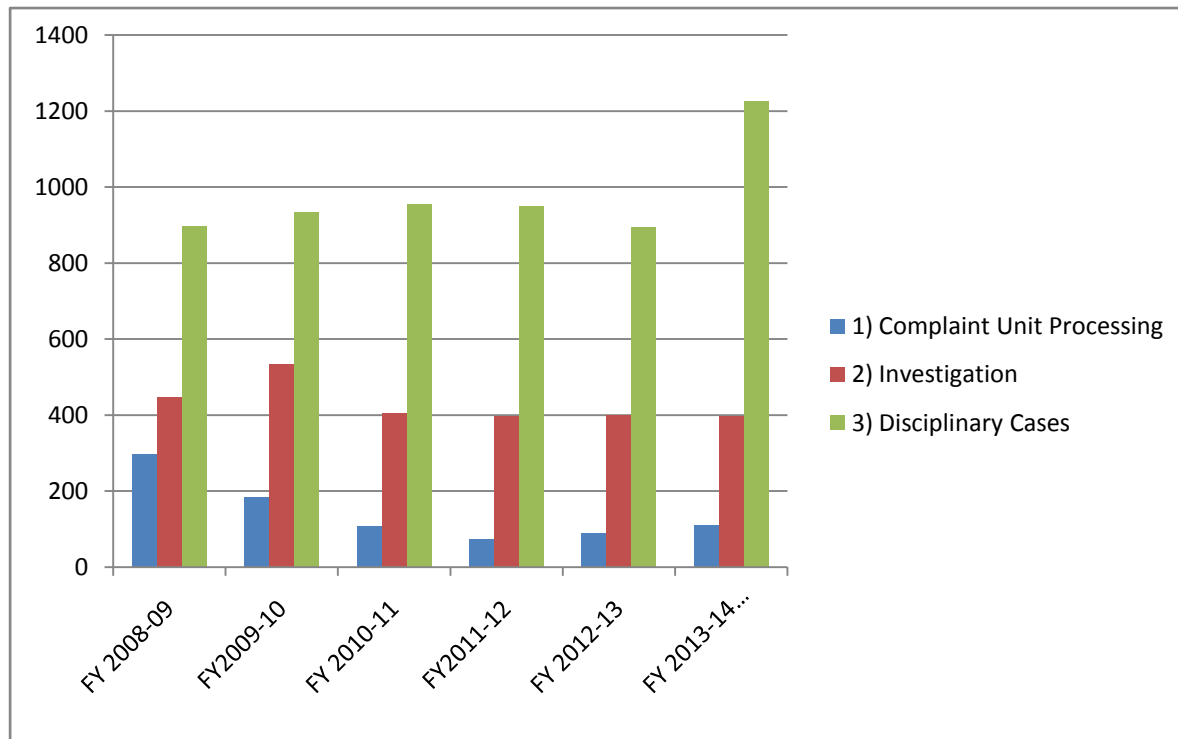
I will be available during the Board meeting to answer any questions or concerns you may have.

**Dental Board of California
Enforcement Program**

STATISTICAL DESCRIPTION	FY 08-09	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 2013-14				
						Jul-Sep	Oct - Dec	Jan - Mar	Apr - Jun	YTD
COMPLAINT UNIT										
Complaints Received	3254	3013	3056	2813	2868	723	725			1448
Complaints Closed	2915	3246	2987	2409	3067	737	745			1482
Convictions/Arrests	290	177	678	750	1210	162	155			317
Pending at end of period	1678	1078	491	734	1070	35	19			
INVESTIGATIONS										
Cases Opened	755	769	1241	916	719	196	252			448
Cases Closed	831	651	997	1094	813	227	262			489
Referred to AG	195	138	144	174	85	24	25			49
Referred for Criminal	20	11	8	12	19	3	14			17
Pending at end of period	661	779	995	1025	767	740	759			
Citations Issued	11	48	42	15	27	54	7			61
ATTORNEY GENERAL'S OFFICE										
Cases Pending at AG	232	191	199	229	183	188	189			
Administrative Actions:										
Accusation	98	97	90	99	52	22	17			39
Statement of Issues	36	27	23	41	9	3	4			7
Petition to Revoke Probation	6	5	5	9	4	4	4			8
Licensee Disciplinary Actions:										
Revocation	23	39	24	30	27	3	5			8
Probation	41	66	65	68	51	14	14			28
Suspension/Probation	1	0	0	2	0	0	0			0
License Surrendered	6	9	10	6	10	2	3			5
Public Reprimand	1	8	9	13	11	3	3			6
Other Action (e.g. exam required, education course, etc.)	6	10	11	8	7	0	1			1
Accusation Withdrawn	3	8	9	8	10	0	1			1
Accusation Declined	8	6	6	1	2	0	0			0
Accusation Dismissed	0	5	0	0	2	0	0			0
Total, Licensee Discipline	89	151	134	136	120	22	27			49
Other Legal Actions:										
Interim Suspension Order Issued	1	1	1	6	5	0	0			0
PC 23 Order Issued	2	0	0	0	2	0	0			0

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

Average Days to Close	FY 2008-09	FY2009-10	FY 2010-11	FY2011-12	FY 2012-13	FY 2013-14 YTD
1) Complaint Unit Processing	298	183	106	72	88	111
2) Investigation	446	534	404	397	400	396
3) Disciplinary Cases	897	933	954	950	893	1226



**Dental Board of California
Enforcement Program
Case Distribution by Allegation Types**

Allegations	Fiscal Years					2013-14					
	2008-09	2009-10	2010-11	2011-12	2012-13	Jul-Sep	Oct - Dec	Jan - Mar	Apr - Jun	Total	% of Total
Substance Abuse, Mental/Physical Impairment	21	10	12	4	7	3	3			6	0%
Drug Related Offenses	29	29	29	38	33	5	8			13	1%
Unsafe/Unsanitary Conditions	81	76	70	79	92	30	25			55	3%
Fraud	102	188	299	123	124	32	52			84	5%
Non-Jurisdictional	374	438	393	251	217	44	60			104	6%
Incompetence / Negligence	2211	2123	2076	1540	1459	446	420			866	49%
Other	315	336	181	266	295	48	39			87	5%
Unprofessional Conduct	330	385	352	205	219	57	69			126	7%
Sexual Misconduct	10	21	15	13	14	9	2			11	1%
Discipline by Another State	15	15	31	25	16	2	1			3	0%
Unlicensed / Unregistered	126	119	127	111	124	47	61			108	6%
Criminal Charges	405	206	456	854	1137	162	155			317	18%
Total	4019	3946	4041	3509	3737	885	895	0	0	1780	



MEMORANDUM

DATE	February 12, 2014
TO	Dental Board Members
FROM	Kim Trefry, Enforcement Chief
SUBJECT	ENF 6: Second Quarter Performance Measures

Performance measures are linked directly to an agency's mission, vision and strategic objectives/initiatives. In some cases, each Board, Bureau, and program was allowed to set their individual performance targets, or specific levels of performance against which actual achievement would be compared. In other cases, some standards were established by DCA. As an example, a target of an average of 540 days for the cycle time of formal discipline cases was set by the previous Director. Data is collected quarterly and reported on the Department's website at: http://www.dca.ca.gov/about_dca/cpei/index.shtml

Q2 (October - December 2013)

PM 1 - Volume: 894 Total (739 Consumer complaints, 155 Conviction reports)
 Number of complaints and convictions received per quarter

Cycle Time:

- PM 2 Intake - Target: 10 Days** **Q2 Average: 6 Days**
 Average cycle time from complaint receipt, to the date the complaint was acknowledged and assigned to an analyst in the Complaint Unit for processing (This 10 day time frame is mandated by Business and Professions Code section 129 (b)) ;
- PM 3 Intake & Investigation - Target: 270 Days** **Q2 Average: 166 Days**
 Average time from complaint receipt to closure of the investigation process (does not include cases sent to the Attorney General (AG) or other forms of formal discipline);
- PM 4 Formal Discipline - Target: 540 Days** **Q2 Average: 1,453 Days**
 Average number of days to complete the entire enforcement process for cases resulting in formal discipline (Includes intake and investigation by the Board, and prosecution by the AG);

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

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

- **PM 7 Probation Intake – Target: 10 Days** **Q2 Average: 16 Days**
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer; and

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

- **PM 8 Probation Violation Response – Target: 10 Days** **Q2 Average: 15 Days**
Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

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

Dental Board of California

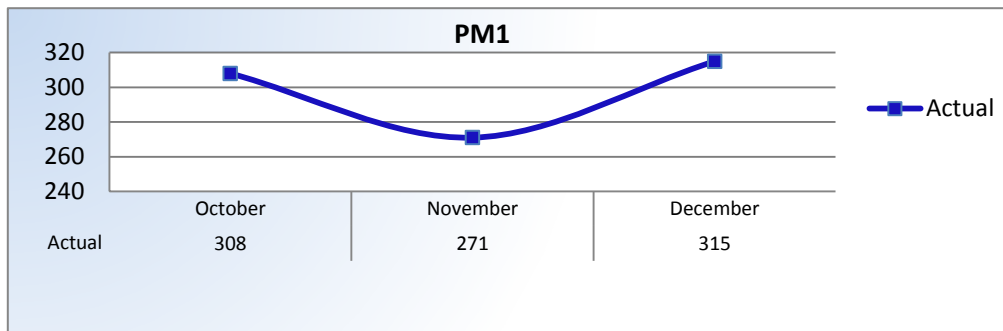
Performance Measures

Q2 Report (October - December 2013)

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

PM1 | Volume

Number of complaints and convictions received.

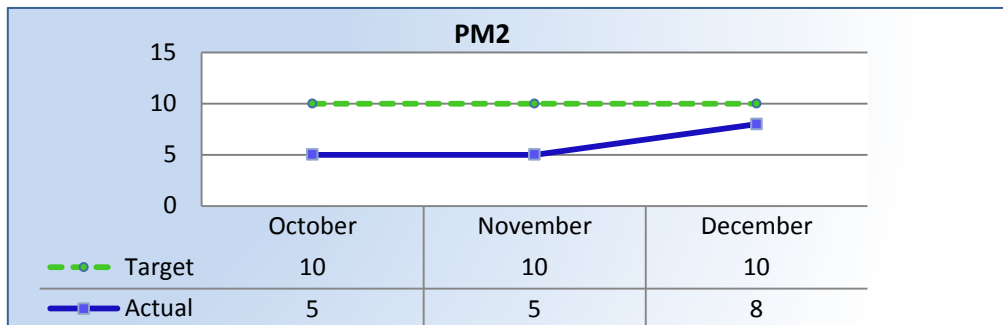


Total Received: 894 Monthly Average: 298

Complaints: 739 | Convictions: 155

PM2 | Intake

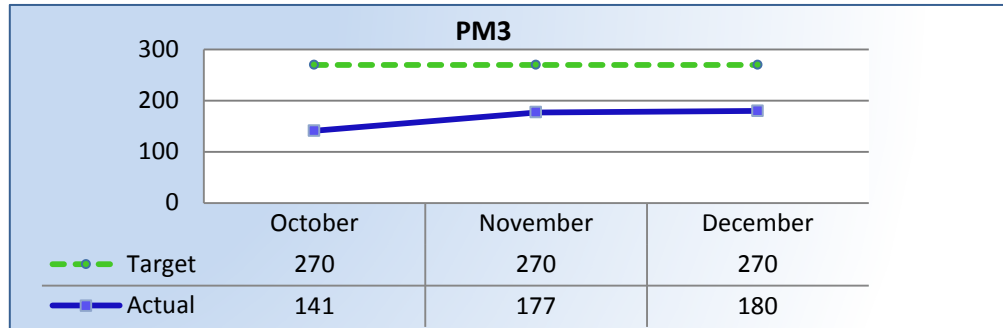
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 10 Days | Actual Average: 6 Days

PM3 | Intake & Investigation

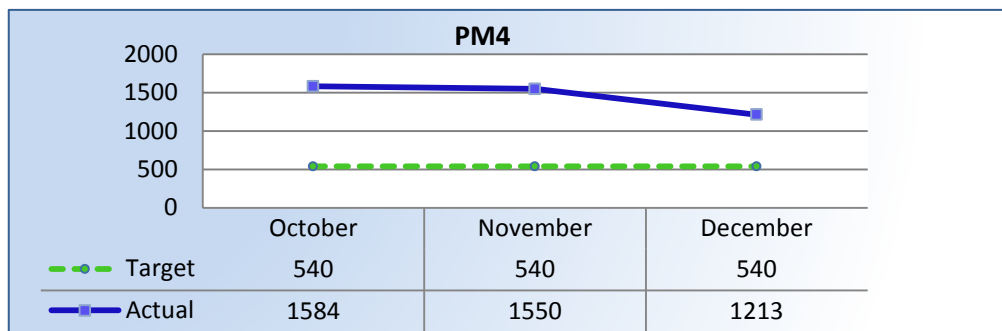
Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.



Target Average: 270 Days | Actual Average: 166 Days

PM4 | Formal Discipline

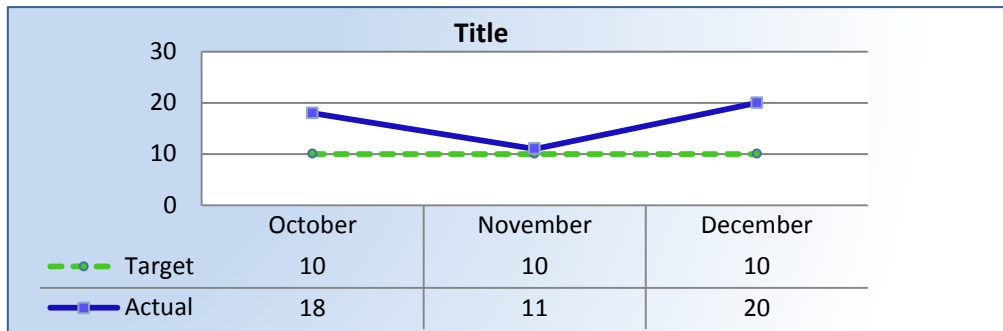
Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).



Target Average: 540 Days | Actual Average: 1,453 Days

PM7 | Probation Intake

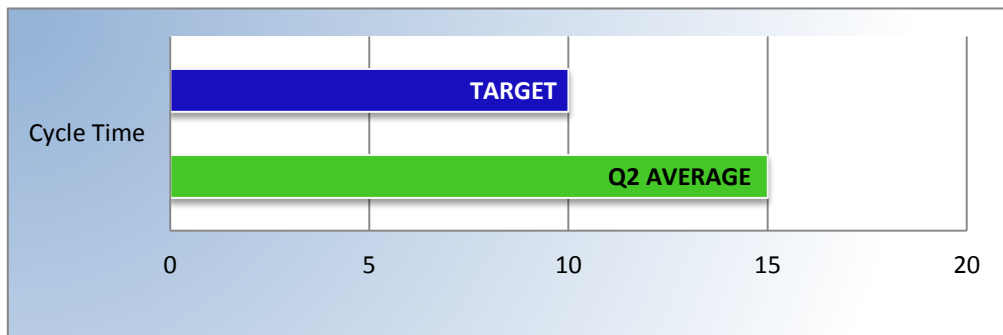
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 10 Days | Actual Average: 16 Days

PM8 | Probation Violation Response

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



Target Average: 10 Days | Actual Average: 15 Days



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board Members
FROM	Lori Reis, Diversion Program Manager
SUBJECT	Agenda Item ENF 7: Diversion Statistics

Diversion Evaluation Committee (DEC) program statistics for quarter ending 12/31/2013 are provided below. These statistics reflect the participant activity in the Diversion (Recovery) Program and are presented for information purposes only.

These statistics are derived from the MAXIMUS monthly reports.

OCTOBER

- Intakes Into Program: One Self-Referral/One Probation Referral
- Participant’s County of Residence: Riverside/Orange
- Gender: Male
- Worksite of Practice Setting: Unemployed
- Specialty at Intake: General Dentist
- Presenting Problem at Intake: Alcohol/Mono Drug
- Marital Status: Divorced
- Closed Cases: Two
- Active Participants: 33

NOVEMBER

- Intakes Into Program: One Probation Referral
- Participant’s County of Residence: Santa Clara
- Gender: Male
- Worksite of Practice Setting: Unemployed
- Specialty at Intake: Oral and Maxillofacial Surgery
- Presenting Problem at Intake: Mono Drug
- Marital Status: Married
- Closed Cases: 0
- Active Participants: 34

DECEMBER

- Intakes Into Program: One Probation Referral
- Participant’s County of Residence: Riverside
- Gender: Male
- Worksite of Practice Setting: Unemployed
- Specialty at Intake: Oral and Maxillofacial Surgery
- Presenting Problem at Intake: Alcohol
- Marital Status: Divorced
- Closed Cases: Four
- Active Participants: 31

There are currently 31 participants in the program, 12 in the Northern DEC and 19 in the Southern DEC.

The Board continues recruitment for the following positions:

- Southern DEC - one Public Member
- Northern DEC - one Dentist and one Licensed Physician or Psychologist

The next DEC meeting is scheduled for March 6th in Northern CA.

ACTION REQUESTED

None

**LEGISLATIVE AND
REGULATORY
COMMITTEE**



NOTICE OF LEGISLATIVE AND REGULATORY COMMITTEE MEETING

Thursday, February 27, 2014

Upon Conclusion of the Enforcement Committee meeting

Wyndham Bayside San Diego

1355 North Harbor Drive, San Diego, CA, 92101

(619) 232-3861 or (916) 263-2300

MEMBERS OF THE LEGISLATIVE & REGULATORY COMMITTEE

Chair – Fran Burton, MSW, Public Member

Vice Chair – Thomas Stewart, DDS

Huong Le, DDS, MA

Meredith McKenzie, Public Member

Steven Morrow, DDS, MS

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

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

1. Call to Order/Roll Call/Establishment of Quorum
2. Approval of the February 28, 2013 Legislative and Regulatory Committee Meeting Minutes
3. Define the 2014 Mission of the Legislative and Regulatory Committee
4. 2014 Tentative Legislative Calendar – Information Only
5. Discussion and Possible Action on the Following Legislation:
 - AB 318 (Logue) Dental Care: Telehealth
 - AB 809 (Logue) Healing Arts: Telehealth
 - AB 1174 (Bocanegra) Oral Health: Virtual Dental Homes
 - Any additional legislation impacting the Board that staff becomes aware of between the time the meeting notice is posted and the Board meeting

6. Update on Pending Regulatory Packages:

- (A) Uniform Standards for Substance Abusing Licensees (California Code of Regulations, Title 16, Sections 1018 and 1018.01);
- (B) Dentistry Fee Increase (California Code of Regulations, Title 16, Section 1021);
- (C) Portfolio Examination Requirements (California Code of Regulations, Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033, 1033.1, 1034, 1034.1, 1035, 1035.1, 1035.2, 1036, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039);
- (D) Abandonment of Applications (California Code of Regulations, Title 16, Section 1004);
- (E) Dental Assisting Educational Program and Course Requirements (California Code of Regulations, Title 16, Division 10, Chapter 3, Article 2); and,
- (F) Licensure by Credential Application Requirements

7. Discussion of Prospective Legislative Proposals:

Stakeholders Are Encouraged to Submit Proposals in Writing to the Board Before or During the Meeting for Possible Consideration by the Board at a Future Meeting

8. Public Comment of Items Not on the Agenda

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

9. Future Agenda Items

Stakeholders are encouraged to propose items for possible consideration by the Committee at a future meeting.

10. Committee Member Comments for Items Not on the Agenda

The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).

11. Adjournment



**LEGISLATIVE AND REGULATORY COMMITTEE
MEETING MINUTES**

Thursday, February 28, 2013

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

DRAFT

Members Present

Chair – Fran Burton, Public Member
Vice Chair – Steve Afriat, Public Member
Huong Le, DDS
Steve Morrow, DDS

Members Absent

Stephen Casagrande, DDS

Staff Present

Karen Fischer, Interim Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit and Dental Assisting Unit Manager
Lori Reis, Complaint and Compliance Unit Manager
Jocelyn Campos, Enforcement Coordinator
Linda Byers, Executive Assistant
Spencer Walker, Senior Legal Counsel
Greg Salute, Deputy Attorney General

Fran Burton called the Legislative and Regulatory Committee meeting to order at 11:40 a.m. Roll was called and a quorum established.

LEG 1 - Approval of the December 3, 2012 Legislative and Regulatory Committee Meeting Minutes

M/S/C (Afriat/Morrow) to approve the December 3, 2012 Legislative and Regulatory Committee meeting minutes. The motion passed unanimously.

LEG 2 - 2013 Tentative Legislative Calendar – Information Only

Fran Burton, Chair, noted that February 23, 2013, was the last day for bills to be introduced.

LEG 3 - Report on Legislative Committee Assignments for the 2013-14 Legislative Session

Fran Burton, Chair, reviewed the Legislative Committee assignments noting that Senator Curran D. Price, Jr. remains Chair of the Senate Business, Professions, and Economic Development Committee and Assembly Member Richard S. Gordon is Chair of the Assembly Business, Professions and Consumer Protection Committee.

LEG 4 - Discussion and Possible Action on the Following Legislation:

Fran Burton, Chair, stated that some of the bills have been assigned to a Committee but most have not been heard yet. She recommended discussion but no action on the following bills.

Assembly Bill 50 (Pan) Health Care Coverage: Medi-Cal Eligibility

Ms. Burton explained that this bill would require the department to establish a process in accordance with federal law to allow a hospital that is a participating Medi-Cal provider to elect to be a qualified

entity for purposes of determining whether any individual is eligible for Medi-Cal and providing the individual with medical assistance during the presumptive eligibility period.

This bill would also require the department to implement a new process by January 1, 2015, to inform Medi-Cal enrollees of their options with regard to the delivery of Medi-Cal services, including fee-for-service, if available, and all managed care options.

This bill would also require that an applicant or recipient of benefits under a state health subsidy program be given an option, with his or her informed consent, to have an application for renewal form prepopulated or electronically verified in real time, or both, as specified.

This bill would declare that it is to take effect immediately as an urgency statute.

Assembly Bill 186 (Maienschein) Professions and Vocations: Military Spouses: Licenses

Ms. Burton explained that this bill would authorize boards within the Department to issue a provisional license to an applicant who qualifies for an expedited license pursuant to Business and Professions Code Section 115.5. This bill specifies that the provisional license would expire after eighteen (18) months. Dr. Morrow asked the Interim Executive Officer to define "expedited". Karen Fischer, Interim Executive Officer stated that staff is in the process of developing a revised form to identify military applicants and make their applications first priority.

Assembly Bill 213 (Logue) Healing Arts: Certification: Military Experience

Ms. Burton explained that this bill would require a healing arts board within the Department and the DPH, upon the presentation of evidence by an applicant for licensure or certification, to accept education, training, and practical experience completed by an applicant in military service toward the qualifications and requirements to receive a license or certificate if that education, training, or experience is equivalent to the standards of the board or department. If a board or the DPH accredits or otherwise approves schools offering educational course credit for meeting licensing and certification qualifications and requirements, the bill would, not later than July 1, 2014, require those schools seeking accreditation or approval to have procedures in place to evaluate an applicant's military education, training, and practical experience toward the completion of an educational program that would qualify a person to apply for licensure or certification, as specified.

Dr. Morrow commented that sufficient information would be needed to evaluate the courses taken to make an educated evaluation of the military courses and their equivalency. Spencer Walker, Senior Legal Counsel stated that page four (4) of the bill addresses compliance.

Assembly Bill 318 (Logue) Dental Care: Telehealth

Ms. Burton explained that this bill would declare the intent of the Legislature to enact legislation that would promote the advancement of telehealth in dental care.

Senate Bill 28 (Hernandez) Medi-Cal: Eligibility

Ms. Burton explained that this bill would, commencing January 1, 2014, implement various provisions of the federal Patient Protection and Affordable Care Act (Affordable Care Act), as amended, by, among other things, modifying provisions relating to determining eligibility for certain groups. The bill would, in this regard, extend Medi-Cal eligibility to specified adults and would require that income eligibility be determined based on modified adjusted gross income (MAGI), as prescribed. The bill would prohibit the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. The bill would also add, commencing January 1, 2014, benefits, services, and coverage included in the essential health benefits package, as adopted by the state and approved by the United States Secretary of Health and Human Services, to the schedule of Medi-Cal benefits.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Senate Bill 128 (Emmerson) Health Care Professionals

Ms. Burton explained that Business and Professions Code Sections 920 through 922 is known as the Health Care Professional Disaster Response Act (Act). This Act states findings of the Legislature regarding the shortage of qualified health care practitioners during times of national or state disasters, and allows a physician and surgeon, whose license has been expired for less than 5 years and who meets specified criteria, to obtain a license without paying fees.

This bill would make a technical, non-substantive change to those provisions.

Bill Lewis, California Dental Association (CDA) commented that, related to the Affordable Care Act, CDA is focused on working with the Covered California group primarily in the area of the benefits selection process upon enrollment. CDA's goal is to maximize patient choice including the ability to retain their current dentist if applicable and which type of plan they prefer. Mr. Lewis went on to say that CDA is sponsoring two (2) bills; SB 562 relating to Mobile and Portable Dental units and AB 836 relating to Continuing Education Requirements for retired dentists providing voluntary care.

Mr. Lewis concluded his comment stating that the last two (2) bills that CDA is following are SB 456 which is currently a spot bill intended to provide a vehicle to work on alternative workforce models (formerly SB 694) and finally AB 1174 intended as a spot for work on the virtual dental home and health workforce in remote locations.

Lori Gagliardi, California Association of Dental Assisting Teachers (CADAT), requested that bills relating to auxiliaries, especially Registered Dental Assistants (RDA) be included with the dental bills.

M/S/C (Morrow/Afriat) to accept the recommendation to watch all legislation. The motion passed unanimously.

LEG 5 - Discussion of Prospective Legislative Proposals:

There were no proposals.

There was no further public comment.

The Legislative and Regulatory Committee meeting adjourned at 12:19 p.m.



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	LEG 3: Define the 2014 Mission of the Legislative and Regulatory Committee

This item is designed as an open forum to define any issues the Committee may want to explore during the year.



MEMORANDUM

DATE	February 11, 2014
TO	Legislative and Regulatory Committee, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item LEG 4: 2014 Tentative Legislative Calendar – Information Only

Background

The 2014 Tentative Legislative Calendar is enclosed for informational purposes

Action Requested:

No action necessary.

2014 TENTATIVE LEGISLATIVE CALENDAR

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

DEADLINES

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

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

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

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

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

- Jan. 1** Statutes take effect (Art. IV, Sec. 8(c)).
- Jan. 6** Legislature Reconvenes (J.R. 51(a)(4)).
- Jan. 10** Budget must be submitted by Governor (Art. IV, Sec. 12(a)).
- Jan. 17** Last day for **policy committees** to hear and report to Fiscal committees fiscal bills introduced in their house in 2013 (J.R. 61(b)(1)).
- Jan. 20** Martin Luther King, Jr. Day.
- Jan. 24** Last day for any committee to hear and report to the **Floor** bills introduced in their house in 2013 (J.R. 61(b)(2)). Last day to submit **bill requests** to the Office of Legislative Counsel.
- Jan. 31** Last day for each house to **pass bills introduced in 2013** in their House (Art. IV, Sec. 10(c)), (J.R. 61(b)(3)).
- Feb. 17** President's Day.
- Feb. 21** Last day for bills to be **introduced** (J.R. 61(b)(4)), (J.R. 54(a)).
- Mar. 31** Cesar Chavez Day
- Apr. 10** **Spring Recess** begins at end of this day's session (J.R. 51(b)(1)).
- Apr. 21** Legislature reconvenes from **Spring Recess** (J.R. 51(b)(1)).
- May 2** Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).
- May 9** Last day for **policy committees** to hear and report to the floor **non-fiscal** bills introduced in their house (J.R. 61(b)(6)).
- May 16** Last day for **policy committees** to meet prior to June 2 (J.R. 61(b)(7)).
- May 23** Last day for **fiscal committees** to hear and report to the floor Bills introduced in their house (J.R. 61(b)(8)). Last day for **fiscal Committees** to meet prior to June 2 (J.R. 61 (b)(9)).
- May 26** Memorial Day
- May 27 - 30 Floor Session Only.** No committee may meet for any purpose (J.R. 61(b)(10)).
- May 30** Last day for bills to be **passed out of the house of origin** (J.R. 61(b)(11)).

2014 TENTATIVE LEGISLATIVE CALENDAR

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

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

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

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

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

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

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

IMPORTANT DATES OCCURRING DURING FINAL RECESS

2014

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

2015

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



MEMORANDUM

DATE	February 19, 2014
TO	Legislative and Regulatory Committee, Dental Board of California
FROM	Sarah Wallace, Legislative and Regulatory Analyst
SUBJECT	LEG 5: Discussion and Possible Action on Legislation

Background:

Staff has been tracking the following three bills that were of interest to the Dental Board during 2013 and made it through the process to the 2014 legislative year:

- AB 318 (Logue) Dental Care: Telehealth;
- AB 809 (Logue) Healing Arts: Telehealth; and,
- AB 1174 (Bocanegra) Dental Professionals: Teledentistry Under Medi-Cal

Since this meeting's agenda has been posted, staff has become aware that Assembly Bill 318 has failed to progress to the second house and has effectually died.

Additionally, staff has become aware that Assembly Bill 809 no longer impacts the Dental Practice Act and is now only applicable to the Medical Practice Act; therefore it is not necessary for the Committee to discuss it at this meeting. Staff will continue to monitor this bill and notify the Committee if there are future amendments that would impact the Dental Practice Act.

Assembly Bill 1174 will be discussed at the February meeting during a joint meeting of the Board's Legislative and Regulatory Committee and the Dental Assisting Council and during the full Board meeting on the morning of February 27th. Further discussion will not be necessary during this Committee meeting.

The last day to introduce new bills for 2014 is Friday, February 21st. Staff will continue to monitor legislation and notify the Committee of any bills that may impact the Dental Board.

Action Requested:

No action necessary at this time.



MEMORANDUM

DATE	February 18, 2014
TO	Legislative and Regulatory Committee, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item LEG 6: Update on Pending Regulatory Packages

A. Uniform Standards for Substance Abusing Licensees (California Code of Regulations, Title 16, §§ 1018 and 1018.01):

At its February 28, 2013 meeting, the Dental Board of California (Board) reconsidered approval of new proposed regulatory language relative to uniform standards for substance abusing licenses. At the meeting, the Board directed staff to initiate a rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on March 5, 2013. The rulemaking was published in the California Regulatory Notice Register on March 15, 2014 and was noticed on the Board's web site and mailed to interested parties. The 45-day public comment period began on March 15, 2013 and ended on April 29, 2013. The Board held a regulatory hearing in Sacramento on April 29, 2013. The Board received one comment from the California Dental Association (CDA) seeking clarification. The Board responded to the comment from CDA at its May 2013 meeting. Since the comment was not considered adverse the Board adopted the proposed language and directed staff to finalize the rulemaking file.

The final rulemaking file was approved by the Director of the Department of Consumer Affairs (Department), the Secretary of the Business, Consumer Services and Housing Agency (Agency), and the Director of the Department of Finance (Finance). The final rulemaking file was submitted to the OAL on November 20, 2013 and the Board received notification of approval of the rulemaking on January 7, 2014. The regulation has been filed with the Secretary of State and will become effective on April 1, 2014

B. Dentistry Fee Increase (California Code of Regulations, Title 16, § 1021):

At its March 1, 2013 meeting, the Board discussed and approved proposed regulatory language relative to a fee increase for dentists. The Board directed staff to initiate a rulemaking. Board staff filed the initial rulemaking documents with the OAL on July 30, 2013. The rulemaking was published in the California Regulatory Notice Register on August 9, 2013 and was noticed on the Board's web site and mailed to interested parties. The 45-day public comment period began on August 9, 2013 and ended on September 23, 2013. The Board held a regulatory hearing in Sacramento on Monday, September 23, 2013. The Board received one comment from the CDA. The Board

responded to the comment at its October 9, 2013 Board teleconference meeting and directed staff to finalize the rulemaking.

The final rulemaking file was approved by the Director of the Department, the Secretary of the Agency, and the Director of Finance. The final rulemaking file was submitted to the OAL on January 10, 2014. Board staff anticipates receiving notification of OAL's determination of approval no later than February 25th. If approved the regulation will be filed with the Secretary of State and will become effective on the requested date of July 1, 2014.

Beginning January 1, 2013, new quarterly effective dates for regulations will be dependent upon the timeframe an OAL approved rulemaking is filed with the Secretary of State, as follows:

- The regulation would take effect on January 1 if the OAL approved rulemaking is filed with the Secretary of State on September 1 to November 30, inclusive.
- The regulation would take effect on April 1 if the OAL approved rulemaking is filed with the Secretary of State on December 1 to February 29, inclusive.
- The regulation would take effect on July 1 if the OAL approved rulemaking is filed with the Secretary of State on March 1 to May 31, inclusive.
- The regulation would take effect on October 1 if the OAL approved regulation is filed on June 1 to August 31, inclusive.

The deadline to submit this final rulemaking file to the Office of Administrative Law for review and determination of approval is August 8, 2014.

C. Portfolio Examination Requirements (California Code of Regulations, Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1032.7, 1032.8, 1032.9, 1032.10, 1033, 1033.1, 1034, 1034.1, 1035, 1035.1, 1035.2, 1036, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039):

At its August 2013 meeting, the Dental Board of California (Board) approved proposed regulatory language relative to the Portfolio Examination Requirements and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on October 29, 2013 and the proposal was published in the California Regulatory Notice Register on November 8, 2013. The 45-day public comment period began on November 8, 2013 and ended on December 23, 2013. The Board held a regulatory hearing in Sacramento on January 6, 2014.

The Board received written comments from: (1) Bruce Sims; (2) the California Dental Association (CDA); (3) Steven W. Friedrichsen, DDS, Professor and Dean, College of Dental Medicine, Western University of Health Sciences; and (4) Avishai Sadan, DMD, Dean, Ostrow School of Dentistry, University of Southern California. Additionally, the Board received verbal testimony from Sharon Golightly, representing the California Dental Hygiene Association (CDHA), at the regulatory hearing.

Pursuant to Government Code Section 11346.9(a)(3), adopted regulations submitted to OAL are required have a final statement of reasons which includes a summary of each objection or recommendation made regarding the specific adoption, amendment, or repeal process, together with an explanation of how the proposed action has been changed to accommodate each objection or recommendation, or the reasons for

making no change. This requirement applies to objections or recommendations specifically directed at the agency's proposed action or to the procedures followed by the agency in proposing or adopting the action. For the purposes of Government Code Section 11346.9(a)(3), a comment is "irrelevant" if it is not specifically directed at the agency's proposed action or to the procedures followed by the agency in proposing or adopting the action.

Staff has reviewed the comments received and has developed recommended responses in consultation with the Board's Portfolio Examination subcommittee and Board Legal Counsel. The full Board will be responding to the comments at its meeting on Thursday, February 27th. In the event the proposed language needs to be modified, staff is prepared to notice the text for a 15-day public comment period on March 3, 2014. The 15-day public comment period would begin on March 4th and end on March 18th.

The deadline to submit the final rulemaking file to the Office of Administrative Law for review and determination of approval is November 7, 2014.

D. Abandonment of Applications (California Code of Regulations, Title 16, §1004):

At its May 18, 2012 meeting, the Board discussed and approved proposed regulatory language relative to the abandonment of applications. The Board directed staff to initiate a rulemaking. The Board has deemed three other regulatory packages as top priority; those regulatory packages were relative to the fee increase, the Uniform Standards for Substance Abusing Licensees, and the Portfolio Examination Requirements. Staff will continue working on the initial rulemaking documents in priority order.

E. Dental Assisting Educational Program and Course Requirements (California Code of Regulations, Title 16, Division 10, Chapter 3, Article 2)

The Dental Assisting Council held its first regulatory development workshop on December 12, 2013. Board staff is working with members of the Dental Assisting Council and stakeholders to formulate a regulatory proposal to forward to the Board for consideration. The Dental Assisting Council will continue to hold regulatory development workshops in 2014.

F. Licensure by Credential Application Requirements

Board staff will be meeting to discuss necessary provisions to include in the regulatory proposal relative to licensure by credential application requirements. Staff anticipates forwarding proposed language to the Board for consideration at a future meeting.

Action Requested:

No action necessary.



MEMORANDUM

DATE	February 11, 2014
TO	Legislative and Regulatory Committee, Dental Board of California
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item LEG 7: Discussion of Prospective Legislative Proposals

Stakeholders are encouraged to submit proposals in writing to the Board before or during the meeting for possible consideration by the Board at a future meeting.

EXAMINATION COMMITTEE



NOTICE OF EXAMINATION COMMITTEE MEETING

Thursday, February 27, 2014

Upon Conclusion of the Legislative and Regulatory Committee meeting

Wyndham Bayside San Diego

1355 North Harbor Drive, San Diego, CA, 92101

(619) 232-3861 or (916) 263-2300

MEMBERS OF THE EXAMINATION COMMITTEE

Chair – Stephen Casagrande, DDS

Vice Chair – Steven Morrow, DDS

Yvette Chappell-Ingram, Public Member

Judith Forsythe, RDA

Ross Lai, DDS

Huong Le, DDS, MA

Debra Woo, DDS

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

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

1. Call to Order/Roll Call/Establishment of Quorum
2. Approval of the February 28, 2013 Examination Committee Meeting Minutes
3. Define the 2014 Mission of the Examination Committee
4. Update on Western Regional Examining Board (WREB) Activities
5. Staff Report on the WREB Occupational Analysis Performed by the Department of Consumer Affairs' (DCA) Office of Professional Examination Services (OPES)

6. Update on the Implementation of the Portfolio Licensure Examination for Dentistry
7. Public Comment of Items Not on the Agenda
The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
8. Future Agenda Items
Stakeholders are encouraged to propose items for possible consideration by the Committee at a future meeting.
9. Committee Member Comments for Items Not on the Agenda
The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
10. Adjournment



**EXAMINATION COMMITTEE
MEETING MINUTES
Thursday, February 28, 2013**
Holiday Inn on the Bay
1355 North Harbor Drive, San Diego, CA, 92101
DRAFT

Members Present

Steven Morrow, DDS, Vice Chair
Fran Burton, Public Member
Luis Dominicus, DDS
Huong Le, DDS
Suzanne McCormick, DDS

Members Absent

Stephen Casagrande, DDS, Chair

Staff Present

Karen Fischer, Interim Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit and Dental Assisting Unit Manager
Lori Reis, Complaint and Compliance Unit Manager
Jocelyn Campos, Enforcement Coordinator
Linda Byers, Executive Assistant
Spencer Walker, Senior Legal Counsel
Greg Salute, Deputy Attorney General

In the absence of Dr. Casagrande, Chair, Dr. Morrow, Vice-Chair called the Examination Committee meeting to order at 1:23 p.m. Roll was called and a quorum established.

EX 1 - Approval of the December 3, 2012 Examination Committee Meeting Minutes

M/S/C (Dominicus/McCormick) to approve the December 3, 2012 Examination Committee meeting minutes. The motion passed unanimously.

EX 2 – Update on Office of Professional Examination Services (OPES) Occupational Analysis of the Western Regional Examining Board (WREB) Examination

Dr. Morrow gave a brief review and reported that a one-day workshop comprised of subject matter experts will be conducted in April 2013. Upon completion of the workshop, OPES will present the final audit report prior to the end of the fiscal year (June 30, 2013).

EX 3 – Update on Western Regional Examining Board (WREB) Activities

Dr. McCormick reported that the annual meeting of state members is coming up soon. She introduced Linda Paul, Former Executive Director of WREB. Ms. Paul reported that Beth Cole, WREB Chief Executive Officer, could not attend the meeting but she was there in her stead to acknowledge the great rapport that WREB has with the Dental Board.

EX 4 - Update on the Portfolio Licensure Examination for Dentistry

Dr. Morrow reported that the Portfolio Licensure Examination for Dentistry is moving forward. He stated that a very productive session was held on December 13, 2012. The candidate Handbook and Examiner Training Manual are being reviewed by legal counsel.

Dr. Morrow reported that another working meeting will be scheduled to prepare the first Final Draft which will be distributed to the Examination Committee members for their review and approval at which time they will be submitted to the full Board for their approval. The documents must be complete before they can be submitted with the regulatory package.

The committee adjourned at 1:31 p.m.

DRAFT



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	EX 3: Define the 2014 Mission of the Examination Committee

This item is designed as an open forum to define any issues the Committee may want to explore during the year.



MEMORANDUM

DATE	February 19, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	EX 4: Update on Western Regional Examining Board (WREB) Activities

Dr. Huong Le will provide a verbal report.



MEMORANDUM

DATE	February 19, 2014
TO	Dental Board Members
FROM	Karen Fischer, Executive Officer
SUBJECT	EX 5: Staff Report on the Western Regional Examination Board (WREB) Occupational Analysis Performed by the Office of Professional Examination Services (OPES)

Background

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs being used in the California licensure process comply with psychometric and legal standards. The California Dental Board (Board) requested that the DCA, Office of Professional Examination Services (OPES), complete a comprehensive review of the Western Region Examination Board's (WREB) licensing examination program. The purpose of the OPES review was to evaluate the suitability of the WREB examinations for continued use in California and to identify if there are areas of California dental practice not covered by the WREB examinations.

OPES received and reviewed documents provided by WREB. Follow-up phone calls were held to clarify WREB procedures and practices. A comprehensive evaluation of the documents was made to determine whether (a) job analysis, (b) examination development, (c) passing scores, (d) test administration, (e) examination performance, and (f) test security procedures met professional guidelines and technical standards. OPES utilized the professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing (Standards)* and the California Business and Professions Code section 139 to determine the validity and defensibility of the WREB examination program components listed above.

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

General Dentist Practice Analysis performed by WREB.

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

OPES has completed its comprehensive analysis and evaluation of the documents provided by WREB and has submitted its report to the Board. Due to the sensitive nature of the examination process, the full report is not available to the public. However the final recommendations will be made public after a subcommittee review.

Action Requested

Chair to appoint a subcommittee to review the findings of the OPES Analysis and to report back to the Committee at the May meeting.



MEMORANDUM

DATE	February 19, 2014
TO	Examination Committee Members Dental Board of California
FROM	Dawn Dill, Manager, Licensing and Examination Unit Dental Board of California
SUBJECT	EX 6: Update on the Implementation of the Portfolio Licensure Examination for Dentistry

Background

As the regulatory package moves forward, staff has been working with the subcommittee and legal counsel to develop courtesy forms to be used by the schools. In addition, staff has updated the Candidate Handbook, Examiner Training Manual and Audit Process Manual to reflect the language in the regulatory package.

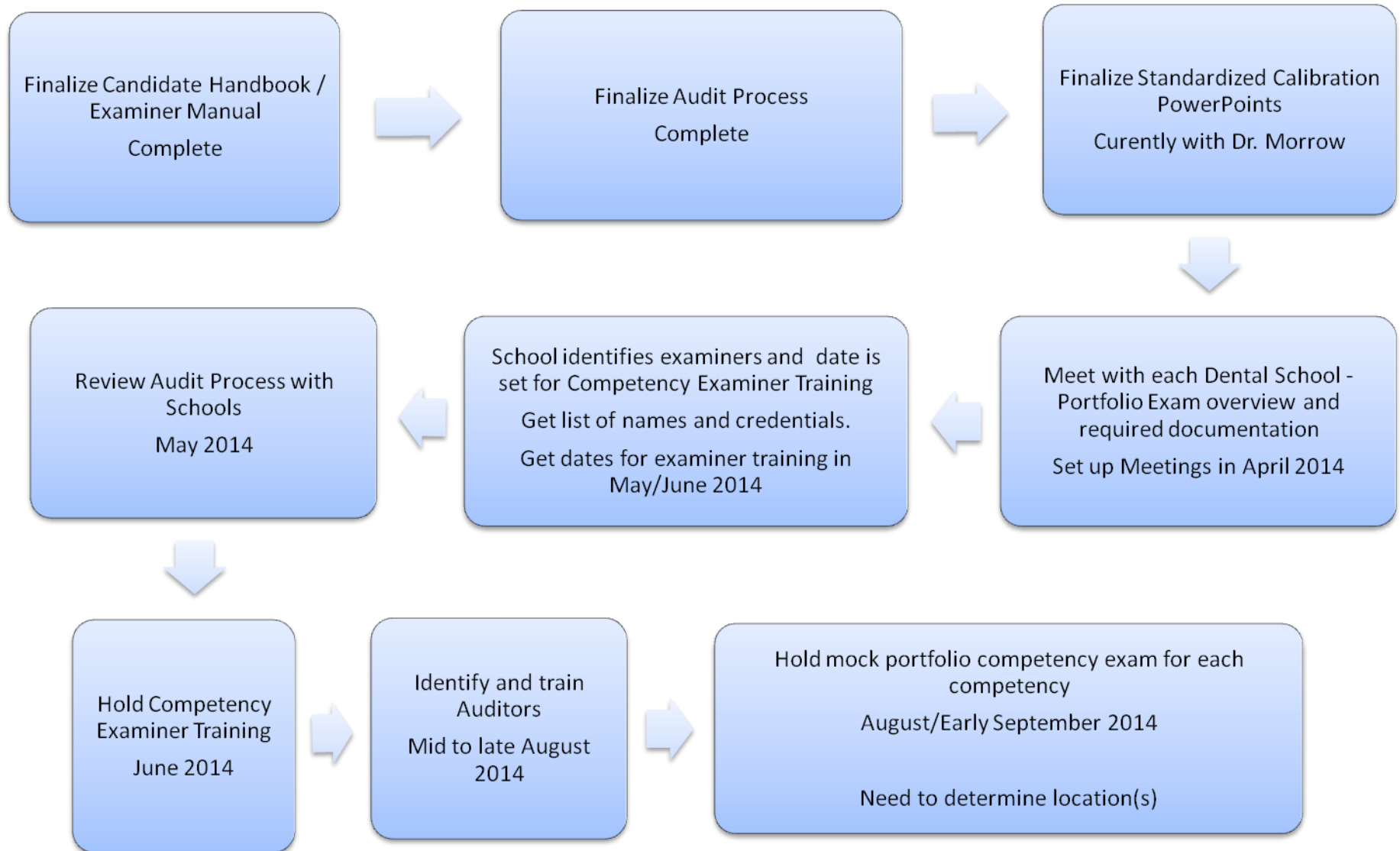
Attached is staff's initial implementation plan with an anticipated effective date of October 1, 2014. Staff will continue to work with the subcommittee to finalize the implementation.

Action Requested:

No action is being requested by staff for this item.

IMPLEMENTATION PLAN CHART

Effective Date of Regulation is October 1, 2014



ACCESS TO CARE COMMITTEE



NOTICE OF ACCESS TO CARE COMMITTEE MEETING

Thursday, February 27, 2014

Upon Conclusion of the Examination Committee meeting

Wyndham Bayside San Diego

1355 North Harbor Drive, San Diego, CA, 92101

(619) 232-3861 or (916) 263-2300

MEMBERS OF THE ACCESS TO CARE COMMITTEE

Chair – Huong Le, DDS

Vice Chair – Meredith McKenzie, Public Member

Fran Burton, MSW, Public Member

Katie Dawson, RDH

Kathleen King, Public Member

Thomas Stewart, DDS

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

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

1. Call to Order/Roll Call/Establishment of Quorum
2. Define the 2014 Mission of the Access to Care Committee
3. Report on Governor's Budget Funding for Dental Awareness Programs - Information Item Only
4. Report on the Dental Board's Workforce Data Collection – Cultural and Linguistic Competency Survey (Assembly Bill 269, Chapter 262, Statutes of 2007) and Office of Statewide Health Planning and Development's (OSHPD) Healthcare Workforce Clearinghouse Project (Senate Bill 139, Chapter 522, Statutes of 2007)
5. Presentation by Conrado Barzaga, MD, Executive Director of the Center for Oral Health Regarding Access to Care – Discussion to Follow

6. **Public Comment of Items Not on the Agenda**
The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
7. **Future Agenda Items**
Stakeholders are encouraged to propose items for possible consideration by the Committee at a future meeting.
8. **Committee Member Comments for Items Not on the Agenda**
The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
9. **Adjournment**



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	ATC 2: Define the 2014 Mission of the Access to Care Committee

This item is designed as an open forum to define any issues the Committee may want to explore during the year.



MEMORANDUM

DATE	February 19, 2014
TO	Access to Care Committee, Dental Board of California
FROM	Sarah Wallace, Legislative and Regulatory Analyst
SUBJECT	Agenda Item ATC 3: Report on Governor's Budget Funding for Dental Awareness Programs – Information Item Only

Background

Governor Brown submitted his proposed Budget for the 2014-15 fiscal year at the beginning of January. The proposed budget includes several significant adjustments to the Health and Human Services Agency, including \$17.5 million to increase dental outreach activities for children ages zero to three years. The Governor's Budget Summary states: "Educating parents of young children about the importance of early dental benefits should provide positive health outcomes and result in decreased future costs associated with more expensive treatment for poor dental hygiene."

A copy of the Governor's Budget Summary 2014-15, as it relates to the Health and Human Services Agency, is included in the meeting materials for reference.

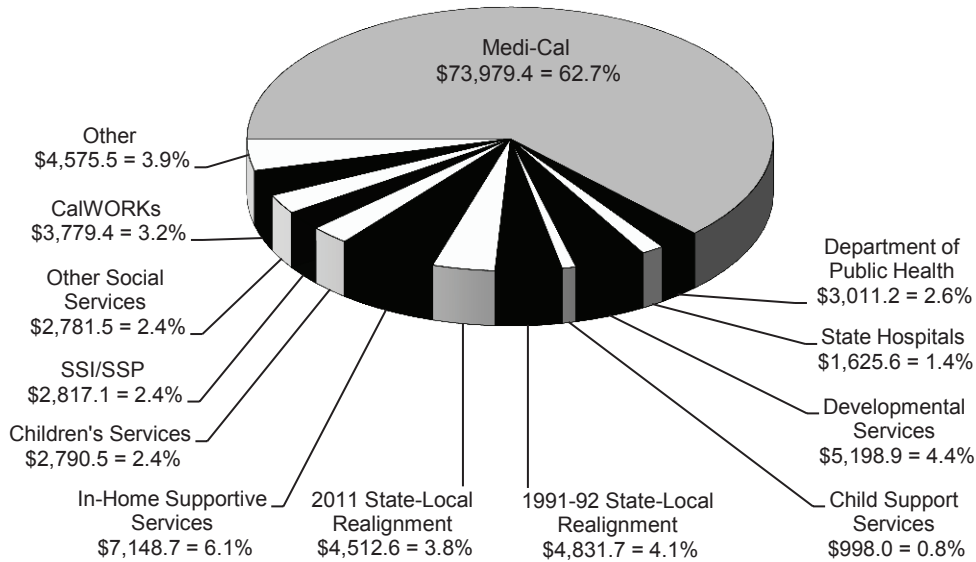
Action Requested

No action. This is an informational item only.

HEALTH AND HUMAN SERVICES

The Health and Human Services Agency oversees departments and other state entities that provide health and social services to California’s vulnerable and at-risk residents. The Budget includes \$118 billion (\$28.8 billion General Fund and \$89.2 billion other funds) for these programs. Figure HHS-01 displays expenditures for each major program area and Figure HHS-02 displays program caseload.

Figure HHS-01
Health and Human Services Proposed 2014-15 Funding¹
All Funds
 (Dollars in Millions)



¹ Totals \$118,050.0 million for support, local assistance, and capital outlay. This figure includes reimbursements of \$11,610.3 million and excludes \$5.2 million in Proposition 98 funding in the Department of Developmental Services budget and county funds that do not flow through the state budget.

Figure HHS-02

Major Health and Human Services Program Caseloads

	2013-14 Revised	2014-15 Estimate	Change
Medi-Cal enrollees	9,170,500	10,106,200	935,700
California Children's Services (CCS) ^a	20,271	19,754	-517
CalWORKs	545,647	529,367	-16,280
CalFresh households	1,733,474	1,956,817	223,343
SSI/SSP (support for aged, blind, and disabled)	1,297,289	1,308,166	10,877
Child Welfare Services ^b	136,172	135,669	-503
Foster Care	41,926	40,129	-1,797
Adoption Assistance	84,535	84,961	426
In-Home Supportive Services	447,702	453,417	5,715
Regional Centers for persons with developmental disabilities	265,709	273,643	7,934
State Hospitals ^c	6,894	7,214	320
Developmental Centers ^d	1,333	1,110	-223
Vocational Rehabilitation	28,318	28,318	0

a Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS clients.

b Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one services area.

c Represents the year-end population. Includes population at Vacaville and Salinas Valley Psychiatric Programs.

d Represents average in-center population.

California is in the midst of implementing federal health care reform that will provide coverage to millions of Californians. Starting this month, Californians have access to affordable, quality health insurance coverage through Covered California, the new health insurance marketplace. By law, health coverage cannot be dropped or denied because of pre-existing conditions or illness. Also this month, California expanded Medi-Cal to cover childless adults and parent/caretaker relatives with incomes up to 138 percent of the federal poverty level.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal, California's Medicaid program, is administered by the Department of Health Care Services (DHCS). Medi-Cal is a public health insurance program that provides comprehensive health care services at no or low cost for low-income individuals including families with children, seniors, persons with disabilities, children in foster care, and pregnant women. The federal government mandates basic services including physician services, family nurse practitioner services, nursing facility services, hospital inpatient and outpatient services, laboratory and radiology services, family planning,

and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits such as outpatient drugs, home and community-based services, and medical equipment. DHCS also operates the California Children's Services program, the Primary and Rural Health program, Targeted Low-Income Children's Program (formerly Healthy Families Program) and oversees county operated community mental health and substance use disorder programs.

Since 2006-07, total Medi-Cal benefit costs grew 11.8 percent annually (approximately \$5.1 billion per year) to \$65.6 billion in 2013-14 because of a combination of health care cost inflation, program expansions, federal funds, provider fees, intergovernmental transfers, and caseload growth. Medi-Cal General Fund spending is projected to increase 4.1 percent from \$16.2 billion in 2013-14 to \$16.9 billion in 2014-15. Growth in Medi-Cal General Fund expenditures has been reduced through the use of other funding sources, including the Gross Premiums Tax (authorized from 2009-10 to 2012-13), the Managed Care Organization Tax (authorized in 2013-14), Hospital Quality Assurance Fee (first authorized in 2011-12), and Medicaid waivers that allow claiming of federal funds for state-only health care costs.

The Budget assumes that caseload will increase approximately 10.2 percent from 2013-14 to 2014-15 (from 9.2 million to 10.1 million), largely because of the implementation of federal health care reform and the shift of children from the Healthy Families Program to Medi-Cal. Caseload would increase by 1 percent absent these changes. Federal health care reform will increase the program's caseload by an estimated 1.03 million in 2013-14 and 1.36 million in 2014-15. The state will receive 100 percent federal funding for childless adults with income up to 138 percent of the federal poverty level (FPL), and parent and caretaker relatives with incomes above 114 percent of FPL. The Medi-Cal caseload is expected to be approximately 24 percent of the state's total population.

The Federal Medical Assistance Percentage (FMAP) determines the level of federal financial support for the Medi-Cal program. California has generally had an FMAP of 50 percent (the minimum percentage authorized under federal law) since the inception of the Medicaid program in 1965. California's percentage is lower than the national average and is lower than those of neighboring states. Oregon, Nevada, and Arizona currently have percentages of 62 percent, 60 percent, and 66 percent, respectively. The state's percentage is also substantially lower than Mississippi's 73 percent FMAP percentage, currently the highest in the country.

The Medi-Cal program cost per case is lower than the national average. California's cost per case of \$3,441 was substantially lower than other low FMAP states such as Massachusetts (\$6,841) and New York (\$8,910) according to data from federal fiscal year 2010.

California is one of 26 states implementing the optional expansion under federal health care reform, which expands Medi-Cal to all parent/caretaker relatives and childless adults under 138 percent of FPL. In addition, California provides coverage for pregnant women up to 208 percent of FPL and for non-working persons with disabilities up to 100 percent of FPL; these two eligibility levels are the 7th highest in the nation.

Significant Adjustments:

- **Forgive Specified AB 97 Retroactive Recoupments**—Chapter 3, Statutes of 2011 (AB 97), generally reduced provider payments by 10 percent. These reductions will result in General Fund savings of \$282.8 million in 2014-15. The state has already exempted key provider categories from the AB 97 provider reductions to maintain access to services. In addition, to provide further support to the state's health care delivery system during the implementation of federal health care reform, the state will forgive the retroactive recoupments for specified providers and services (physicians/clinics, certain drugs that are typically high-cost and used to treat serious conditions, dental, intermediate care facilities for the developmentally disabled, and medical transportation), resulting in an increase of \$5.8 million General Fund in 2013-14 and \$36.3 million General Fund in 2014-15. Given the retroactive recoupments are spread over a period of up to 72 months depending on the service type, the total cost is \$217.7 million General Fund over the next several years. DHCS will continue to monitor access to covered services as health care reform is implemented.
- **Pediatric Dental and Vision Services Outreach**—The state is constantly monitoring utilization of Medi-Cal services to maintain access to critical health services. Recent reviews have focused on children's dental and vision utilization. The Medi-Cal program provides children with comprehensive dental benefits and screenings, exams, and eyeglasses to promote improved vision. The Budget includes \$17.5 million to increase dental outreach activities for children ages zero to three years. Educating parents of young children about the importance of early dental benefits should provide positive health outcomes and result in decreased future costs associated with more expensive treatment for poor dental hygiene. The Budget assumes Proposition 10 funding provided by the California Children and

Families Commission will be available for the non-federal share of costs. In addition, the state will continue to evaluate methods for improving the utilization and quality of children's vision benefits offered through the Medi-Cal program.

- Pregnancy Coverage—Medi-Cal beneficiaries with incomes under 100 percent of FPL will receive full-scope Medi-Cal services. Pregnancy-only Medi-Cal beneficiaries with incomes between 100 and 208 percent of FPL will receive comprehensive health coverage through Covered California. The Budget proposes to pay for the out-of-pocket costs for pregnancy-only Medi-Cal beneficiaries electing to receive comprehensive coverage through Covered California beginning in January 2015, which will result in General Fund savings of \$16.6 million in 2014-15.

COORDINATED CARE INITIATIVE

Under the Coordinated Care Initiative (CCI), persons eligible for both Medicare and Medi-Cal (dual eligibles) will receive medical, behavioral health, long-term supports and services, and home and community-based services coordinated through a single health plan. These changes will be accomplished through a federal demonstration project known as Cal MediConnect. The CCI will also enroll all dual eligibles in managed care plans for their Medi-Cal benefits. The CCI will operate in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The following changes have occurred to the structure of the CCI since enactment of the 2013 Budget Act:

- Dual-eligibles in Medicare fee-for-service will be passively enrolled for both Medicare and Medi-Cal benefits beginning April 2014 in all participating counties except Los Angeles, Alameda, and Santa Clara. In Los Angeles, dual-eligibles may voluntarily enroll in Cal MediConnect or opt out beginning April 2014 and the remaining dual-eligibles will be passively enrolled beginning July 2014. Alameda and Santa Clara counties will passively enroll dual-eligibles no sooner than July 2014.
- Dual-eligibles in Medicare Advantage plans and those opting out of Cal MediConnect in all participating counties will be enrolled in managed care for Medi-Cal benefits beginning in July 2014. Dual-eligibles in Medicare Advantage plans who do not opt out of Cal MediConnect will be enrolled into Cal MediConnect for Medicare benefits in January 2015.
- Those only eligible for Medi-Cal or for partial Medicare coverage in all participating counties will have long-term supports and services and home and community-based services included in managed care beginning July 2014.

The Budget projects net General Fund savings for the CCI of \$159.4 million in 2014-15. General Fund savings from the sales tax on managed care organizations is included in the net savings figure. Without the tax revenue, the CCI would have a General Fund cost of \$172.9 million in 2014-15.

HEALTH CARE REFORM IMPLEMENTATION

In the past year, California has implemented significant portions of the Affordable Care Act (ACA). On October 1, 2013, Covered California, the new insurance marketplace, began offering affordable health insurance, including plans subsidized with federally funded tax subsidies and products for small businesses with coverage that started January 1, 2014.

In addition, the Medi-Cal program was expanded in two ways:

- The mandatory expansion simplified eligibility, enrollment, and retention rules making it easier to get on and stay on the program.
- The optional expansion extended eligibility to adults without children and parent and caretaker relatives with incomes up to 138 percent of the federal poverty level.

Further, California increased the mental health and substance use disorder benefits available through Medi-Cal to provide needed services, including to those who are released from prisons or jails and need these types of services to better support their reentry into the community.

Significant reforms in the individual and small group insurance markets will also take effect January 1, 2014. Most health plans and insurers in California are required to cover the 10 essential health benefits as required by federal law: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric oral and vision care.

With these reforms and coverage opportunities, an estimated 1.4 million additional people will enroll in Medi-Cal and 1.9 million people will enroll in Covered California by the end of 2015-16. Covered California has received over \$1 billion in start-up funding from the federal government with the vast majority of the funds paying for staff, information

technology systems, and marketing. It must be self-sustaining by January 1, 2015, and will assess fees on its 11 qualified health plans to fund its operating budget.

PAYING FOR THE MEDI-CAL EXPANSION

The Budget assumes net costs of \$867.4 million (\$404.9 million General Fund) in 2014-15 to provide for the mandatory Medi-Cal expansion. California will split these costs with the federal government. Additionally, the federal government has committed to pay 100 percent of the cost of the new adult group optional expansion for the first three years; by 2020-21, the federal share will have decreased to 90 percent and the state will pay 10 percent. The Budget assumes net costs of \$6.7 billion in 2014-15 for the optional Medi-Cal expansion.

Under the ACA, county costs and responsibilities for indigent health care are expected to decrease as more individuals gain access to health care coverage. The state-based Medi-Cal expansion will result in indigent care costs previously paid by counties shifting to the state.

Chapter 24, Statutes of 2013 (AB 85), modifies 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect savings counties will experience from the implementation of federal health care reform effective January 1, 2014. County savings are estimated to be \$300 million in 2013-14 and \$900 million in 2014-15, and those savings will be redirected to counties for CalWORKs expenditures. This redirection mechanism frees up General Fund resources to pay for rising Medi-Cal costs.

Counties can either choose a reduction of 60 percent of their health realignment funds, including their maintenance of effort, or choose a formula that accounts for the revenues and costs of indigent care programs in their county. Counties have the following options:

- **Option 1** uses a formula that measures actual county health care costs and revenues. The state receives 80 percent of any calculated savings, with the county retaining 20 percent of savings to invest in the local health care delivery system or spend on public health activities.
- **Option 2** transfers 60 percent of a county's health realignment allocation plus the county maintenance of effort to the state to be captured as savings; the county retains 40 percent of its realignment funding for public health, remaining uninsured, or other health care needs.

Counties participating in the County Medical Services Program (CMSP) are subject to an alternative similar to Option 2. Total realignment funding for CMSP consists of a direct allocation that grows over time and \$89 million that CMSP counties collectively contribute annually to the CMSP Governing Board. For CMSP counties, AB 85 redirects the \$89 million as savings, and the Governing Board will be responsible for covering the remainder of the amount equal to 60 percent of the program's total realignment and MOE funding.

Future year savings for all counties will be estimated in January and May, prior to the start of the year, based on the most recently available data. Further, for counties that choose the formula, reconciliation will occur within two years of the close of each fiscal year. Counties have until January 22, 2014 to adopt a resolution to select Option 1 or Option 2 and inform DHCS of the final decision. DHCS will issue a final determination on the historical percentage spent on indigent health care to each county no later than January 31, 2014.

1991 STATE-LOCAL REALIGNMENT—REVISED FLOW OF FUNDS

LRF sales tax revenues are first allocated to base funding to the subaccounts (Mental Health, Health, Social Services, and CalWORKs) within the fund. Any sales tax revenues deposited into the LRF in excess of base funding are distributed through various growth formulas. These growth funds are first distributed to fund cost increases in social services programs, followed by CMSP growth pursuant to a statutory formula. Any remaining growth funds, or general growth, is distributed to each of the subaccounts within the LRF.

AB 85 established two new subaccounts within the LRF beginning in 2013-14: (1) the Family Support Subaccount, which will receive sales tax funds redirected from the Health Subaccount, as noted above, and then redistributed to counties in lieu of General Fund for the CalWORKs program, and (2) the Child Poverty and Family Supplemental Support Subaccount, which will receive base and growth revenues dedicated solely towards funding increases to CalWORKs grant levels. Additionally, under AB 85, the Health Subaccount will receive a fixed percentage of general growth funds, 18.5 percent, while the Mental Health Subaccount will continue to receive general growth without any changes to the original statutory formula. The Child Poverty and Family Supplemental Support Subaccount will receive any remaining general growth funds.

Based on current revenue estimates, the Child Poverty and Family Supplemental Support Subaccount is projected to receive \$69 million in general growth funds in 2013-14. Of this amount, \$57.5 million will be used to fund the 5-percent increase to CalWORKs grant levels that takes effect on March 1, 2014. The remaining \$11.4 million will be carried over to 2014-15 to help fund the full-year costs of the grant increase, estimated to be \$168 million. Including the carryover funding, total deposits to the Child Poverty and Family Supplemental Support Subaccount in 2014-15 are projected to be \$161.7 million. The Budget includes an increase of \$6.3 million General Fund to support the full-year costs of the 5-percent grant increase.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

California has expanded the mental health and substance use disorder benefits available to those eligible for Medi-Cal, including individuals released from prisons or jails who need these types of services to better support their reentry into the community. The Budget reflects the costs of expanding both the services provided and the population served.

To achieve these and other benefits, DHCS will seek a waiver from the federal Centers for Medicare and Medicaid Services to better coordinate substance use disorder treatment services and build upon the experience and positive results California has achieved in the specialty mental health system. The waiver will give state and county officials more authority to select quality providers to meet drug treatment needs.

Due to concerns about program integrity in the Drug Medi-Cal program, DHCS took steps in July 2013 to eliminate fraud and abuse in the program, including temporarily suspending the certification of 177 facilities providing drug treatment inconsistent with program goals, and referring 68 drug treatment providers to the Department of Justice for potential criminal prosecution. DHCS has conducted a review of internal operations to improve oversight and monitoring of drug treatment programs, and has improved coordination with counties to ensure appropriate monitoring and recertification of all drug treatment providers. The Budget proposes 21 positions and \$2.2 million (\$1.1 million General Fund) to continue the state's intensive focus on program integrity and expansion of drug treatment services by recertifying all providers in the state.

2011 REALIGNMENT FUNDING

In an effort to provide services more efficiently and effectively, 2011 Realignment shifted responsibility and dedicated funding for public safety services to local governments.

In addition, community mental health programs previously funded in 1991 State-Local Realignment are now funded by revenue dedicated for 2011 Realignment.

2011 Realignment is funded through two sources: a state special fund sales tax of 1.0625 cents totaling \$6.3 billion and \$497.1 million in Vehicle License Fees. Pursuant to Chapter 40, Statutes of 2012 (SB 1020), these funds are deposited into the Local Revenue Fund 2011 for allocation to the counties and are constitutionally guaranteed for the purposes of 2011 Realignment. Figure HHS-03 identifies the programs and funding for 2011 Realignment.

Figure HHS-03

2011 Realignment Estimate¹ - at 2014-15 Governor's Budget

	2012-13	2012-13 Growth	2013-14	2013-14 Growth	2014-15	2014-15 Growth
Law Enforcement Services	\$1,942.6		\$2,124.3		\$2,075.4	
Trial Court Security Subaccount	496.4	11.6	508.0	8.6	516.6	21.3
Enhancing Law Enforcement Activities Subaccount ²	489.9	-	489.9	-	489.9	7.2
Community Corrections Subaccount ³	842.9	86.7	998.9	64.3	934.1	159.8
District Attorney and Public Defender Subaccount ³	14.6	5.8	17.1	4.3	15.8	10.7
Juvenile Justice Subaccount	98.8	11.6	110.4	8.6	119.0	21.3
<i>Youthful Offender Block Grant Special Account</i>	<i>(93.4)</i>	<i>(11.0)</i>	<i>(104.3)</i>	<i>(8.1)</i>	<i>(112.4)</i>	<i>(20.1)</i>
<i>Juvenile Reentry Grant Special Account</i>	<i>(5.5)</i>	<i>(0.6)</i>	<i>(6.1)</i>	<i>(0.5)</i>	<i>(6.6)</i>	<i>(1.2)</i>
Growth, Law Enforcement Services	115.7	115.7	85.8	85.8	220.3	220.3
Mental Health⁴	1,120.6	10.7	1,120.6	8.0	1,120.6	19.8
Support Services	2,604.9		2,829.3		2,996.1	
Protective Services Subaccount	1,640.4	176.2	1,837.0	98.5	1,950.8	191.8
Behavioral Health Subaccount ⁵	964.5	27.9	992.3	52.8	1,045.3	184.3
<i>Women and Children's Residential Treatment Services</i>	<i>(5.1)</i>	-	<i>(5.1)</i>	-	<i>(5.1)</i>	-
Growth, Support Services	214.8	214.8	159.3	159.3	395.9	395.9
Account Total and Growth	\$5,998.6		\$6,319.3		\$6,808.3	
Revenue						
1.0625% Sales Tax	5,516.6		5,880.5		6,311.2	
Motor Vehicle License Fee	482.0		438.8		497.1	
Revenue Total	\$5,998.6		\$6,319.3		\$6,808.3	

This chart reflects estimates of the 2011 Realignment subaccount and growth allocations based on current revenue forecasts and in accordance with the formulas outlined in Chapter 40, Statutes of 2012 (SB 1020).

¹ Dollars in millions.

² Allocation is capped at \$489.9 million. 2014-15 growth will not add to subsequent fiscal year's subaccount base allocations.

³ 2012-13 and 2013-14 growth is not added to subsequent fiscal year's subaccount base allocations.

⁴ Growth does not add to base.

⁵ The Early and Periodic Screening, Diagnosis, and Treatment and Drug Medi-Cal programs within the Behavioral Health Subaccount do not yet have a permanent base.

The Administration continues to develop an allocation for the 2011 Realignment Behavioral Health Services Growth Special Account, in consultation with county partners and stakeholders. From 2012-13 revenues, the Account has \$27.9 million. The first priority for growth funds is federal entitlement programs: Medi-Cal Specialty Mental Health, including the Early Periodic Screening, Diagnosis, and Treatment benefit, and Drug Medi-Cal.

MANAGED RISK MEDICAL INSURANCE BOARD

The Managed Risk Medical Insurance Board (MRMIB) currently administers three programs that provide health coverage through commercial health plans, local initiatives, and county organized health systems to eligible individuals who do not have health insurance: the Access for Infants and Mothers Program, which provides comprehensive health care to lower middle-income pregnant women, the County Health Initiative Matching Fund Program, which provides comprehensive health benefits through county-sponsored insurance programs, and the Major Risk Medical Insurance Program, which provides health coverage for individuals with pre-existing conditions.

Given the substantial reduction in the Board's role in recent years, the Budget proposes to eliminate MRMIB and transfer these programs to the Department of Health Care Services effective July 1, 2014. The Budget includes \$177.6 million (\$1.2 million General Fund) for the programs currently administered by MRMIB.

DEPARTMENT OF PUBLIC HEALTH

The Department of Public Health is charged with protecting and promoting the health and well-being of the people in California. Funding for 2013-14 is \$3.5 billion (\$115.2 million General Fund), and proposed funding for 2014-15 is \$3 billion (\$110.6 million General Fund).

Significant Adjustments:

- **Drinking Water Program Reorganization**—The Budget proposes to transfer \$200.3 million (\$5 million General Fund) and 291.2 positions for the administration of the Drinking Water Program from the Department to the State Water Resources Control Board. Please see the State Water Resources Control Board narrative in the Environmental Protection Agency chapter for additional information.

- Genetic Disease Screening Program—The activities of the Prenatal Screening Program focus on detecting birth defects during pregnancy. Although participation is voluntary, providers are required to offer the screening to all women in California. The program is planning to implement a fee increase of \$45 in the Prenatal Screening Program, effective July 1, 2014. This increase will bring the total fee to \$207. The fee covers a blood test for participating women and follow-up services offered to women with positive screening results. The fee increase is necessary to correct for the historic overstatement of caseload and inadequate fee revenue in recent years to cover costs.

DEPARTMENT OF DEVELOPMENTAL SERVICES

The Department of Developmental Services (DDS) provides consumers with developmental disabilities a variety of services and supports that allow them to live and work independently, or in supported environments. California is the only state providing developmental services as an entitlement. DDS serves approximately 273,000 individuals with developmental disabilities in the community and 1,110 individuals in state-operated developmental centers (DCs). For 2014-15, the Budget includes \$5.2 billion (\$2.9 billion General Fund) for support of the Department.

FUTURE OF THE DEVELOPMENTAL CENTERS TASK FORCE

In May 2013, the California Health and Human Services Agency convened a task force on the future of the DCs. Since the passage of the Lanterman Act in 1967, the role of the DCs has been evolving. The resident population has dropped from a high of 13,400 in 1968, with thousands on a waiting list for admission, to 1,110 residents in 2014-15. The 2012 Budget Act placed a moratorium on new admissions except for individuals involved in the criminal justice system and consumers in an acute crisis needing short-term stabilization. In addition, funding is provided to regional centers to expand and improve services to meet the needs of DC residents transitioning to the community. While the moratorium has reduced the reliance on DCs and expedited the population decrease in these facilities, it also resulted in higher average costs per resident.

The Task Force recommends that the future role of state-operated facilities should be to provide secure treatment services; smaller, safety-net crisis and residential services; and specialized health care resource centers. As the state moves in this direction, the stakeholder process will continue to be used to monitor changes and make recommendations for the most effective use of available resources.

Significant Adjustments:

- **Certification Issues**—The Budget includes \$9.2 million (\$5.1 million General Fund) to reflect anticipated costs related to the ongoing implementation of the Sonoma Developmental Center Program Improvement Plan. The Plan was entered into on March 13, 2013 with the California Department of Public Health and the Centers for Medicare and Medicaid Services (CMS) to bring the facility back into compliance with federal requirements. DDS is currently working with Public Health and CMS on certification actions at the Fairview, Porterville and Lanterman Developmental Centers and anticipates entering into an agreement in January specifying a path to resolving these certification issues.
- **Labor Regulations and Minimum Wage**—In September 2013, the United States Department of Labor announced new regulations, effective January 1, 2015, that affect pay for domestic workers. The Budget includes \$7.5 million (\$4 million General Fund) to adjust for these new rules. Chapter 351, Statutes of 2013 (AB 10), incrementally increases California’s minimum wage to \$10 per hour, effective January 1, 2016. To accommodate the increase to \$9 per hour, effective July 1, 2014, the Budget includes \$110.1 million (\$69.5 million General Fund).
- **Deferred Maintenance**—The Budget provides \$100 million to various state agencies to address critical infrastructure deferred maintenance needs. Of this amount, \$10 million will be allocated to DDS.

DEPARTMENT OF STATE HOSPITALS

The Department of State Hospitals (DSH) was established as a stand-alone department in July 2012 to administer the state mental health hospital system, the Forensic Conditional Release Program, the Sex Offender Commitment Program, and the evaluation and treatment of judicially and civilly committed patients. The Budget includes \$1.6 billion (\$1.5 billion General Fund) in 2014-15 for support of DSH. The patient population is projected to reach a total of 7,214 in 2014-15.

A CHANGING POPULATION

The composition of the patients served by DSH has changed greatly over time, with over 90 percent currently coming from the criminal justice system. In addition, the class action lawsuit (*Coleman v. Brown*) involving mental health care in state prisons has increased referrals from the Department of Corrections and Rehabilitation to DSH for inpatient treatment. The inmates referred to DSH tend to have a more violent history.

Significant Adjustments:

- **Enhanced Treatment Program**—The state hospital facilities were not designed to accommodate a forensic population. The Budget includes \$1.5 million General Fund to design and plan for specialized short-term housing units at most hospitals, totaling approximately 44 beds. On a long-term basis, DSH is looking at the feasibility of creating a new facility model specializing in longer-term treatment and stabilization of the most violent patients. Improving the physical configuration, screening, and treatment space will increase employee safety and protection of other patients, and enable those with behavioral issues more opportunities for treatment.
- **Personal Duress Alarm System**—In 2011, DSH began the process of updating its antiquated alarm system, beginning with Napa State Hospital. The new alarm system is more reliable, alerts employees in the affected area, and provides campus-wide coverage. The new system is currently being installed in Patton and Metropolitan State Hospitals, and installation will begin at Atascadero and Coalinga in 2014. The Budget includes \$8 million General Fund to conclude deployment of the new alarm system.
- **Deferred Maintenance**—The Budget provides \$100 million to various state agencies to address critical infrastructure deferred maintenance needs. Of this amount, \$10 million will be allocated to DSH.

WAITLISTS

The population of DSH continues to increase. This trend is most pronounced in two patient categories, incompetent to stand trial (IST) and *Coleman* patients. Currently, DSH has over 300 IST and approximately 100 *Coleman* patients waiting to be admitted.

Significant Adjustments:

- **Patient Management Unit**—Currently, DSH has no centralized intake management of its patient population. Referrals are made from individual courts to individual hospitals, regardless of current capacity at each facility. This lack of coordination leads to inefficient use of state hospital resources and results in ad hoc management of bed capacity. The Budget includes \$1.1 million General Fund to establish a Patient Management Unit to centralize admissions and transfers. The unit will improve utilization of beds, and direct patients to the hospital most appropriate for their individual needs, thereby reducing the waitlist.

- **IST Workgroup**—The Administration has engaged in an ongoing series of meetings with stakeholders to work on issues related to the IST population with the goal of improving coordination to reduce the waitlist. The Budget includes \$27.8 million General Fund to increase IST bed capacity by 105 beds to help ameliorate the waitlist. The Administration will continue to work with county partners and other stakeholders on the larger IST system issues.
- **Coleman**—The Budget includes \$26.3 million General Fund to keep 137 beds active in the psychiatric programs at Salinas Valley and Vacaville to maintain sufficient capacity for DSH to serve *Coleman* patients during the activation of the California Health Care Facility in Stockton.

DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services (DSS) serves, aids, and protects needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. The Department's major programs include CalWORKs, CalFresh, In-Home Supportive Services (IHSS), Supplemental Security Income/State Supplementary Payment (SSI/SSP) program, Child Welfare Services, Community Care Licensing, and Disability Determination.

The Budget includes \$19.3 billion (\$6.5 billion General Fund) for DSS, a decrease of \$383 million General Fund from the revised 2013-14 budget, primarily due to an increase from the 1991 Realignment Family Support Subaccount that will be used to offset General Fund costs in the CalWORKs program.

Significant Adjustments:

- **Community Care Licensing**—In response to a number of high-profile incidents at children's and adult residential care facilities licensed by the state, the Budget includes \$7.5 million (\$5.8 million General Fund) and 71.5 positions for quality enhancement and program improvement in Community Care Licensing. By significantly increasing civil penalties and improving the timeliness of investigations, this proposal will strengthen enforcement. A specialized complaint hotline will assist in acquiring better initial information, conducting consistent prioritization, and dispatching incoming complaints to regional offices. Further, the Department will assist with policy and practice development for medical and mental health conditions in community facilities to enhance quality and accountability by increasing training for new field staff and creating training for

supervisors and managers. The Department will also commit resources to achieve quality assurance and consistency for consumer safety and protection throughout the state. These changes are funded in part by a proposed 10-percent increase in licensing fees.

- State Hearings Division—The Budget includes \$9.8 million (\$1.3 million General Fund) and 63 two-year limited-term positions in 2014-15 to address the anticipated workload impact on the State Hearings Division resulting from implementation of the Affordable Care Act. The additional resources will provide timely hearing decisions to address disputes from Medi-Cal and Covered California applicants.

CALIFORNIA WORK OPPORTUNITY AND RESPONSIBILITY TO KIDS

The CalWORKs program, California's version of the federal Temporary Assistance for Needy Families (TANF) program, provides temporary cash assistance to low-income families with children to meet basic needs. It also provides welfare-to-work services so that families may become self-sufficient. Eligibility requirements and benefit levels are established by the state. Counties have flexibility in program design, services, and funding to meet local needs.

Total TANF expenditures are \$7.1 billion (state, local, and federal funds) in 2014-15. The amount budgeted includes \$5.5 billion for CalWORKs program expenditures and \$1.6 billion in other programs. Other programs primarily include expenditures for Cal Grants, Department of Education child care, Child Welfare Services, Foster Care, Department of Developmental Services programs, the Statewide Automated Welfare System, California Community Colleges child care and education services, and the Department of Child Support Services.

Average monthly CalWORKs caseload is estimated to be about 529,000 families in 2014-15, a 4-percent decrease from the 2013 Budget projection.

Significant Adjustments:

- Parent/Child Engagement Demonstration Pilot—To support some of the most vulnerable low-income families who have multiple barriers of entry into the workforce, and do not have access to licensed child care, or who fall into CalWORKs sanction status, the Budget proposes a six-county, 2,000-family pilot project over three years to:
 - Connect vulnerable children with stable licensed child care.

- Engage parents with their children in the child care setting.
- Enhance parenting and life skills.
- Provide parents with work readiness activities that will move the family toward self-sufficiency.

The project will cost \$9.9 million General Fund in 2014-15, assuming March 2015 enrollment of the first cohort of families, and \$115.4 million General Fund over three years.

- **Maximum Aid Payment Levels**—The 2013 Budget increases Maximum Aid Payment levels by 5 percent, effective March 1, 2014. The 5-percent increase is expected to cost approximately \$168 million annually. The increase will be funded by 1991 Realignment growth funds deposited in the Child Poverty and Family Supplemental Support Subaccount (see Health Care Reform Implementation section within Department of Health Care Services), as well as a \$6.3 million General Fund augmentation. Subsequent increases will be based on analysis of revenue and caseload estimates in future years.

IN-HOME SUPPORTIVE SERVICES

The IHSS program provides domestic and related services such as housework, transportation, and personal care services to eligible low-income aged, blind, and disabled persons. These services are provided to assist individuals to remain safely in their homes and prevent institutionalization.

The Budget includes \$2 billion General Fund for the IHSS program in 2014-15, a 6.4-percent increase over the 2013 Budget. Average monthly caseload in this program is estimated to be 453,000 recipients in 2014-15, a 1.2-percent increase from the 2013 Budget projection.

In September 2013, the United States Department of Labor announced new regulations, effective January 1, 2015, that require overtime pay for domestic workers. In addition, new requirements were added that require compensation for providers traveling between multiple recipients, wait time that is associated with medical accompaniment, and time spent in mandatory provider training. These regulations have the potential to increase IHSS program costs by over \$600 million by 2015-16.

To control costs and promote the continued health and safety of Medicaid recipients in the program, the Budget proposes to prohibit providers from working overtime. As the

employer for purposes of hiring, firing, scheduling, and supervising the work of his/her IHSS provider, this restriction will require some recipients to hire and train additional providers to fully provide their authorized services. The IHSS workforce will need to increase to accommodate this change.

A Provider Backup System will be established to assist recipients in an unexpected circumstance to obtain a provider for continued care when their regular provider would exceed the limitations on hours worked by continuing to provide services. In these circumstances, a recipient could contact the Provider Backup System for assistance in obtaining a backup provider who would be available in a short amount of time. Any services provided by the backup provider will be deducted from the recipient's authorized hours.

Combined implementation of the new federal requirements will cost \$208.9 million (\$99 million General Fund) in 2014-15 and \$327.9 million (\$153.1 million General Fund) thereafter.

The IHSS program is also a key component of the Coordinated Care Initiative (CCI). No earlier than April 2014, certain Medi-Cal beneficiaries residing in a county authorized to participate in the CCI demonstration will begin transitioning from the traditional fee-for-service model to a managed care model for receiving health care services, including IHSS services. Under CCI, the fundamental structure of the IHSS program will remain the same, with eligibility determination, assessment of hours, and program administration conducted by county social workers and administrative staff. For additional information on CCI, refer to the Department of Health Care Services section.

SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT

The federal SSI program provides a monthly cash benefit to eligible aged, blind, and disabled persons who meet the program's income and resource requirements. In California, the SSI payment is augmented with a SSP grant. These cash grants assist recipients with basic needs and living expenses. The federal Social Security Administration (SSA) administers the SSI/SSP program, making eligibility determinations, grant computations, and issuing combined monthly checks to recipients. The state-only Cash Assistance Program for Immigrants (CAPI) provides monthly cash benefits to aged, blind, and disabled legal non-citizens who are ineligible for SSI/SSP due solely to their immigration status.

Effective January 2013, maximum SSI/SSP grant levels are \$866 per month for individuals and \$1,462 per month for couples. SSA applies an annual cost-of-living adjustment to the SSI portion of the grant equivalent to the year-over-year increase in the Consumer Price Index (CPI). The current CPI growth factors are 1.5 percent for 2014 and a projected 0.6 percent for 2015. Maximum SSI/SSP monthly grant levels will increase by \$11 and \$16 for individuals and couples, respectively, effective January 2014. CAPI benefits are equivalent to SSI/SSP benefits, less \$10 per month for individuals and \$20 per month for couples.

The Budget includes \$2.8 billion General Fund for the SSI/SSP program. This represents a 1.2-percent increase (\$34 million) from the revised 2013-14 budget. The average monthly caseload in this program is estimated to be 1.3 million recipients in 2014-15, a slight increase over the 2013-14 projected level. The SSI/SSP caseload consists of 27-percent aged, 2-percent blind, and 71-percent disabled persons.



MEMORANDUM

DATE	February 19, 2014
TO	Dental Board Members
FROM	Karen Fischer, Executive Officer
SUBJECT	Agenda Item ATC 4: Report on the Dental Board’s Workforce Data Collection – Cultural and Linguistic Competency Survey (Assembly Bill 269, Chapter 262, Statutes of 2007) and Office of Statewide Health Planning and Development’s (OSHPD) Healthcare Workforce Clearinghouse Project (Senate Bill 239, Chapter 522, Statutes of 2007)

Background

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

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

Assembly Bill 269

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

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

- License Number
- License Type
- Employment Status (see attached survey for detail)
- Primary Practice Location (by zip code and number of hours worked at that location)
- Secondary Practice Location (by zip code and number of hours worked at that location)

- Postgraduate Training
- Dental Practice/Specialty and Board Certifications or Permits
- Ethnic Background (which is optional)
- Foreign Language Fluency, other than English (which is also optional).

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

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

The Medical Board of California has the same work force survey requirements for physicians upon initial licensure and renewals. (AB 2283 (Oropeza) Chapter 612, Statutes of 2006). The Medical Board's survey results are reported in the same way as the Dental Board's survey results – raw data.

Senate Bill 139

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

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

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

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

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

The Dental Board, along with six other DCA healing arts boards, participated in the Clearinghouse Database design phase of the project (data collection). An MOU was entered into between the Board and OSHPD in December 2011 and data is being collected, the results of which can be found in the OSHPD Facts Sheets for Dentists,

Registered Dental Assistants, and Registered Dental Hygienists that are available at <http://www.oshpd.ca.gov/hwdd/hwc/>. Copies are attached for review and comment.

This information is being provided to the Access to Care (ATC) Committee as a basis for discussion. Dr. Conrado Barzaga, Executive Director of the Center for Oral Health has expressed an interest in accessing the Board's statistics and working with the Board on issues relating to access to care. He will be addressing the ATC Committee following this discussion.

Action Requested:

None



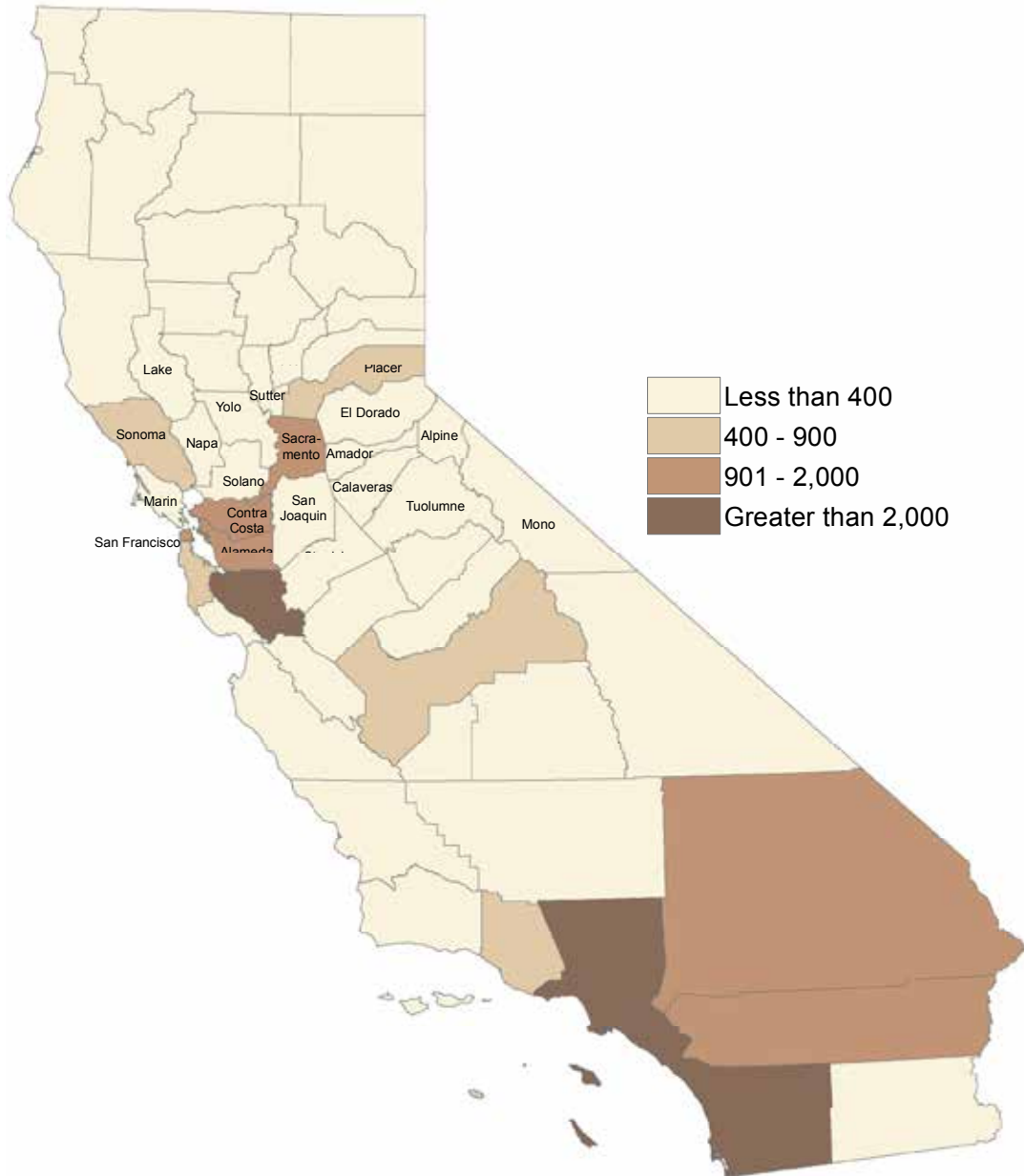
Dentists

November 2013



Dentists are licensed by the Dental Board of California (DBC). Dentists diagnose and treat problems with a patient’s teeth, gums, and other parts of the mouth. They provide advice and instruction on taking care of teeth, gums, and diet choices that affect oral health. As of June 1, 2013, there were 31,624 currently licensed dentists in the State of California by county of record. The map below and the table on page 2 display the current supply of active dentists’ licenses by county of record.

Current Supply of Dentists by County of Record



Fact Sheet



Fact Sheet

Dentists

November 2013

Current Supply of Dentists by County of Record

County	Number of Providers	County	Number of Providers	County	Number of Providers
Alameda	1,453	Marin	348	San Mateo	856
Alpine	0	Mariposa	7	Santa Barbara	342
Amador	26	Mendocino	64	Santa Clara	2,201
Butte	163	Merced	95	Santa Cruz	196
Calaveras	24	Modoc	6	Shasta	127
Colusa	N/A	Mono	N/A	Sierra	N/A
Contra Costa	1,044	Monterey	296	Siskiyou	31
Del Norte	16	Napa	118	Solano	298
El Dorado	162	Nevada	94	Sonoma	405
Fresno	559	Orange	3,704	Stanislaus	279
Glenn	7	Placer	445	Sutter	61
Humboldt	93	Plumas	16	Tehama	29
Imperial	43	Riverside	1,079	Trinity	N/A
Inyo	13	Sacramento	1,098	Tulare	203
Kern	344	San Benito	23	Tuolumne	55
Kings	63	San Bernardino	1,318	Ventura	635
Lake	26	San Diego	2,680	Yolo	117
Lassen	31	San Francisco	1,220	Yuba	11
Los Angeles	8,428	San Joaquin	377		
Madera	50	San Luis Obispo	234	Total	31,624

Counties reporting five and under dentists are categorized as N/A (not available) for confidentiality purposes. The counties that display N/A account for a total of 11 licensed dentists.

Specialties

California Business and Professions Code 1715.5 authorizes the Dental Board of California to collect information from dental healthcare workers at the time of license renewal (every two years). Thus, there is an annual update to the survey results. The workers may self-report his/her employment status, postgraduate training, practice specialty, cultural background and foreign language proficiency. The table below identifies dentist specialties.

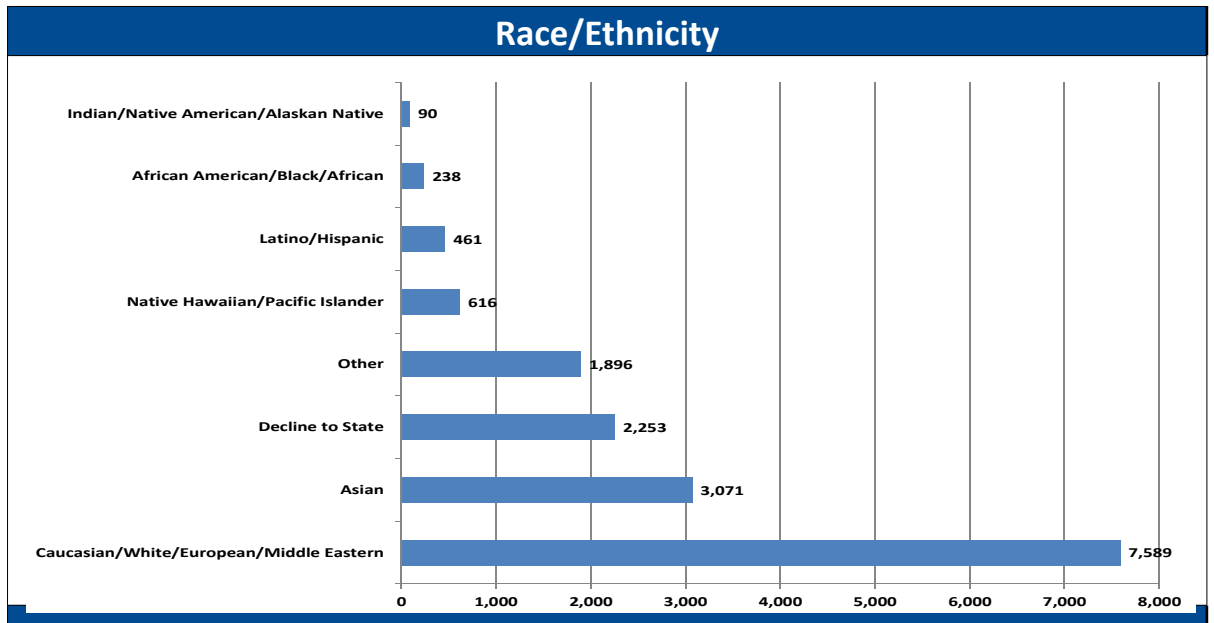
Specialties					
Oral Radiology	11	<1%	Periodontics	458	3%
Conscious Sedation	17	<1%	Pediatrics	472	3%
Oral Pathology	19	<1%	Endodontics	476	3%
General Anesthesia	26	<1%	Oral/Maxillofacial Surgery	479	3%
Public Health	29	<1%	Orthodontics	848	6%
Oral Conscious Sedation	49	<1%	General Practice	12,377	80%
Prosthodontics	289	2%	Total Responses	15,550	100%

Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.
For purposes of this Fact Sheet, currently licensed dentists are defined as "renewed and current".
Revised 10/30/2013



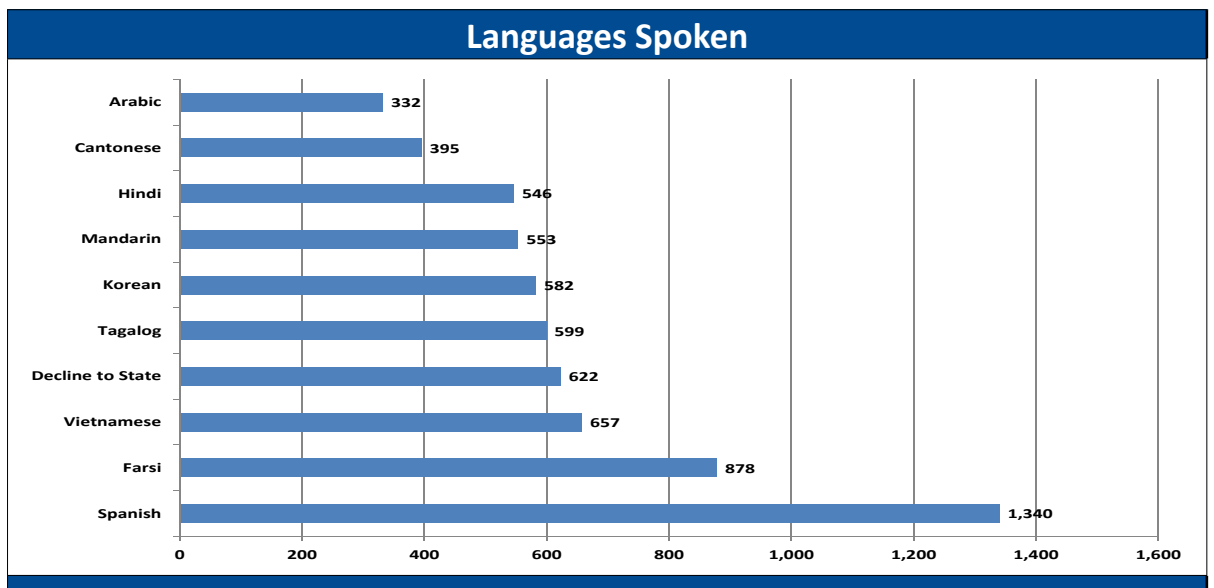
Race/Ethnicity

There are 28 races/ethnicities in which a dentist may identify with on the Dental Healthcare Workforce Survey.* The races/ethnicities have been combined into six major categories. A licensee may select more than one race/ethnicity, resulting in duplicate counts for a single licensee and a total greater than 100%. The survey results for 16,214 responses are displayed in the chart below. In addition, the responses for “Other” and “Decline to State”** are displayed.



Languages Spoken

The DBC recognizes 30 language categories which include “Other” and “Decline to State” for which a dentist may indicate on the Dental Healthcare Workforce Survey. A licensee may select more than one language, resulting in duplicate counts for a single licensee. The survey results for 7,912 responses are displayed in the chart below. The most predominate language is English. Not including English, the top 10 languages spoken are displayed.



Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.

For purposes of this Fact Sheet, currently licensed dentists are defined as “renewed and current”.

*The Dental Healthcare Workforce Survey for dentists’ race/ethnicity and languages spoken categories can be viewed at <http://www.dbc.ca.gov/survey/index.shtml>

**Decline to State” signified that a dentist did not want to disclose this information.

Revised 10/30/2013



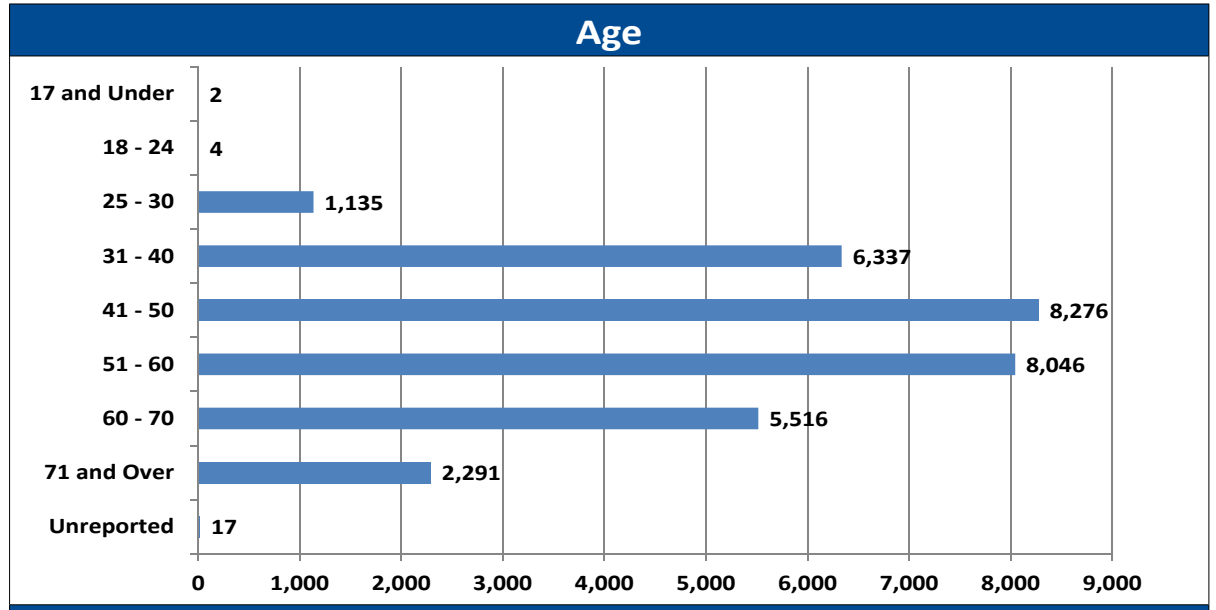
Dentists

November 2013

Fact Sheet

Age

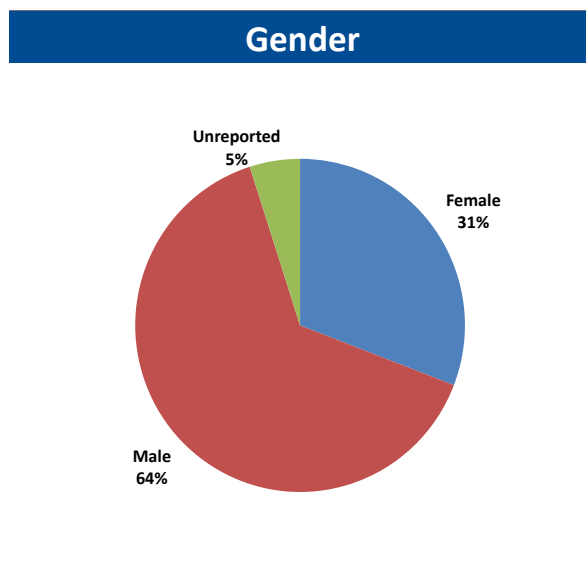
The currently licensed dentists in California by age group can be seen in the chart and table below.



Age	17 and Under	18 - 24	25 - 30	31 - 40	41 - 50	51 - 60	61 - 70	71 and Over	Unreported	Total Dentists
Total Responses	2	4	1,135	6,337	8,276	8,046	5,516	2,291	17	31,624
% of Total Dentists	<1%	<1%	4%	20%	26%	25%	17%	7%	<1%	100%

Gender

The currently licensed dentists in California can be seen in the chart and table below.



Gender	Total Dentists	% of Total Dentists
Male	20,309	64%
Female	9,753	31%
Unreported	1,562	5%
Total Dentists	31,624	100%



Dentists

November 2013



The following data are based on Employment Development Department's Labor Market Information Division Statewide 2010-2020 Occupational Employment Projections.*

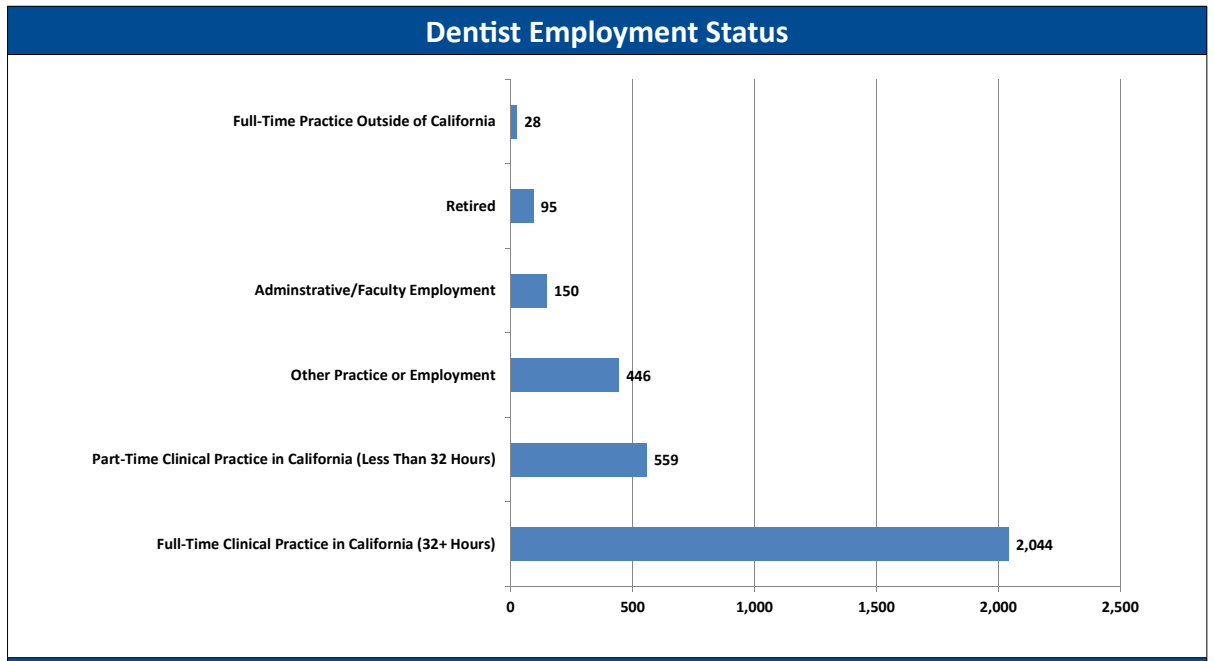
As displayed in the "Average Annual Job Openings" table below, the average annual job openings are an estimate of jobs created, resulting from economic growth and jobs created when workers retire or permanently leave an occupation and need to be replaced.

As displayed in the "2012 - 1st Quarter Wages" table below, the wages are the most recent estimates available for the 2010-2020 statewide employment projections.

Average Annual Job Openings	
New Jobs	70
Replacement Needs	510
Total	580
2012 - 1st Quarter Wages	
Median Hourly	\$64.52
Median Annual	\$134,204

Top Industries Which Employ This Occupation
1. Offices of Dentists
2. State Government
3. Outpatient Care Centers
4. Offices of Physicians
5. General Medical and Surgical Hospitals

Based on the Dental Healthcare Workforce Survey, the Dentist licensee employment status is displayed in the chart and table below.



Employment Status	Full-Time Practice outside of CA	Retired	Administrative /Faculty Employment	Other Practice Or Employment	Part-Time Clinical Practice in California (Less Than 32 Hours)	Full-Time Clinical Practice in California (32+ Hours)	Total
Total Dentists	28	95	150	446	559	2,044	3,322
% of Total	1%	3%	4%	13%	17%	62%	100%

Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.

For purposes of this Fact Sheet, currently licensed dentists are defined as "renewed and current".

*Employment Development Department's Labor Market Information Division, Statewide 2010-2020 Occupational Employment Projections, July 2012.

Revised 10/30/2013

Fact Sheet



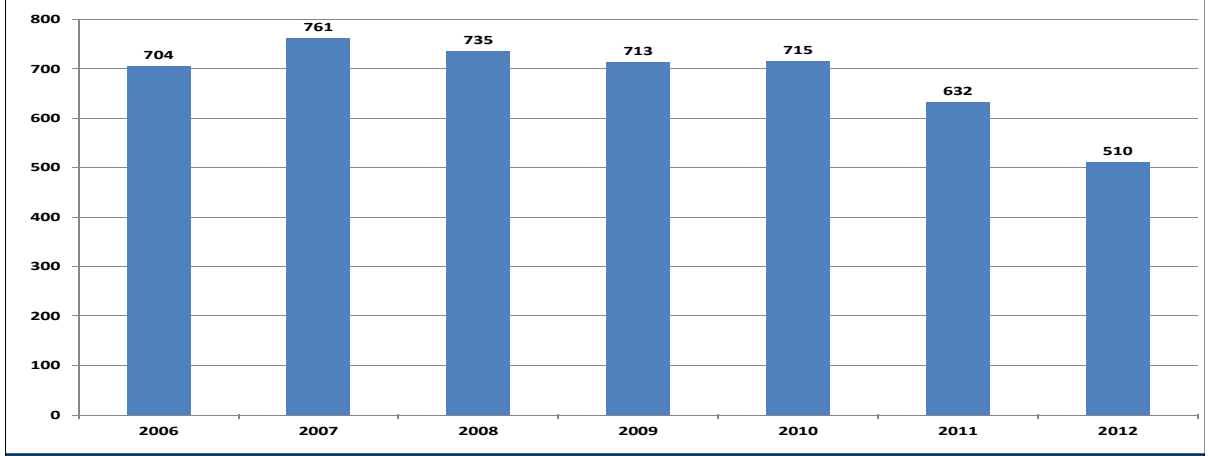
Dentists

November 2013



The chart and table below display the number of students who received degrees from California dental programs in years 2006 – 2012.

Degrees Awarded



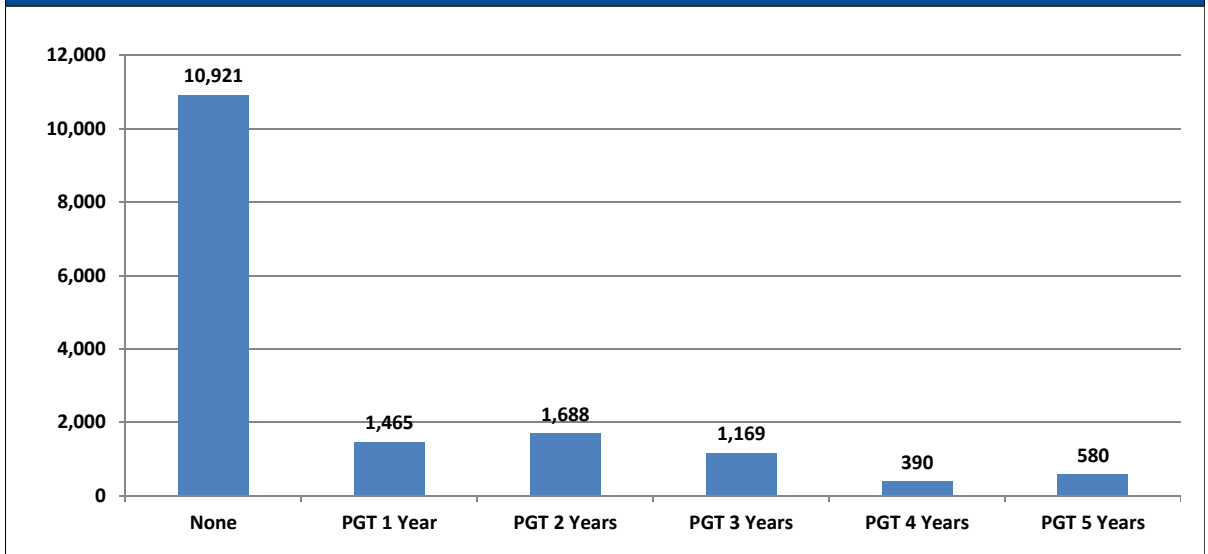
Year Graduated	2006	2007	2008	2009	2010	2011	2012
Degrees Awarded	704	761	735	713	715	632	510

Based on the Dental Healthcare Workforce Survey, the table and chart below show the number of dentists who received postgraduate training recognized by the American Dental Association. Postgraduate training is training beyond the receipt of the initial dentist training degree/certification. The chart ranges from no postgraduate training up to five years of training.

Dental Postgraduate Training

Postgraduate Training (PGT)	None	PGT 1 Year	PGT 2 Years	PGT 3 Year	PGT 4 Years	PGT 5 Years	Total
Number of Dentists	10,921	1,465	1,688	1,169	390	580	16,213
% of Total	67%	9%	11%	7%	2%	4%	100%

Dental Postgraduate Training



Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.
For purposes of this Fact Sheet, currently licensed dentists are defined as "renewed and current".
Revised 10/30/2013

Fact Sheet



Dentists

November 2013

The table and map below display universities that offer dental education programs in California.

Dental Education Programs in California

Public Universities

University of California, Los Angeles (UCLA)

University of California, San Francisco (UCSF)

Private Universities

Loma Linda University (LLU)

University of the Pacific (UOP)

University of Southern California (USC)

Dental Education Programs in California



Fact Sheet



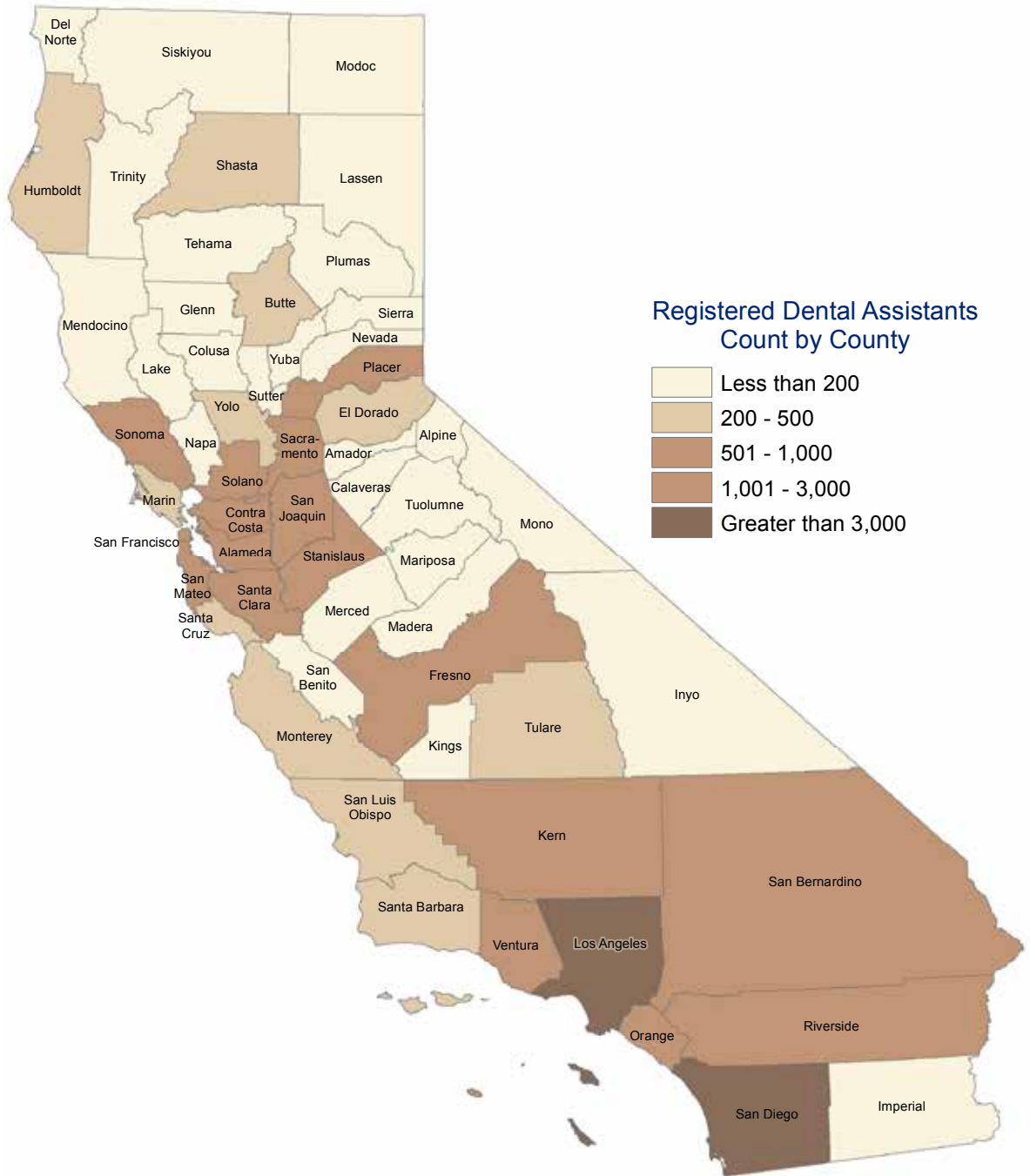
Registered Dental Assistants (RDA)

September 2013

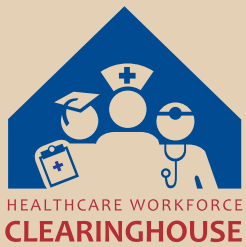


Registered Dental Assistants (RDAs) are licensed and regulated by the Department of Consumer Affairs, Dental Board of California (DBC). RDAs, under the general supervision of a dentist, perform basic supportive dental procedures, such as (1) mouth-mirror inspection of the oral cavity, including charting of lesions, existing restorations and missing teeth and (2) placement and removal of temporary sedative dressings. As of June 1, 2013, there were 34,159 licensed RDAs in the State of California. The table below identifies the current supply of active RDA licenses by county of record.

Current Supply of RDAs by County of Record



Fact Sheet



Registered Dental Assistants (RDA)

September 2013

Fact Sheet

Current Supply of RDAs by County of Record

County	Number of Providers	County	Number of Providers	County	Number of Providers
Alameda	1,465	Marin	250	San Mateo	885
Alpine	0	Mariposa	15	Santa Barbara	341
Amador	63	Mendocino	105	Santa Clara	1,974
Butte	303	Merced	195	Santa Cruz	260
Calaveras	68	Modoc	9	Shasta	320
Colusa	20	Mono	9	Sierra	N/A
Contra Costa	1,613	Monterey	424	Siskiyou	45
Del Norte	44	Napa	153	Solano	662
El Dorado	282	Nevada	137	Sonoma	844
Fresno	810	Orange	2,325	Stanislaus	707
Glenn	53	Placer	640	Sutter	139
Humboldt	218	Plumas	22	Tehama	68
Imperial	84	Riverside	2,044	Trinity	8
Inyo	14	Sacramento	1,848	Tulare	420
Kern	662	San Benito	104	Tuolumne	94
Kings	137	San Bernardino	1,771	Ventura	646
Lake	80	San Diego	3,010	Yolo	247
Lassen	62	San Francisco	551	Yuba	90
Los Angeles	5,530	San Joaquin	826		
Madera	152	San Luis Obispo	308	Total	34,159

Counties reporting five and under registered dental assistants are categorized as N/A (not available) for confidentiality purposes.

Specialties

California Business and Professions Code 1715.5 authorizes the DBC to collect information from dental healthcare workers at the time of license renewal (every two years). Thus, there is an annual update to the survey results. The workers may self-report his/her employment status, postgraduate training, practice specialty, cultural background and foreign language proficiency. The map on page 3 identifies the top four active RDA specialties by practice location.

Specialties

Oral Pathology	11	< 1%	Periodontics	58	2%
Facial Cosmetic Surgery	11	< 1%	Oral/Maxillofacial Surgery	67	3%
General Anesthesia	30	1%	Pediatric Dentistry	138	6%
Conscious Sedation	32	1%	Orthodontics	254	11%
Public Health	39	2%	Oral Radiology	313	13%
Oral Conscious Sedation	40	2%	General Practice	1,301	55%
Prosthodontics	41	2%			
Endodontics	51	2%	Total Responses	2,386	100%

Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.
For purposes of this Fact Sheet, currently licensed RDAs are defined as "renewed and current".
08/09/13

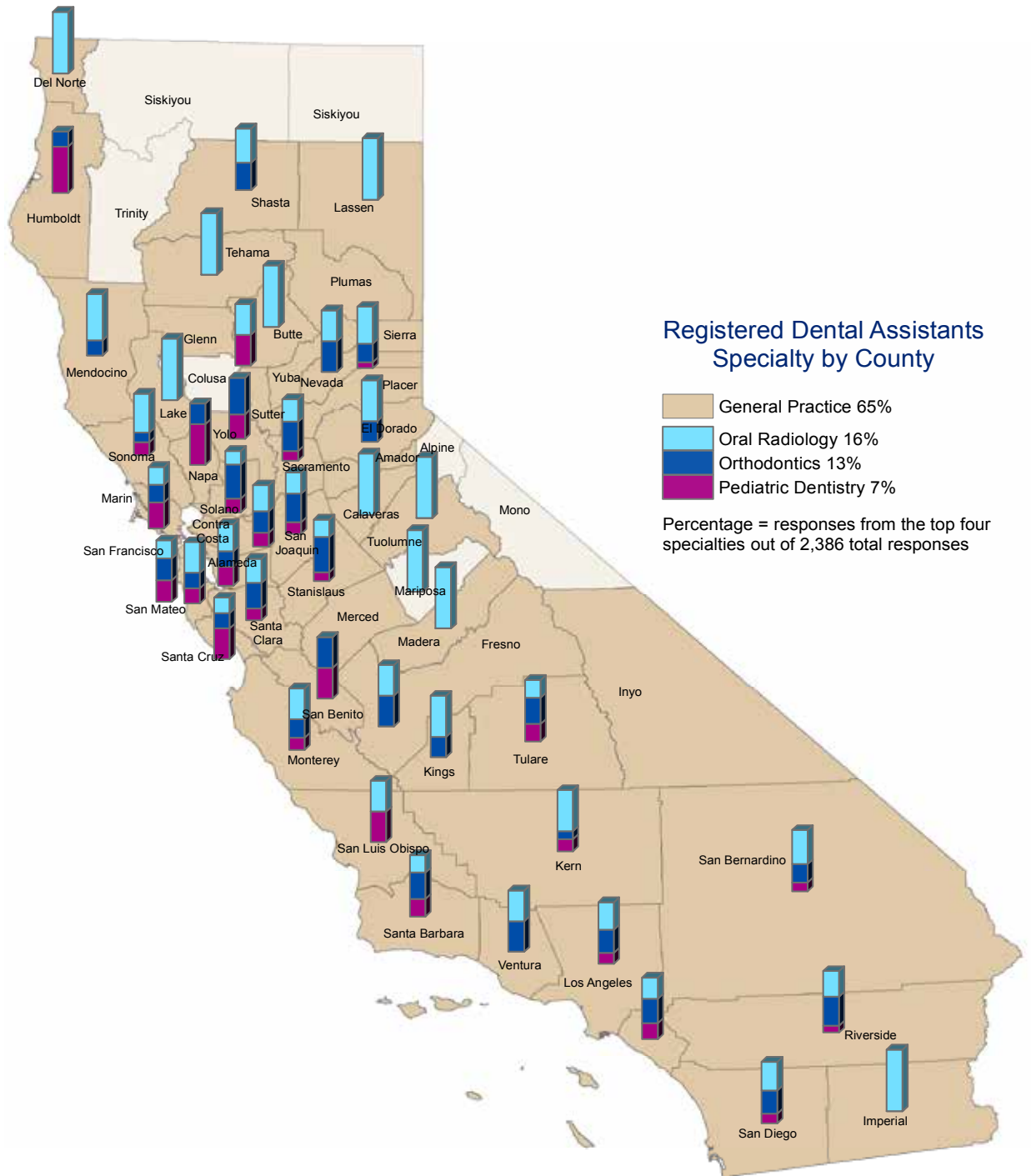


Registered Dental Assistants (RDA)

September 2013

The map below identifies the top four active RDA specialties by practice location.

RDA Specialties by Practice Location



Fact Sheet



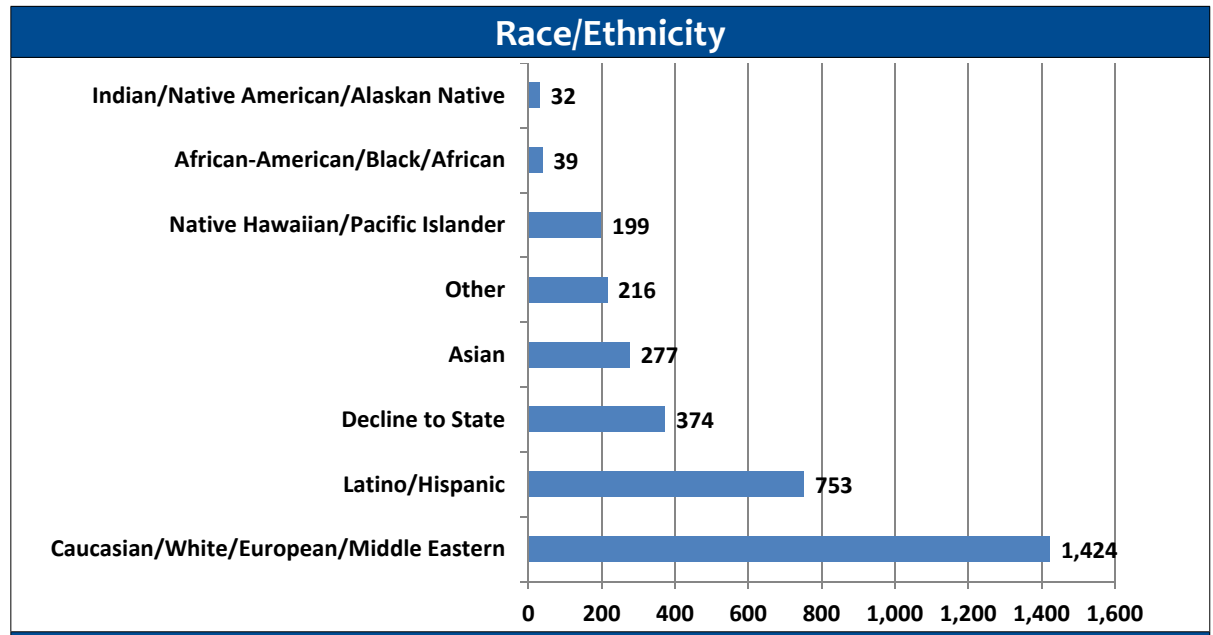
Registered Dental Assistants (RDA)

September 2013

Fact Sheet

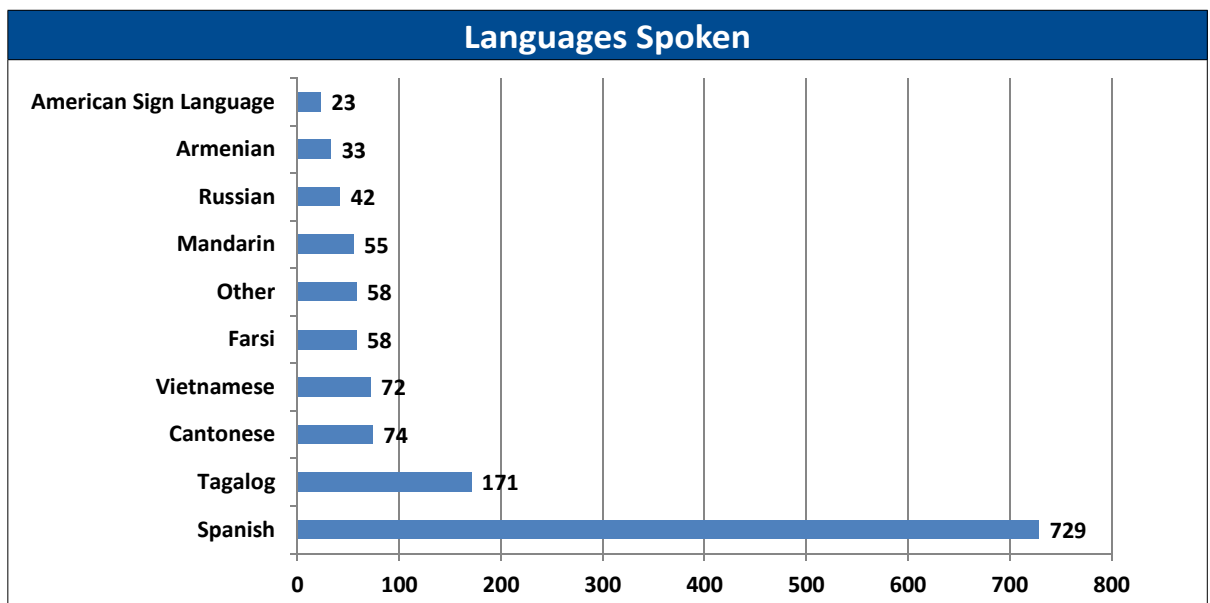
Race/Ethnicity

There are 28 race/ethnicity categories in which an RDA may identify with on the Dental Healthcare Workforce Survey.* The races/ethnicities have been combined into six major categories. A licensee may select more than one race/ethnicity resulting in duplicate counts for a single licensee and a total greater than 100%. The survey results for 3,314 responses are displayed in the chart below. In addition, the responses for "Other" and "Decline to State" are also displayed.



Languages Spoken

The DBC recognizes 30 language categories which include "Other" and "Decline to State" for which an RDA may indicate on the Dental Healthcare Workforce Survey. A licensee may select more than one language, resulting in duplicate counts for a single licensee. The survey results for 1,464 responses are displayed in the chart below. The most predominate language is English. Not including English, the top 10 languages spoken are identified.



Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.

For purposes of this Fact Sheet, currently licensed RDAs are defined as "renewed and current".

*The Dental Healthcare Workforce Survey's race/ethnicity and languages spoken categories can be viewed at <http://www.dbc.ca.gov/survey/index.shtml>

**Decline to State" signified that a RDA did not want to disclose this information.

08/09/13



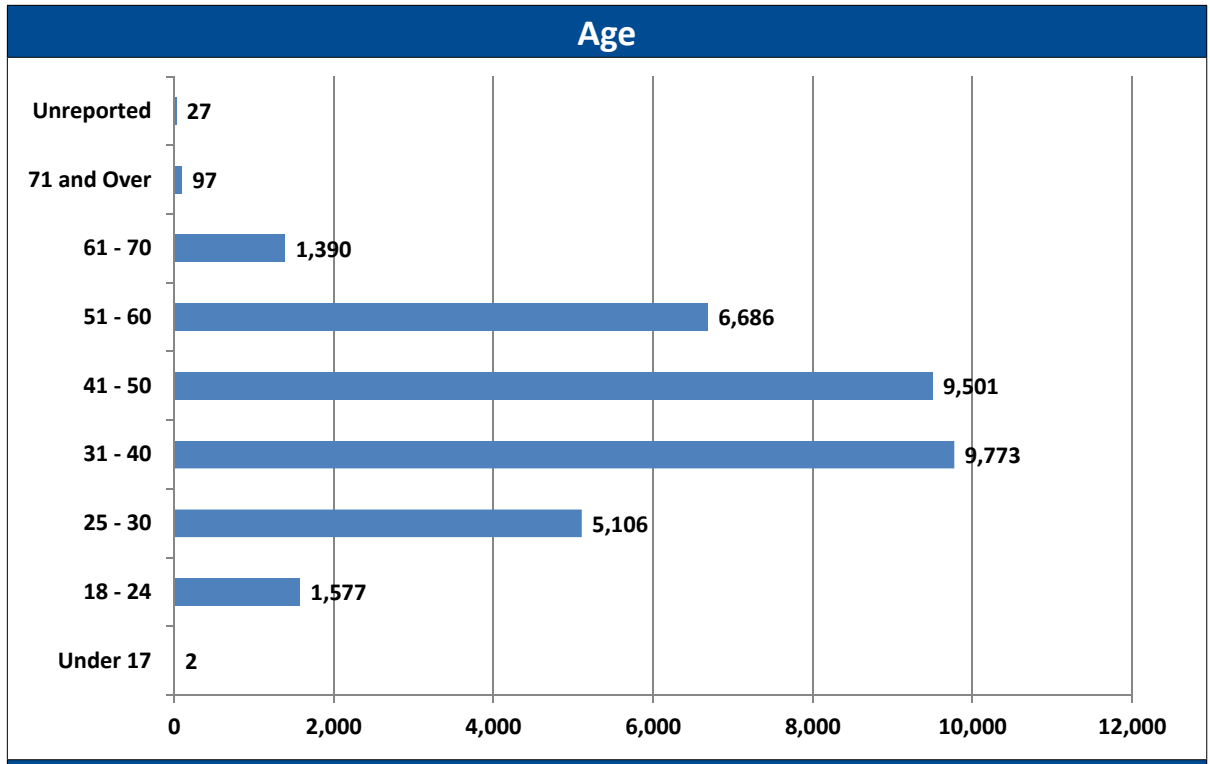
Registered Dental Assistants (RDA)

September 2013

Fact Sheet

Age

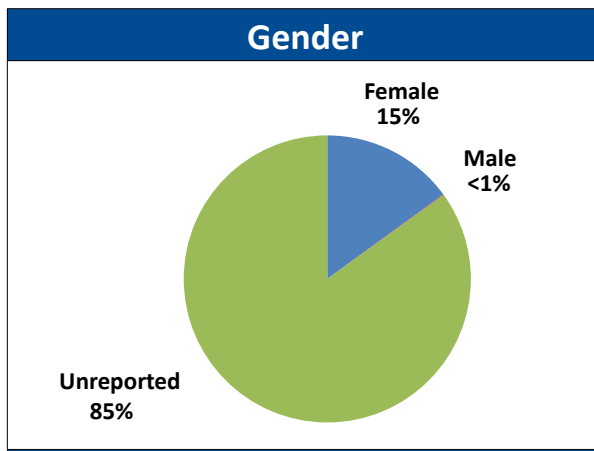
The currently licensed RDAs in California by age group can be seen in the chart and table below.



Age	17 and Under	18 - 24	25 - 30	31 - 40	41 - 50	51 - 60	61 - 70	71 and Over	Unreported	Total RDAs
Total Responses	2	1,577	5,106	9,773	9,501	6,686	1,390	97	27	34,159
% of Total RDAs	<1%	5%	15%	29%	28%	19%	4%	<1%	<1%	100%

Gender

The currently licensed RDAs in California by gender can be seen in the table and chart below.



Gender	Total RDAs	% of Total RDAs
Female	5,120	15%
Male	21	<1%
Unreported	29,018	85%
Total RDAs	34,159	100%

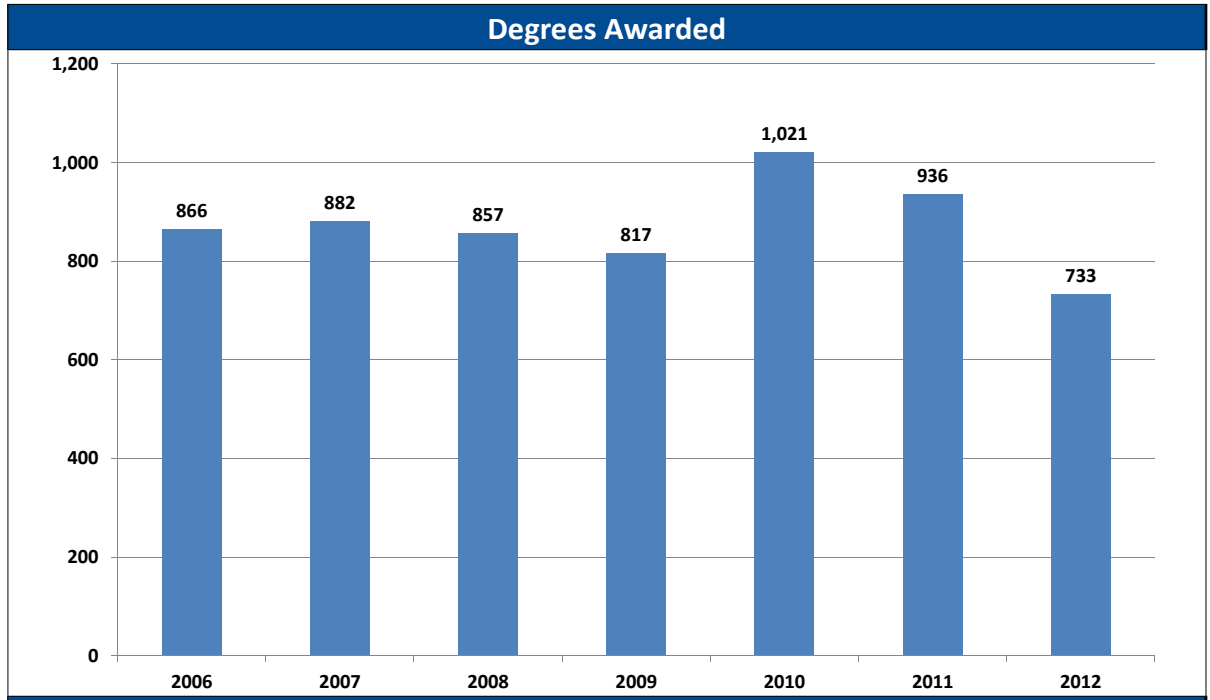


Registered Dental Assistants (RDA)

September 2013



The chart and table below display the number of students who received degrees from California RDA programs in years 2006 - 2012.



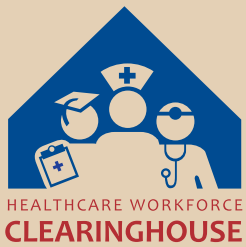
Degrees Awarded							
Year Graduated	2006	2007	2008	2009	2010	2011	2012
Degrees Awarded	866	882	857	817	1,021	936	733

The following table below displays adult education and community college RDA education programs in California. The information can be seen geographically in the map on page 8.

RDA Education Programs in California				
Adult Education Programs				
Hacienda-La Puente Valley	Mt. Diablo Adult Education			
Community Colleges				
Cerritos Community College	College of the Redwoods	Modesto Junior College	Reedley College	Santa Rosa Junior College
City College of San Francisco	Contra Costa College	Monterey Peninsula College	Riverside Community College	
College of Alameda	Cypress College	Orange Coast College	Sacramento City College	
College of Marin	Diablo Valley College	Palomar College	San Diego Mesa College	
College of San Mateo	Foothill Community College	Pasadena City College	San Jose City College	

Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.
For purposes of this Fact Sheet, currently licensed RDAs are defined as "renewed and current".
08/09/13

Fact Sheet



Registered Dental Assistants (RDA)

September 2013

The following table below display RDA education programs in California. The information can be seen geographically in the map on page 8.

RDA Education Programs in California

Regional Occupational Programs (ROP) and Regional Occupational Centers (ROC)

Baldy View ROP	Eden Area ROP	Hesperia Alternative Center ROP	Riverside County ROP	Shasta-Trinity ROP
Butte County ROP	Grossmont Health Occupational Center	North Orange County ROP	San Bernardino County ROP	Southern California ROC

Private College Programs

Allan Hancock College	Carrington College California - San Jose	Everest College - Los Angeles Wilshire	Kaplan College - Bakersfield	North-West College - Pomona
American Career College - Anaheim	Carrington College California - San Leandro	Everest College - West Los Angeles	Kaplan College - Clovis	North-West College - West Covina
American Career College - Los Angeles	Chaffey College	Everest College - Ontario	Kaplan College - Palm Spring	Pima Medical Institute
American Career College - Ontario	Charter College	Everest College - Reseda	Kaplan College - Riverside	San Joaquin Valley College - Bakersfield
Anthem College	Citrus College	Everest College - San Bernardino	Kaplan College - Sacramento	San Joaquin Valley College - Fresno
Blake Austin College	Concorde Career College - Garden Grove	Everest College - San Francisco	Kaplan College - Salida	San Joaquin Valley College - Visalia
Carrington College California - Antioch	Concorde Career College - North Hollywood	Everest College - San Jose	Kaplan College - San Diego	UEI College - Chula Vista
Carrington College California - Chico	Concorde Career College - San Bernardino	Galen College - Fresno	Kaplan College - Stockton	UEI College - El Monte
Carrington College California - Citrus Heights	Concorde Career College - San Diego	Galen College - Modesto	Kaplan College - Vista	UEI College - Huntington Park
Carrington College California - Emeryville	Everest College - Alhambra	Heald College - Concord	Milan Institute - Indio	UEI College - Los Angeles
Carrington College California - Pleasant Hill	Everest College - Anaheim	Heald College - Hayward	Milan Institute - Visalia	UEI College - Ontario
Carrington College California - Pomona	Everest College - City of Industry	Heald College - Salida	My Dentist School for Dental Assistants	UEI College - San Diego
Carrington College California - Sacramento	Everest College - Gardena	Heald College - Stockton	Newbridge College	UEI College - Van Nuys

Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013. For purposes of this Fact Sheet, currently licensed RDAs are defined as "renewed and current". 08/09/13

Fact Sheet

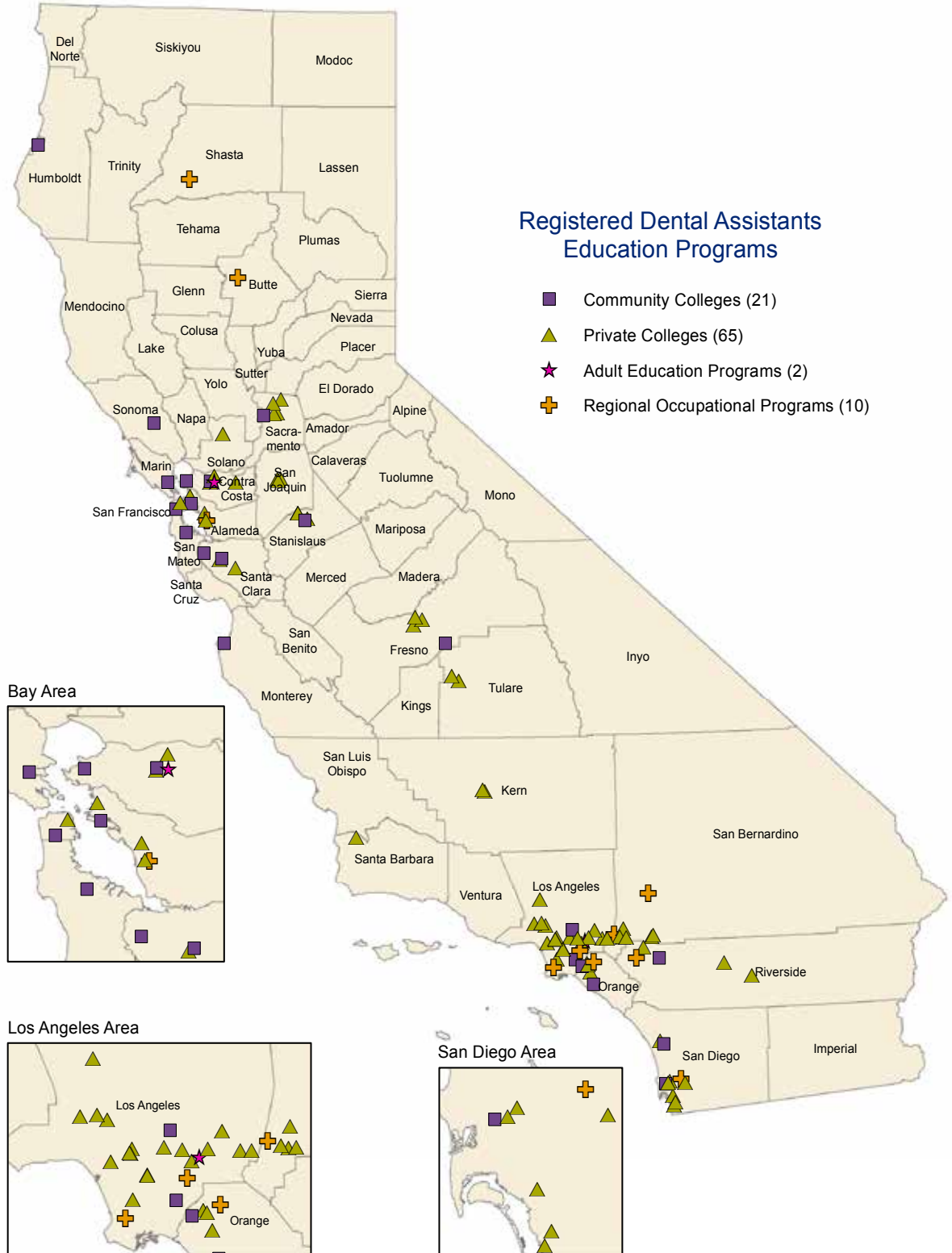


Registered Dental Assistants (RDA)

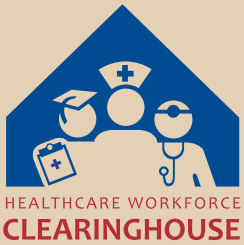
September 2013

The names of the RDA education programs can be seen in the tables on pages 6 and 7.

RDA Education Programs in California



Fact Sheet

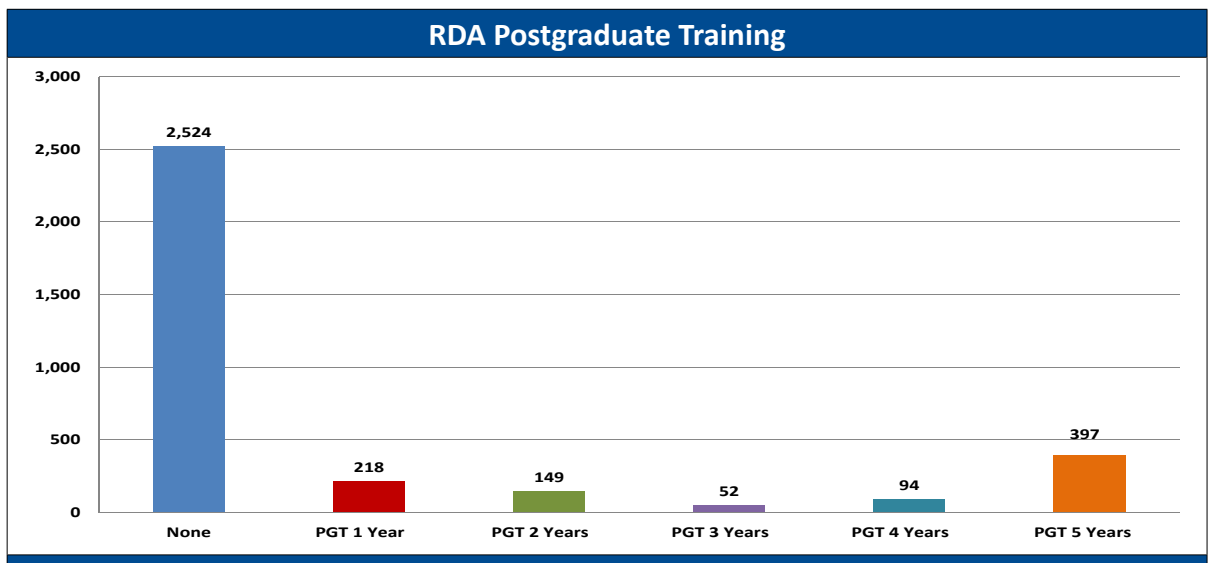
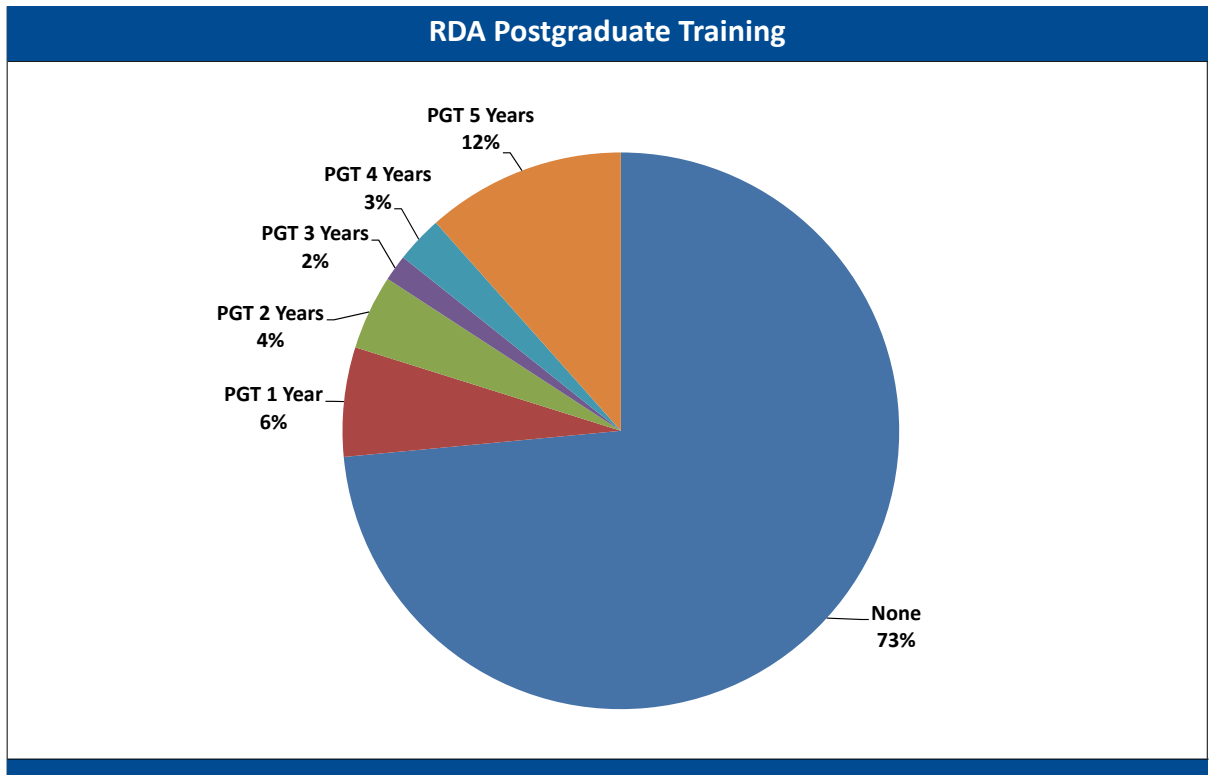


Registered Dental Assistants (RDA)

September 2013

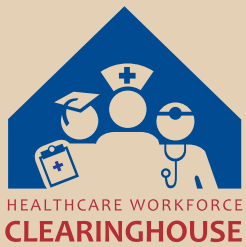
Based on the Dental Healthcare Workforce Survey, the table and charts below show the number of RDAs who received postgraduate training in a dental specialty recognized by the American Dental Association. Postgraduate is training beyond the receipt of the initial RDA training degree/certification. The chart ranges from no postgraduate training up to five years of training.

RDA Postgraduate Training							
Postgraduate Training (PGT)	None	PGT 1 Year	PGT 2 Years	PGT 3 Year	PGT 4 Years	PGT 5 Years	Total
Number of RDAs	2,524	218	149	52	94	397	3,434
% of Total	73%	6%	4%	2%	3%	12%	100%



Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013.
For purposes of this Fact Sheet, currently licensed RDAs are defined as "renewed and current".
08/09/13

Fact sheet



Registered Dental Assistants (RDA)

September 2013



The following data are based on Employment Development Department's Labor Market Information Division Statewide 2010-2020 Occupational Employment Projections.*

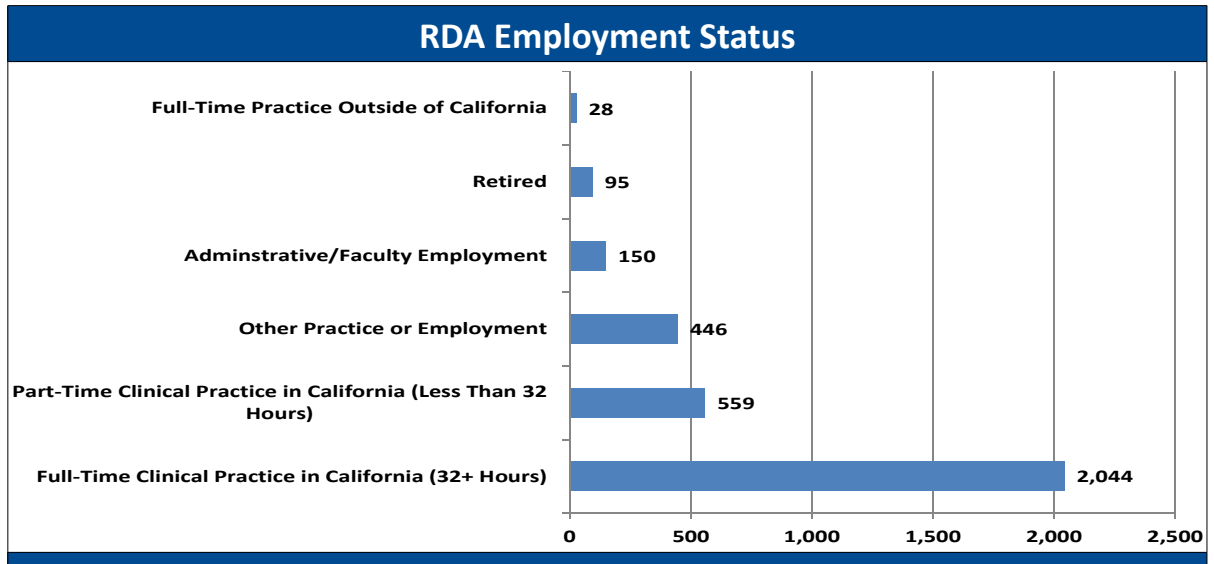
As displayed in the "Average Annual Job Openings" table below, the average annual job openings are an estimate of jobs created, resulting from economic growth and jobs created when workers retire or permanently leave an occupation and need to be replaced.

As displayed in the "2012 – 1st Quarter Wages" table below, the wages are the most recent estimates available for the 2010-2020 statewide employment projections.

Average Annual Job Openings	
New Jobs	530
Replacement Needs	920
Total	1,450
2012 – 1st Quarter Wages	
Median Hourly	\$17.08
Median Annual	\$35,516

Top Industries Which Employ This Occupation
1. Offices of Dentists
2. Offices of Physicians
3. State Government
4. Outpatient Care Centers
5. Federal Government

Based on the Dental Healthcare Workforce Survey results for 3,322 responses, the RDA licensee employment status is displayed in the chart and table below.

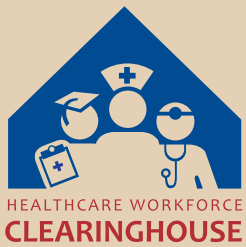


Employment Status	Full-Time Practice outside of CA	Retired	Administrative /Faculty Employment	Other Practice Or Employment	Part-Time Clinical Practice in California (Less Than 32 Hours)	Full-Time Clinical Practice in California (32+ Hours)	Total
Total RDAs	28	95	150	446	559	2,044	3,322
% of Total	1%	3%	4%	13%	17%	62%	100%

Source of Data: Department of Consumer Affairs, Dental Board of California Public Master File, June 2013. For purposes of this Fact Sheet, currently licensed RDAs are defined as "renewed and current".

*Employment Development Department's Labor Market Information Division, Statewide 2010-2020 Occupational Employment Projections, July 2012. 08/09/13

Fact Sheet



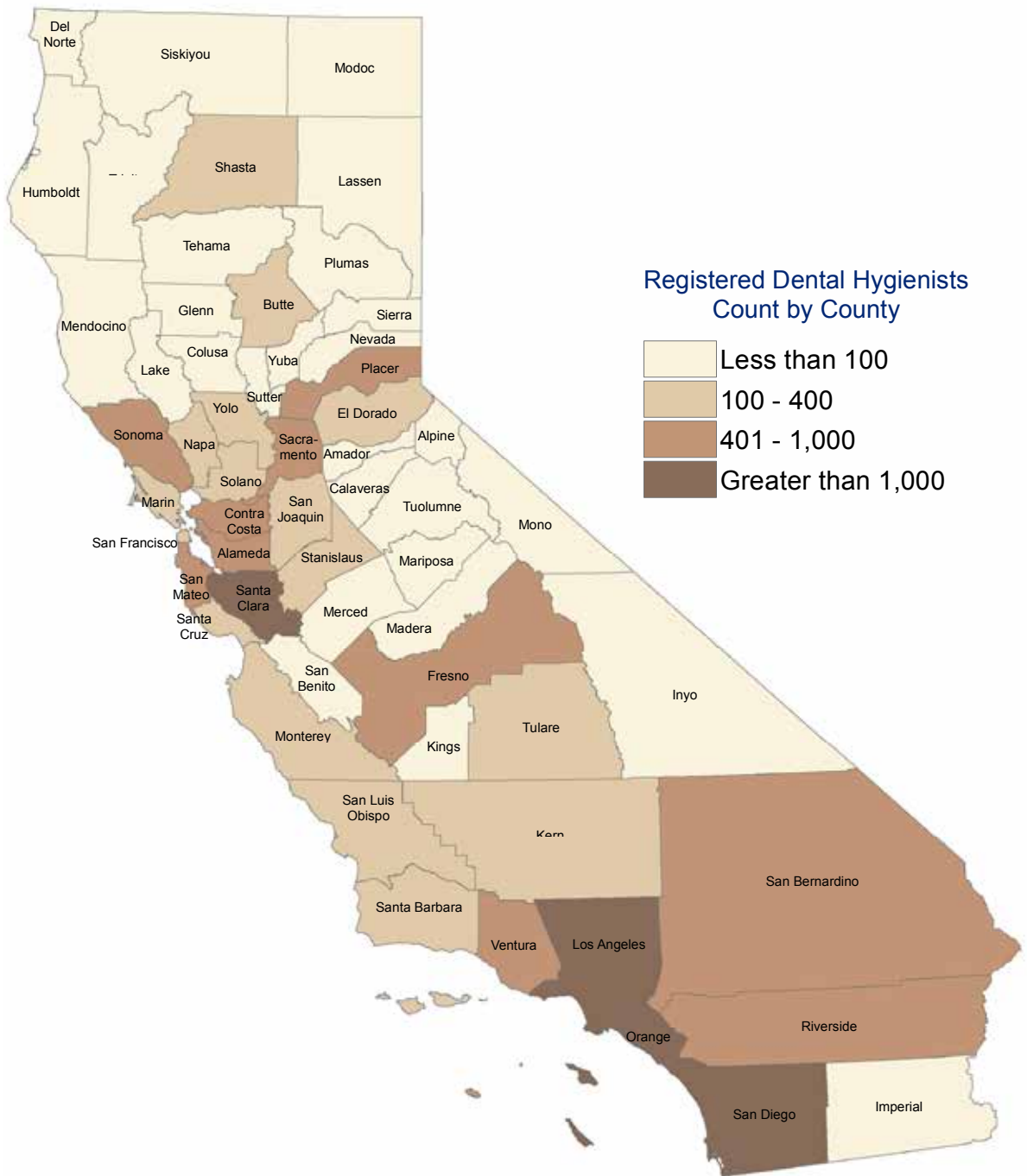
Registered Dental Hygienists (RDH)

November 2013



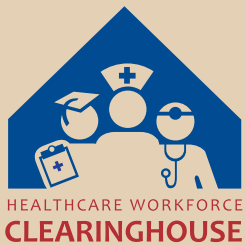
Registered Dental Hygienists (RDHs) are licensed and regulated by the Dental Hygiene Committee of California (DHCC). The practice of dental hygiene includes oral health education; counseling; health screenings; hygiene care plan; application of topical therapeutic, and subgingival agents used for the control of caries and periodontal disease; taking tooth impressions for bleaching trays; and placements of in-office, tooth-whitening devices. As of June 1, 2013, there were 20,670 currently licensed RDHs in the State of California by county of record. The map below and the table on page 2 display the current supply of active RDHs by licensee county of record.

Current Supply of RDHs by County of Record



Source of Data: Department of Consumer Affairs, Dental Hygiene Committee of California Public Master File, June 2013. For purposes of this Fact Sheet, currently licensed RDHs are defined as "renewed and current". 11/18/13

Fact Sheet



Registered Dental Hygienists (RDH)

November 2013

Fact Sheet

Current Supply of RDHs by County of Record

County	Number of Providers	County	Number of Providers	County	Number of Providers
Alameda	951	Marin	222	San Mateo	494
Alpine	0	Mariposa	7	Santa Barbara	276
Amador	30	Mendocino	58	Santa Clara	1,183
Butte	191	Merced	91	Santa Cruz	273
Calaveras	32	Modoc	N/A	Shasta	194
Colusa	7	Mono	11	Sierra	0
Contra Costa	887	Monterey	223	Siskiyou	25
Del Norte	6	Napa	125	Solano	269
El Dorado	249	Nevada	97	Sonoma	482
Fresno	548	Orange	1,938	Stanislaus	340
Glenn	5	Placer	502	Sutter	64
Humboldt	94	Plumas	17	Tehama	31
Imperial	25	Riverside	887	Trinity	N/A
Inyo	18	Sacramento	942	Tulare	219
Kern	334	San Benito	46	Tuolumne	52
Kings	84	San Bernardino	910	Ventura	579
Lake	26	San Diego	1,919	Yolo	100
Lassen	29	San Francisco	299	Yuba	17
Los Angeles	3,619	San Joaquin	300		
Madera	67	San Luis Obispo	271	Total	20,670

Counties reporting five and under registered dental hygienists are categorized as N/A (not available) for confidentiality purposes. The counties that display N/A account for a total of five registered dental hygienists.

Specialties

California Business and Professions Code 1715.5 authorizes the Dental Board of California to collect information from dental healthcare workers at the time of license renewal (every two years). Thus, there is an annual update to the survey results. The workers may self-report his/her employment status, postgraduate training, practice specialty, cultural background and foreign language proficiency.

Specialties

Specialty	Number of Providers	Percentage	Specialty	Number of Providers	Percentage
Facial Cosmetic Surgery	2	<1%	Oral Conscious Sedation	225	3%
Oral/Maxillofacial Surgery	9	<1%	Conscious Sedation	254	3%
Oral Pathology	17	<1%	General Anesthesia	331	5%
Endodontics	19	<1%	Periodontics	365	5%
Orthodontics	46	1%	Oral Radiology	863	12%
Prosthodontics	81	1%	General Practice	5,107	68%
Pediatric Dentistry	85	1%			
Public Health	103	1%	Total Responses	7,507	100%

Source of Data: Department of Consumer Affairs, Dental Hygiene Committee of California Public Master File, June 2013. For purposes of this Fact Sheet, currently licensed RDHs are defined as "renewed and current". 11/18/13

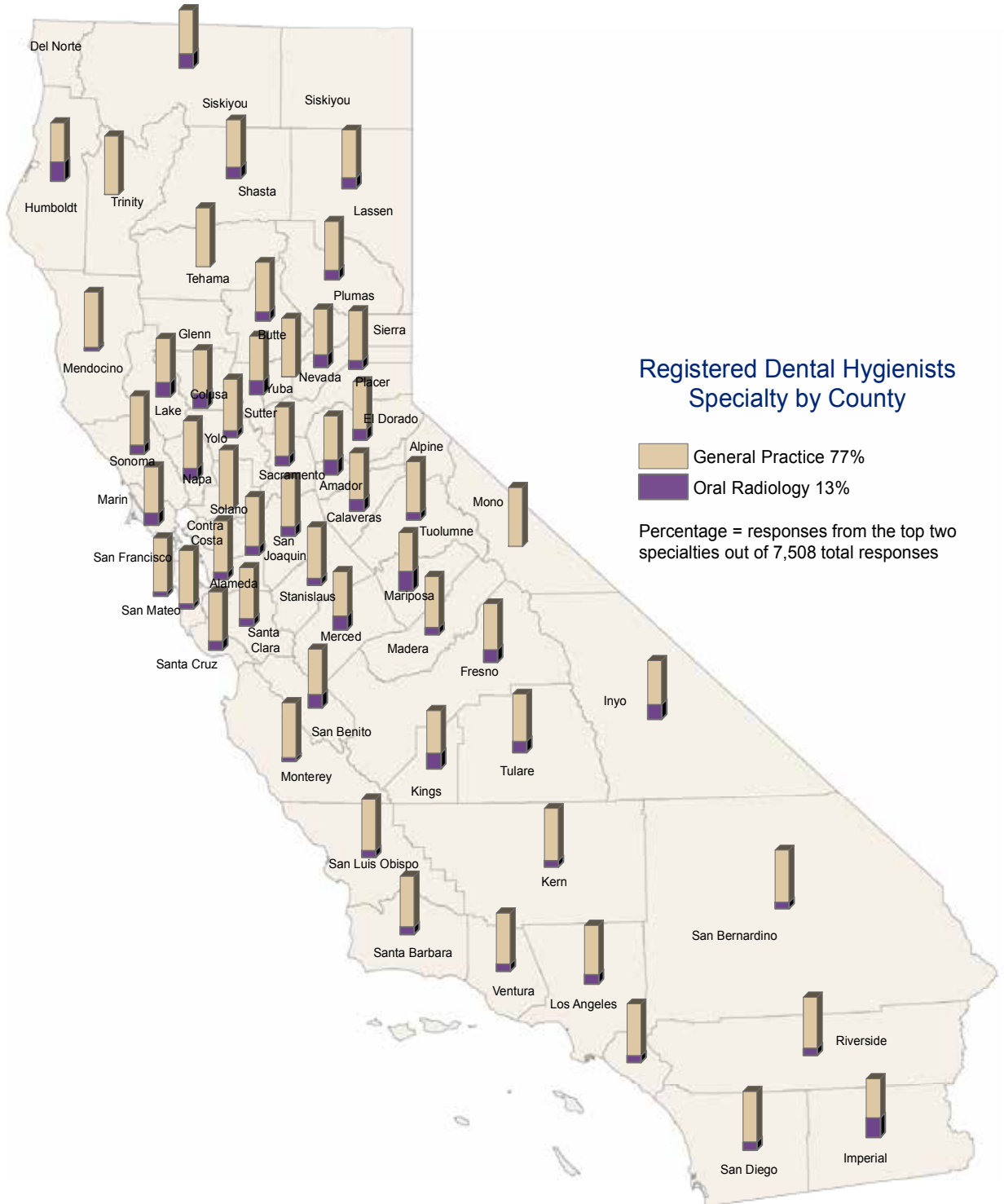


Registered Dental Hygienists (RDH)

November 2013

The map below identifies the top two active RDA specialties by practice location.

RDH Specialties by Practice Location



Fact Sheet



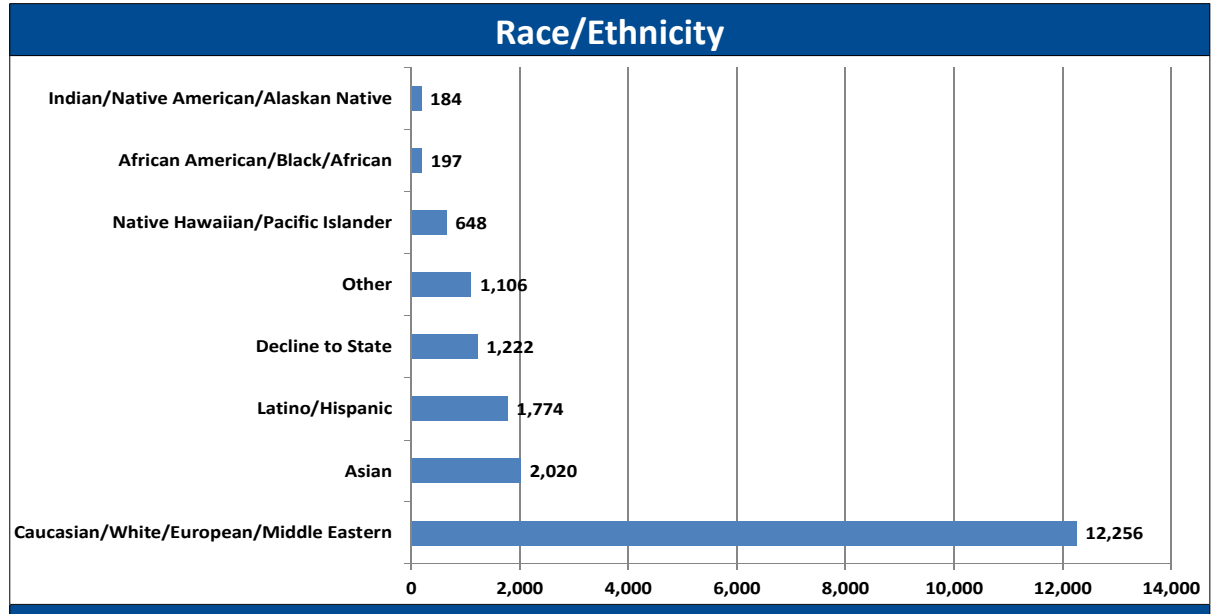
Registered Dental Hygienists (RDH)

November 2013

Fact Sheet

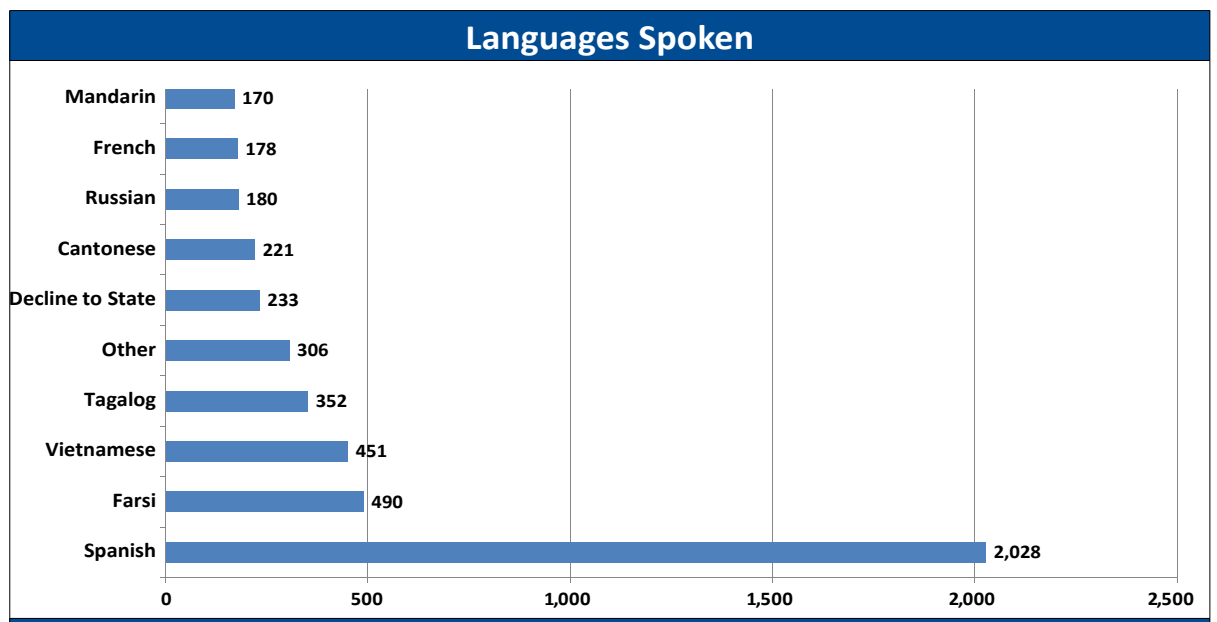
Race/Ethnicity

There are 28 races/ethnicities in which an RDH may identify with on the Dental Healthcare Workforce Survey.* The races/ethnicities have been combined into six major categories. A licensee may select more than one race/ethnicity, resulting in duplicate counts for a single licensee and a total greater than 100%. The survey results for 19,407 responses are displayed in the chart below. In addition, the responses for “Other” and “Decline to State”** are displayed.



Languages Spoken

The DHCC recognizes 30 language categories which include “Other” and “Decline to State” for which an RDH may indicate on the Dental Healthcare Workforce Survey. A licensee may select more than one language, resulting in duplicate counts for a single licensee. The survey results for 5,834 responses are displayed in the chart below. The most predominate language is English. Not including English, the top 10 languages spoken are displayed.



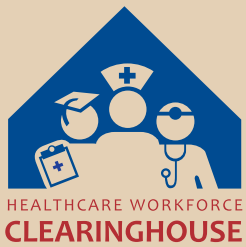
Source of Data: Department of Consumer Affairs, Dental Hygiene Committee of California Public Master File, June 2013.

For purposes of this Fact Sheet, currently licensed RDHs are defined as “renewed and current”.

*The Dental Healthcare Workforce Survey for RDH’s race/ethnicity and languages spoken categories can be viewed at <http://www.dcc.ca.gov/survey/index.shtml>

**“Decline to State” signified that an RDH did not want to disclose this information.

11/18/13



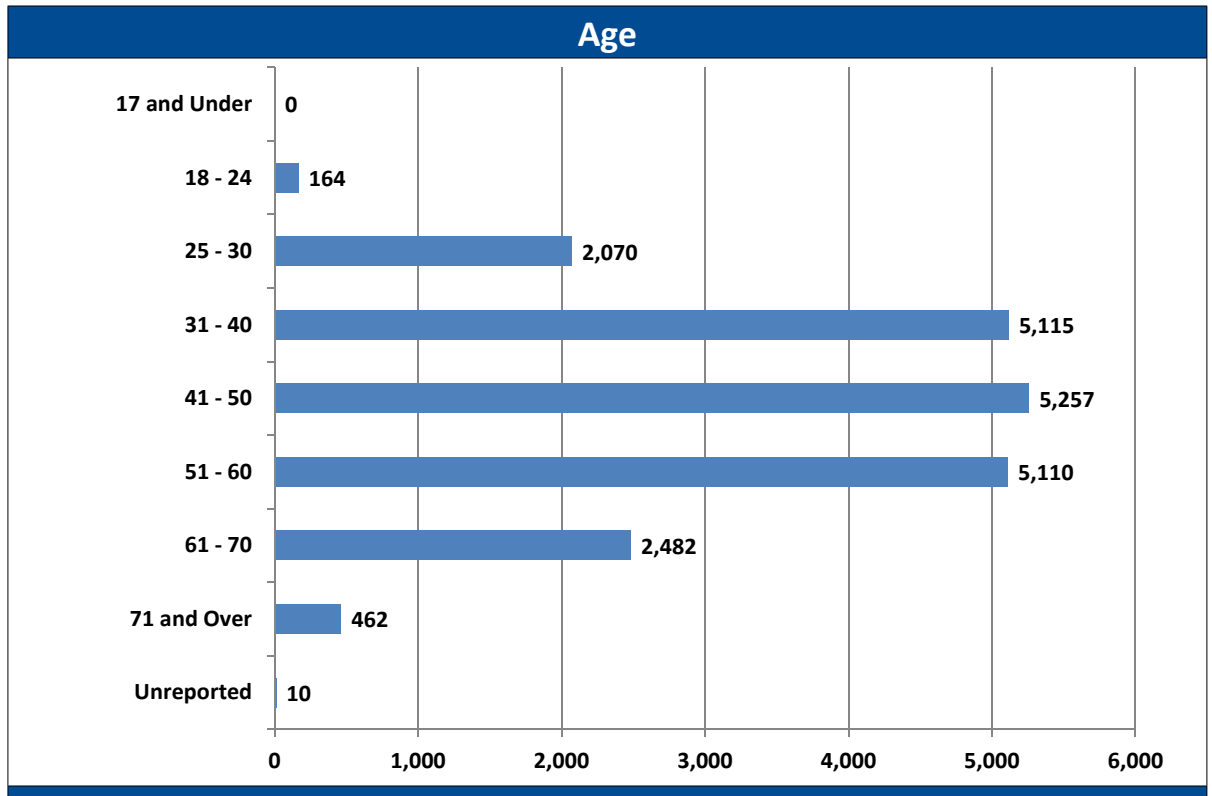
Registered Dental Hygienists (RDH)

November 2013

Fact Sheet

Age

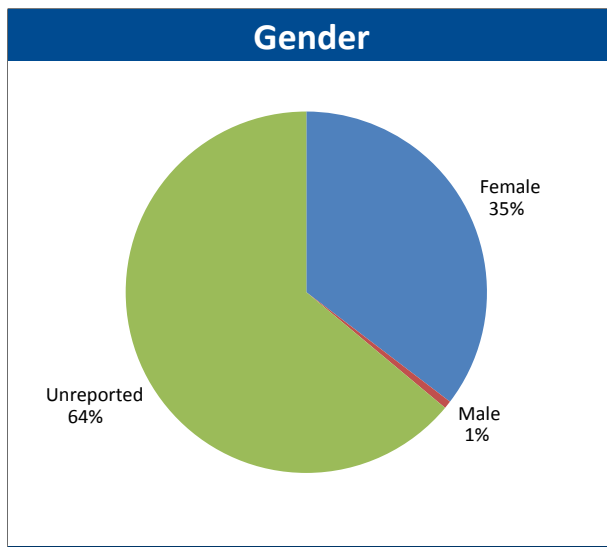
The currently licensed RDHs in California by age group can be seen in the table and chart below.



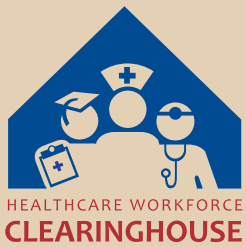
Age	17 and Under	18 - 24	25 - 30	31 - 40	41 - 50	51 - 60	61 - 70	71 and Over	Unreported	Total RDHs
Total Responses	0	164	2,070	5,115	5,257	5,110	2,482	462	10	20,670
% of Total RDHs	<1%	1%	10%	25%	25%	25%	12%	2%	<1%	100%

Gender

The currently licensed RDHs in California by gender can be seen in the table to the right and the chart below.



Gender	Total RDHs	% of Total RDHs
Female	7,311	35%
Male	141	1%
Unreported	13,218	64%
Total RDHs	20,670	100%



Registered Dental Hygienists (RDH)

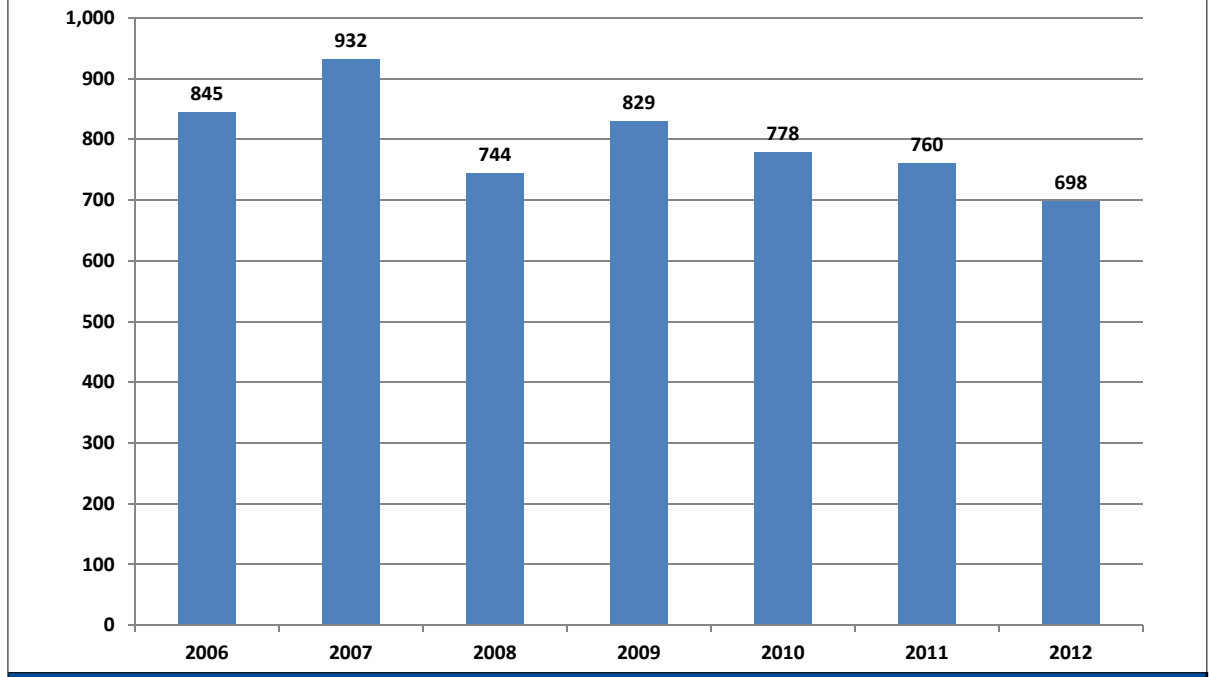
November 2013



The chart and table below display the number of students who received degrees from California RDH programs in years 2006-2012.

Fact Sheet

Degrees Awarded



Year Graduated	2006	2007	2008	2009	2010	2011	2012
Degrees Awarded	845	932	744	829	778	760	698

The table below shows colleges and universities that offer RDH education programs in California. The information can be seen geographically in the map on page 7.

RDH Education Programs in California

Public Colleges and Universities

Cabrillo College	Diablo Valley College	Oxnard College	Shasta College
Cerritos College	Foothill College	Pasadena City College	Southwestern College
Chabot College	Fresno City College	Sacramento City College	Taft College
Cypress College	Moreno Valley College	Santa Rosa Junior College	West Los Angeles College

Private Colleges and Universities

Carrington College California - Sacramento	Concorde Career College - Garden Grove	San Joaquin Valley College, Inc.	University of Southern California Herman Ostrow School of Dentistry
Carrington College California - San Jose	Concorde Career College - San Diego	San Joaquin Valley College - San Diego	West Coast University
Concorde Career College - San Bernardino	Loma Linda University School of Dentistry	University of the Pacific Arthur A. Dugoni School of Dentistry	



Office of Statewide Health Planning and Development

Source of Data: Department of Consumer Affairs, Dental Hygiene Committee of California Public Master File, June 2013. For purposes of this Fact Sheet, currently licensed RDHs are defined as "renewed and current". 11/18/13



Registered Dental Hygienists (RDH)

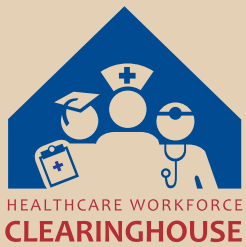
November 2013

The map below shows colleges and universities that offer RDH education programs in California. The names of the colleges and universities are shown in the table on page 6.

RDH Education Programs in California



Fact sheet

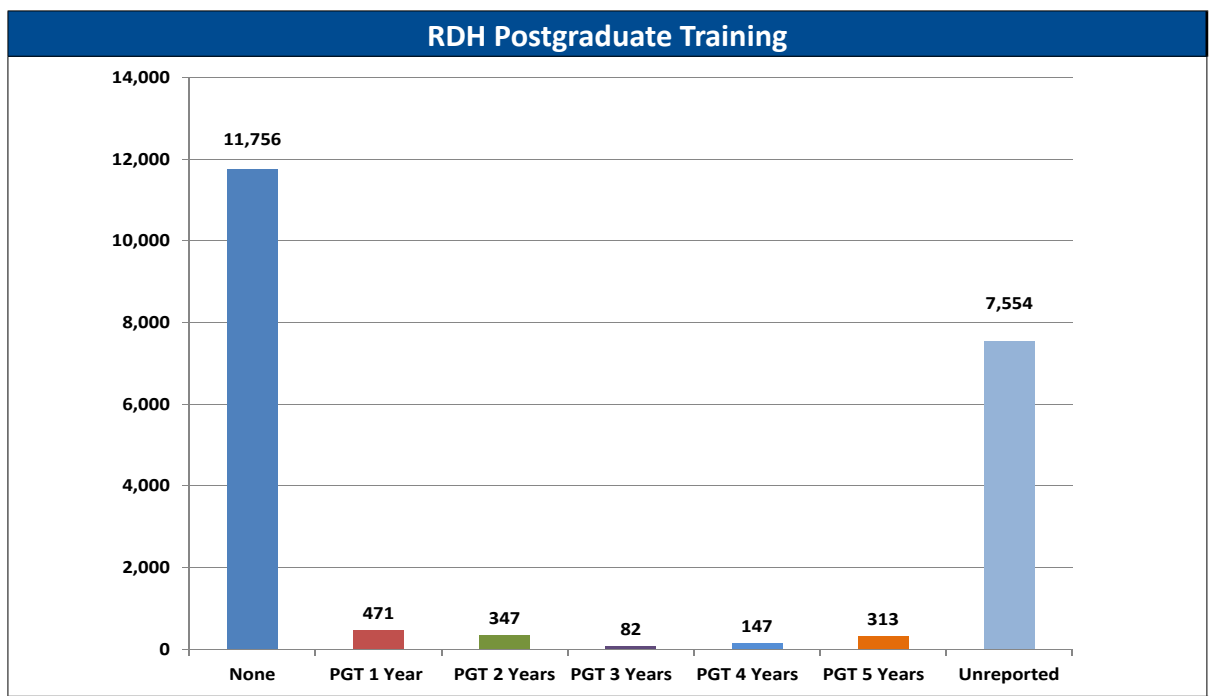
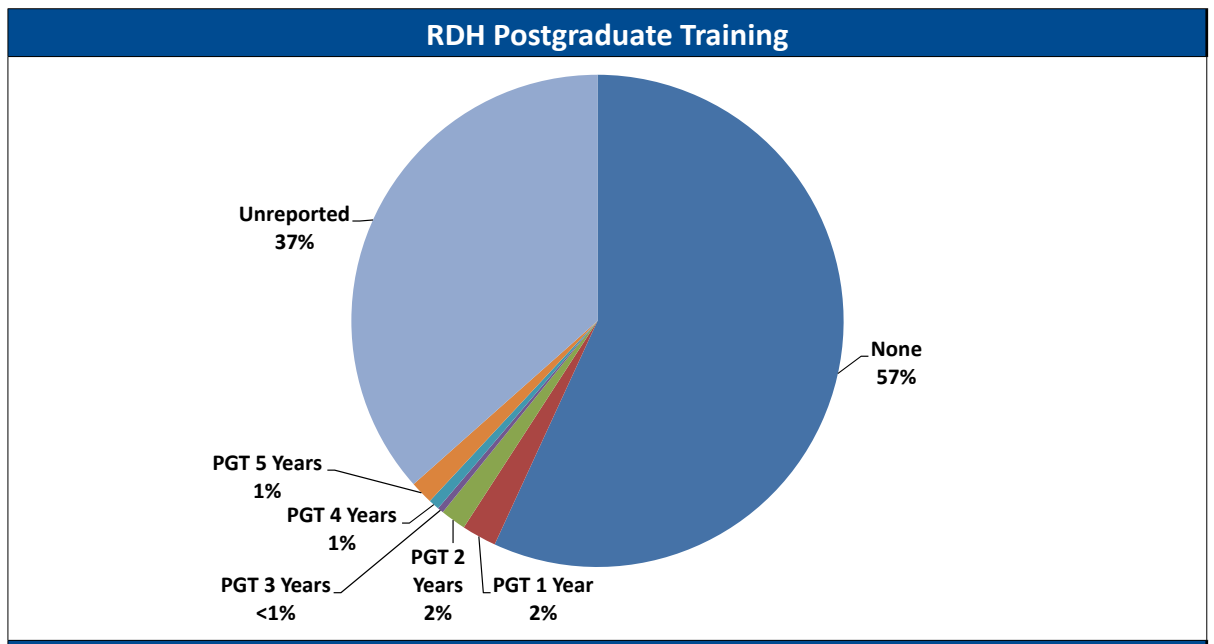


Registered Dental Hygienists (RDH)

November 2013

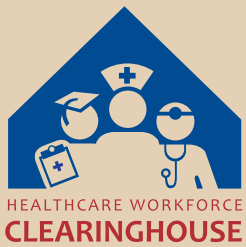
Based on the Dental Healthcare Workforce Survey, the table and charts below show the number of RDHs who received postgraduate training in a dentist specialty recognized by the American Dental Association. Postgraduate is training beyond the receipt of the initial RDH training degree/certification. The chart ranges from no postgraduate training up to five years of training.

RDH Postgraduate Training								
Postgraduate Training (PGT)	None	PGT 1 Year	PGT 2 Years	PGT 3 Years	PGT 4 Years	PGT 5 Years	Unreported	Total
Number of RDHs	11,756	471	347	82	147	313	7,554	20,670
% of Total	57%	2%	2%	<1%	1%	1%	37%	100%



Source of Data: Department of Consumer Affairs, Dental Hygiene Committee of California Public Master File, June 2013.
For purposes of this Fact Sheet, currently licensed RDHs are defined as "renewed and current".
11/18/13

Fact sheet



Registered Dental Hygienists (RDH)

November 2013



The following data are based on the Employment Development Department's Labor Market Information Division Statewide 2010-2020 Occupational Employment Projections.*

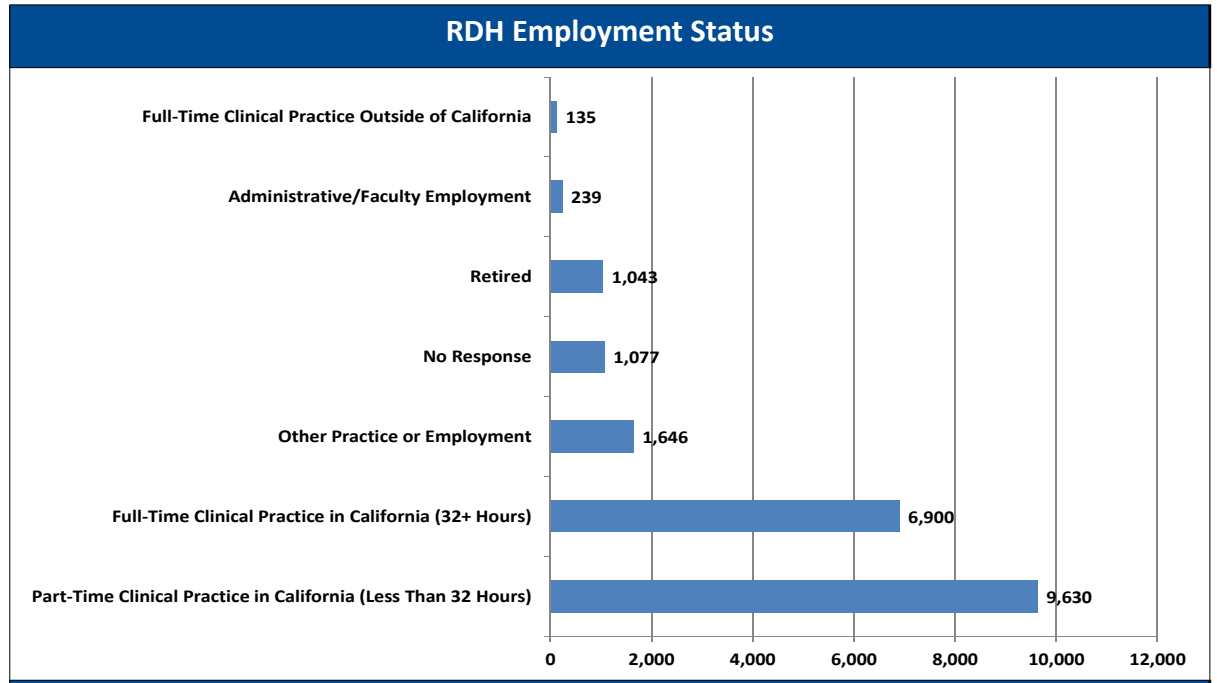
As displayed in the "Average Annual Job Openings" table below, the average annual job openings are an estimate of jobs created, resulting from economic growth and jobs created when workers retire or permanently leave an occupation and need to be replaced.

As displayed in the "2012 – 1st Quarter Wages" table below, the wages are the most recent estimates available for the 2010-2020 statewide employment projections.

Average Annual Job Openings	
New Jobs	350
Replacement Needs	400
Total	750
2012 – 1st Quarter Wages	
Median Hourly	\$46.31
Median Annual	\$96,317

Top Industries Which Employ This Occupation
1. Offices of Dentists
2. Offices of Physicians
3. Colleges and Universities
4. Outpatient Care Centers
5. Employment Services

Based on the Dental Healthcare Workforce Survey, the RDH licensee employment status is displayed in the chart and table below.



Employment Status	Full-Time Practice outside of CA	Administrative/Faculty Employment	Retired	No Response	Other Practice or Employment	Full-Time Clinical Practice in CA (32+ hrs)	Part-Time Clinical Practice in CA (less than 32 hrs)	Total
Total RDH	135	239	1,043	1,077	1,646	6,900	9,630	20,670
% of Total	1%	1%	5%	5%	8%	33%	47%	100%

Source of Data: Department of Consumer Affairs, Dental Hygiene Committee of California Public Master File, June 2013.

For purposes of this Fact Sheet, currently licensed RDHs are defined as "renewed and current".

*Employment Development Department's Labor Market Information Division, Statewide 2010-2020 Occupational Employment Projections, July 2012. 11/18/13

Fact Sheet



MEMORANDUM

DATE	February 19, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	ATC 5: Presentation by Conrado Barzaga, MD, Executive Director of the Center for Oral Health Regarding Access to Care – Discussion to Follow

Dr. Conrado Barzaga, MD, Executive Director of the Center for Oral Health Regarding Access to Care will provide a presentation.

**LICENSING,
CERTIFICATION, AND
PERMITS COMMITTEE**



NOTICE OF LICENSING, CERTIFICATION, AND PERMITS COMMITTEE MEETING

Thursday, February 27, 2014

Upon Conclusion of the Access to Care Committee meeting

Wyndham Bayside San Diego
1355 North Harbor Drive, San Diego, CA, 92101
(619) 232-3861 or (916) 263-2300

MEMBERS OF THE LICENSING, CERTIFICATION, AND PERMITS COMMITTEE

Chair – Bruce Whitcher, DDS
Vice Chair – Yvette Chappell-Ingram, Public Member
Steven Afriat, Public Member
Luis Dominicus, DDS
Judith Forsythe, RDA

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

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

1. Call To Order/Roll Call/Establishment Of Quorum
2. Approval of the February 28, 2013 Licensing, Certification, and Permits Committee Meeting Minutes
3. Define the 2014 Mission of the Licensing, Certification, and Permits Committee
4. Dental and Dental Assisting Program Licensure and Permit Statistics
5. General Anesthesia/Conscious Sedation Permit Evaluation Statistics
6. Discussion and Possible Action Regarding the Board's General Anesthesia and Conscious Sedation Evaluation Program
7. Update on General Anesthesia/Conscious Sedation Calibration Course Webinar Dates

8. Discussion and Possible Action Regarding Future Proposal to Amend Business and Professions Code §§1646 to 1647.26 Relating to General Anesthesia, Conscious Sedation, and Oral Conscious Sedation
9. Public Comment of Items Not on the Agenda
The Committee may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
10. Future Agenda Items
Stakeholders are encouraged to propose items for possible consideration by the Committee at a future meeting.
11. Committee Member Comments for Items Not on the Agenda
The Committee may not discuss or take action on any matter raised during the Committee Member Comments section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 and 11125.7(a)).
12. Adjournment



**LICENSING, CERTIFICATION, AND PERMITS COMMITTEE
MEETING MINUTES**

Thursday, February 28, 2013

Holiday Inn on the Bay
1355 North Harbor Drive, San Diego, CA, 92101

DRAFT

Members Present

Suzanne McCormick, DDS, Chair
Steve Afriat, Public Member
Judith Forsythe, RDA
Bruce Whitcher, DDS

Members Absent

Staff Present

Karen Fischer, Interim Executive Officer
Kim Trefry, Enforcement Chief
April Alameda, Investigative Analysis Unit and Dental Assisting Unit Manager
Lori Reis, Complaint and Compliance Unit Manager
Jocelyn Campos, Enforcement Coordinator
Linda Byers, Executive Assistant
Spencer Walker, Senior Legal Counsel
Greg Salute, Deputy Attorney General

Dr. McCormick, Chair, called the Licensing, Certification and Permits Committee meeting to order at 1:32 p.m. Roll was called and a quorum established.

LCP 1 – Approval of the December 3, 2012 Licensing, Certification, and Permits Committee Meeting Minutes

M/S/C (Afriat/Forsythe) to approve the December 3, 2012, Licensing, Certification, and Permits Committee meeting minutes. The motion was unanimously approved.

LCP 2 – Dental and Dental Assisting Program Licensure and Permit Statistics

Dr. McCormick reviewed the statistics provided, including the breakdown of licensees by county.

LCP 3 – General Anesthesia/Conscious Sedation Permit Evaluation Statistics

Dr. Whitcher reviewed the statistics provided. He stated that there is still a great need for conscious sedation evaluators throughout California. The Board is actively recruiting for the evaluation program.

LCP 4 – Update on General Anesthesia/Conscious Sedation Calibration Course Dates

Dr. Whitcher reported that currently the Dental Board does not have an Evaluator Calibration Training Course scheduled for 2013. He suggested that a subcommittee be appointed to see what can be done to keep the program going and possibly modernize it. Dr. Whitcher investigated the possibility of conducting the training through webinars. He found that training through the webinar would be feasible but not as a stand-alone course, only as a supplement.

There was no public comment.

The Licensing, Certification, and Permits Committee meeting adjourned at 1:41 p.m.



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant
SUBJECT	LCP 3: Define the 2014 Mission of the Licensing, Certifications, and Permits Committee

This item is designed as an open forum to define any issues the Committee may want to explore during the year.

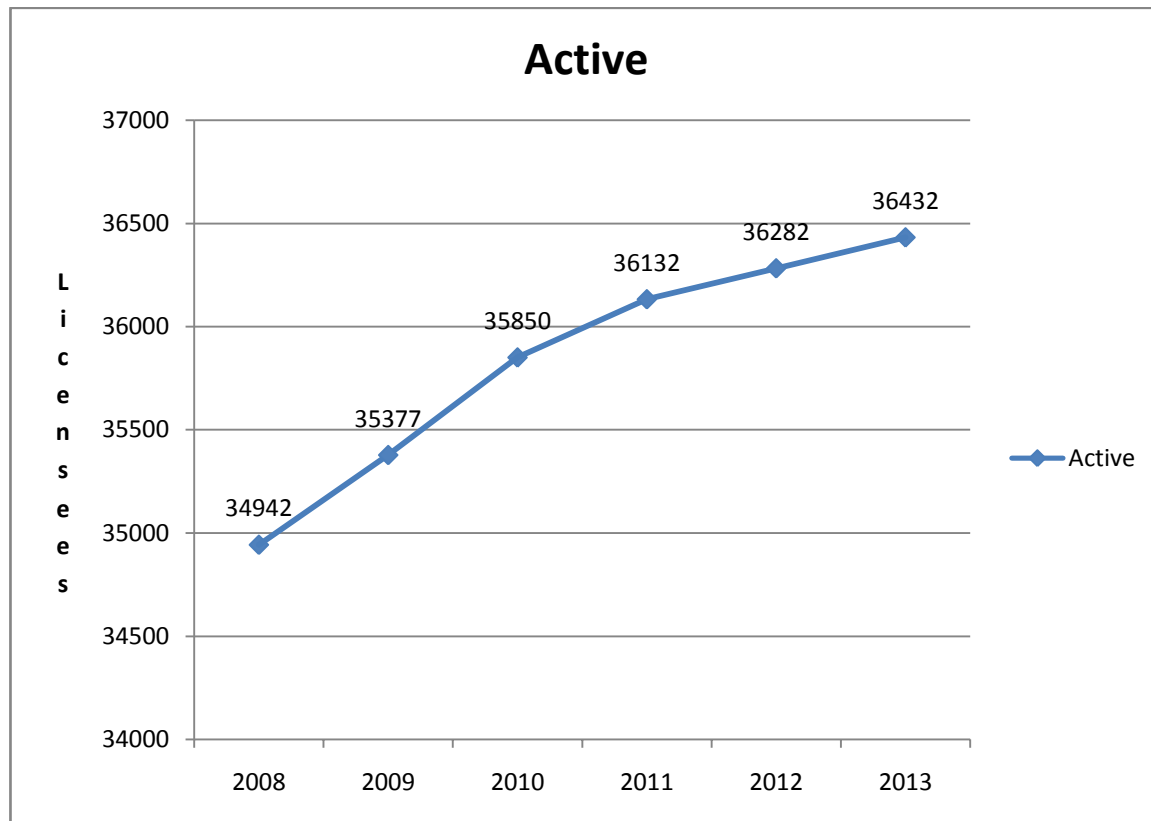


MEMORANDUM

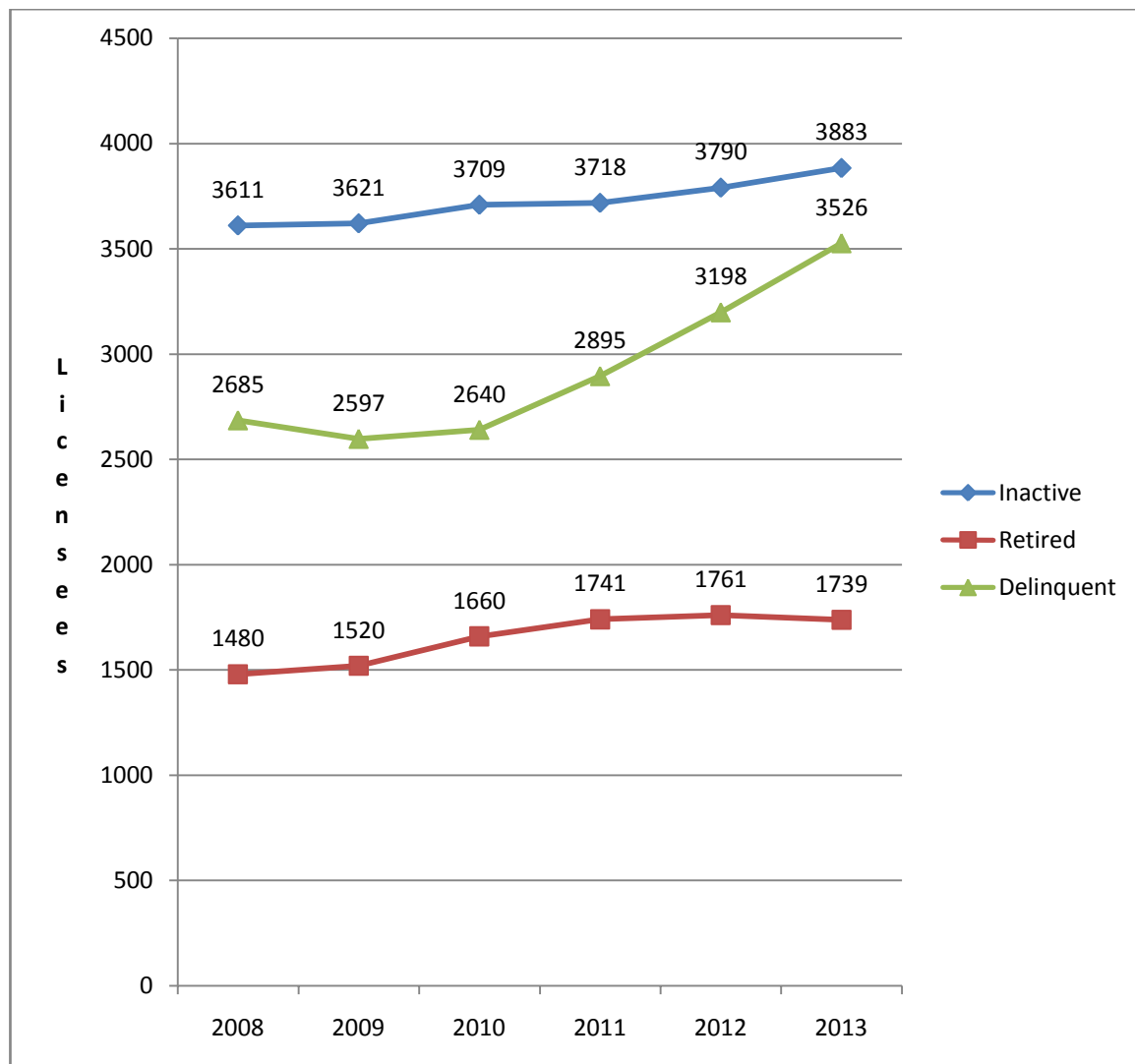
DATE	February 14, 2014
TO	Dental Board Members
FROM	Dawn Dill, Manager, Licensing and Examination Unit Dental Board of California
SUBJECT	Agenda Item LCP 4: Dental and Dental Assisting Program Licensure and Permit Statistics

Background

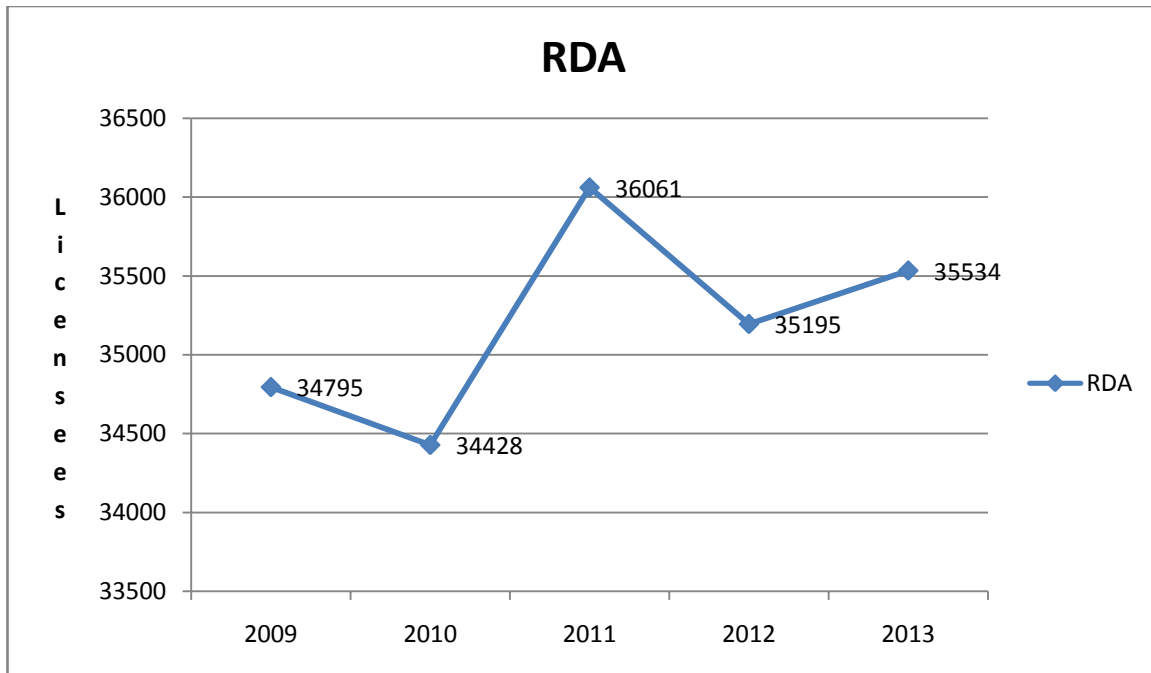
At the November 2013 Board Meeting there was a request for statistics showing trends. Below is a graph showing the number of active dental licensees from 2008 to 2013. Over the last 6 years the number of active licensees has decreased from a growth rate of 2% annually to approximately .5% in 2013.



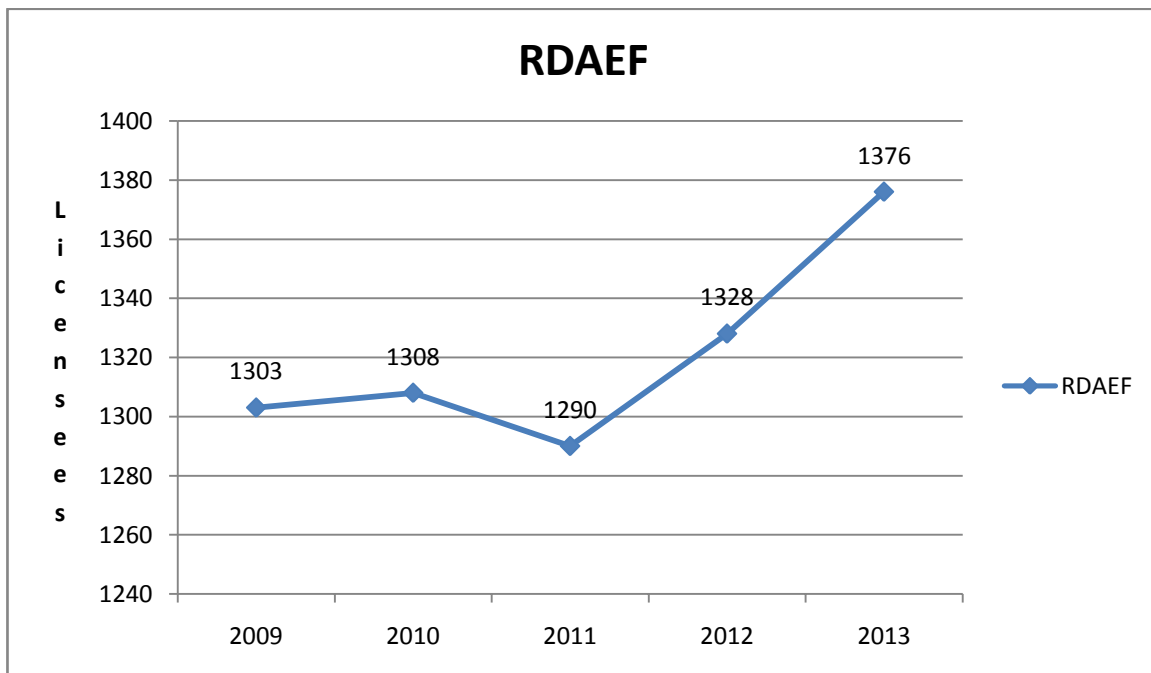
The graph below displays the number of inactive, retired or delinquent licensees. The number of current inactive licensees has increased from .3% in 2008 to 2.5% in 2013. The number of current retired licensees has fluctuated from 3% in 2008 to 9% in 2010 and decreased to less than 2% in 2013. The number of delinquent licensees decreased from 2008 to 2009. In 2009 a letter was sent to all delinquent licensees notifying them that their license would be cancelled five years from the expiration date if the fees were not paid. Approximately 5% of the licensees paid the renewal fees. Since 2010 the number of delinquent licensees has steadily increased.



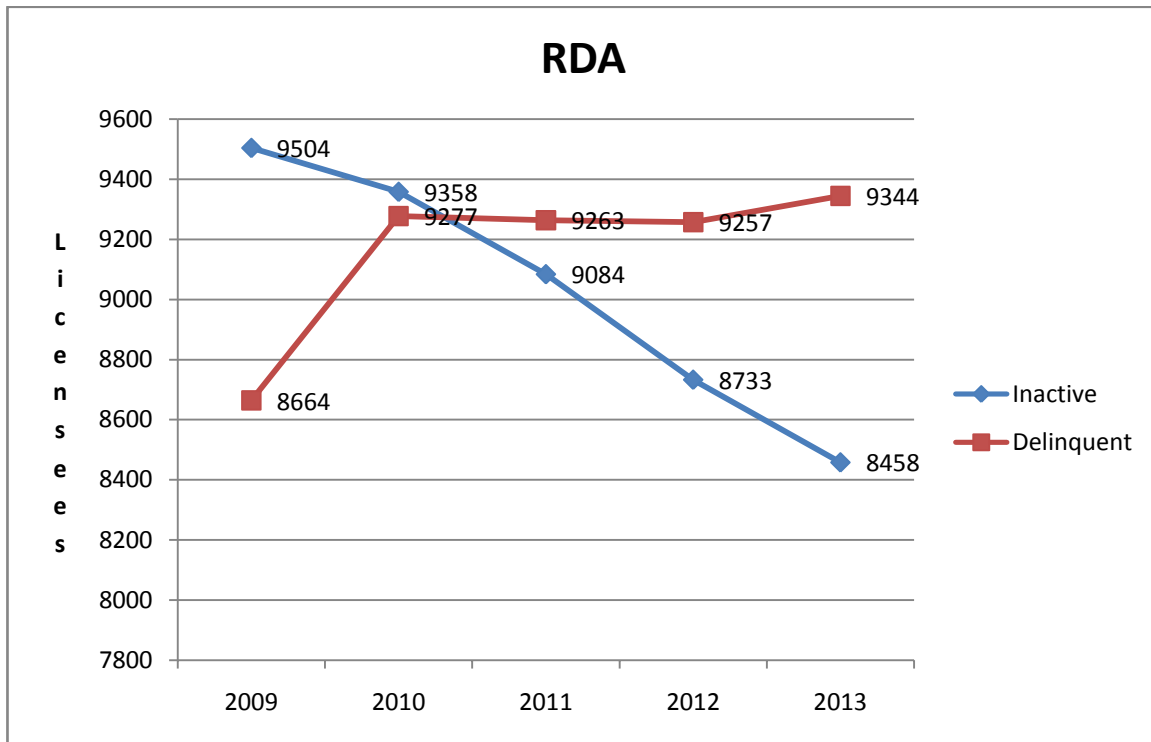
The graph below displays the number of active RDA licenses from 2009 to 2013. There was a 1% decrease in the number of licensees in 2010. In 2011 there was an increase of 5% in the number of active licensees. In 2012 the number of active licensees decreased 2.5% and increased 1% in 2013.



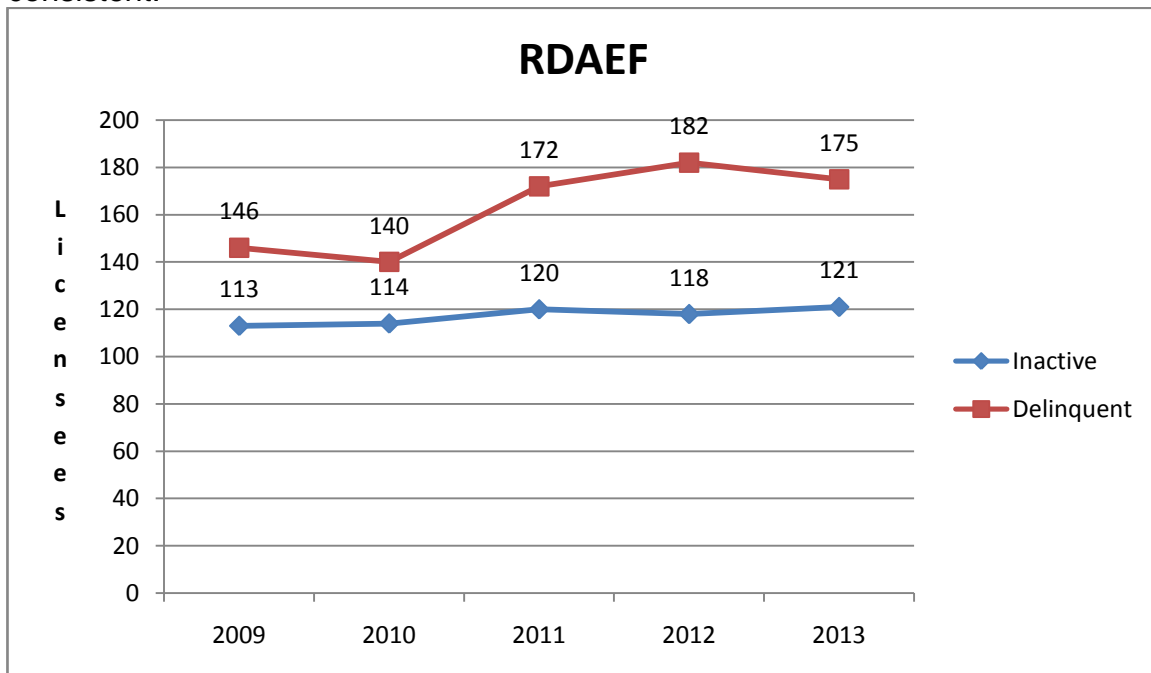
Below is a graph showing the number of active RDAEF licenses from 2009 to 2013. There has been an increase of 5% in the number of active licensees since 2009. This may be attributed to the enhancement of the allowable duties that went into effect on January 1, 2010.



The graph below displays the number of inactive and delinquent licensees from 2009 to 2013. There was an increase of 7% for delinquent licenses between 2009 and 2010. In 2010 the number of inactive and delinquent licensees was very similar. Since 2010 the number of inactive licensees has decreased 10%, while the number of delinquent licensees as remained fairly consistent.



Below is a graph displaying the number of delinquent and inactive RDAEF licensees from 2009 to 2013. There was an increase of 19% in the number of delinquent licenses between 2010 and 2011. The number of inactive licensees has remained fairly consistent.



Dental Licenses Issued via Pathway	Issued in 2014	Issued in 2013	Issued in 2012	Issued to Date	Date Pathway Implemented
California Exam	0	0	0	53,977	Prior to 1929
WREB Exam	30	767	697	5,289	January 1, 2006
Licensure by Residency	5	175	163	957	January 1, 2007
Licensure by Credential	9	141	148	2,498	July 1, 2002
LBC Clinic Contract	0	3	1	25	July 1, 2002
LBC Faculty Contract	0	0	0	3	July 1, 2002

License/Permit /Certification/Registration Type	Current Active Permits	Delinquent	Total Cancelled Since Implemented
Additional Office Permit	2,228	402	5,416
Conscious Sedation Permit	508	23	338
Continuing Education Registered Provider Permit	1,353	728	1,179
Elective Facial Cosmetic Surgery Permit	26	0	0
Fictitious Name Permit	5,793	1,094	3,913
General Anesthesia Permit	832	31	776
Mobile Dental Clinic Permit	25	13	29
Medical General Anesthesia Permit	74	32	132
Oral Conscious Sedation Certification (Adult Only 1,103; Adult & Minors 1,275)	2,378	561	141
Oral & Maxillofacial Surgery Permit	85	6	12
Special Permits	31	14	154
Dental Sedation Assistant Permit	23	0	0
Orthodontic Assistant Permit	118	2	0

Active Licensees by County as of February 2, 2014

County	DDS	RDA	RDAEF	Population
Alameda	1,455	1,378	48	1,554,720
Alpine	0	0	0	1,129
Amador	28	68	5	37,035
Butte	166	286	4	221,539
Calaveras	24	64	0	44,742
Colusa	3	22	2	21,411
Contra Costa	1,059	1,573	46	1,079,597
Del Norte	17	46	2	28,290
El Dorado	162	271	13	180,561
Fresno	560	793	17	947,895
Glenn	8	53	3	27,992
Humboldt	90	234	2	134,827
Imperial	40	79	2	176,948
Inyo	12	14	0	18,495
Kern	345	662	41	856,158
Kings	62	134	6	151,364

County	DDS	RDA	RDAEF	Population
Lake	26	80	13	63,983
Lassen	28	62	2	33,658
Los Angeles	8,473	5,377	230	9,962,789
Madera	52	146	2	152,218
Marin	343	238	10	256,069
Mariposa	6	15	1	17,905
Mendocino	61	101	8	87,428
Merced	88	191	14	262,305
Modoc	4	8	0	9,327
Mono	2	8	0	14,348
Monterey	301	420	21	426,762
Napa	117	159	3	139,045
Nevada	95	134	4	98,292
Orange	3,761	2,226	69	3,090,132
Placer	447	635	32	361,682
Plumas	17	22	1	19,399
Riverside	1,098	2,019	68	2,268,783
Sacramento	1,095	1,847	92	1,450,121
San Benito	27	99	6	56,884
San Bernardino	1,330	1,711	61	2,081,313
San Diego	2,699	2,956	91	3,177,063
San Francisco	1,233	500	17	825,863
San Joaquin	373	798	41	702,612
San Luis Obispo	240	302	3	274,804
San Mateo	867	847	27	739,311
Santa Barbara	345	352	6	431,249
Santa Clara	2,232	1,910	58	1,837,504
Santa Cruz	200	270	9	266,776
Shasta	132	303	8	178,586
Sierra	3	4	0	3,086
Siskiyou	30	41	1	44,154
Solano	297	672	33	420,757
Sonoma	418	815	35	491,829
Stanislaus	282	694	35	521,726
Sutter	59	132	12	95,022
Tehama	29	72	5	63,406
Trinity	4	7	0	13,526
Tulare	213	413	8	451,977
Tuolumne	57	91	0	54,008
Ventura	638	616	54	835,981
Yolo	117	243	8	204,118
Yuba	11	96	9	72,926

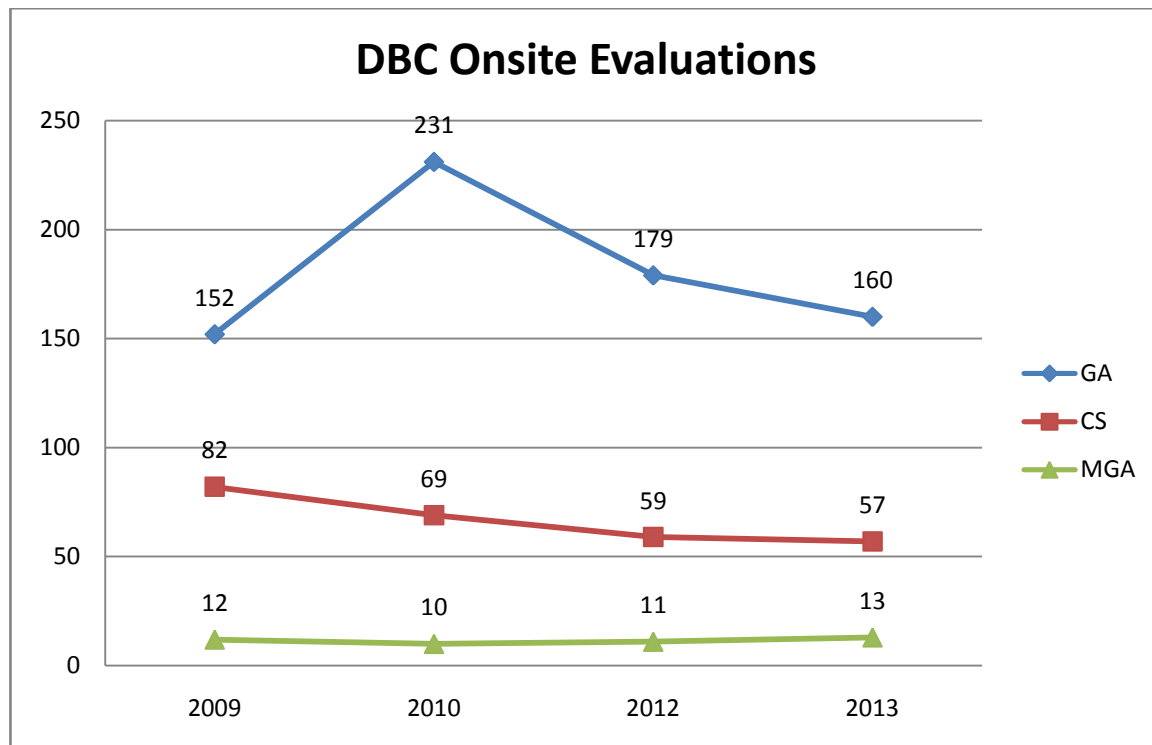
Population is from the US Censuses, estimates for 2012. All California 38,041,430.

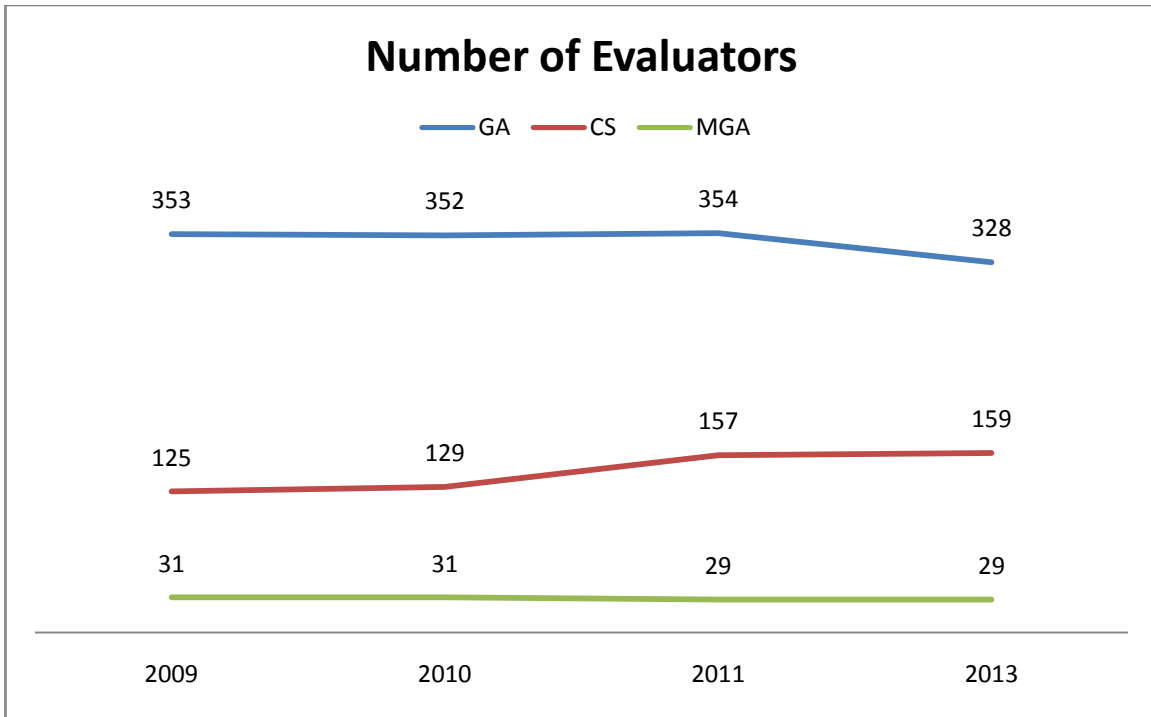


MEMORANDUM

DATE	February 14, 2014
TO	Dental Board Members
FROM	Bruce Whitcher, Board Member Dental Board of California
SUBJECT	LCP 5: General Anesthesia/Conscious Sedation Permit Evaluation Statistics

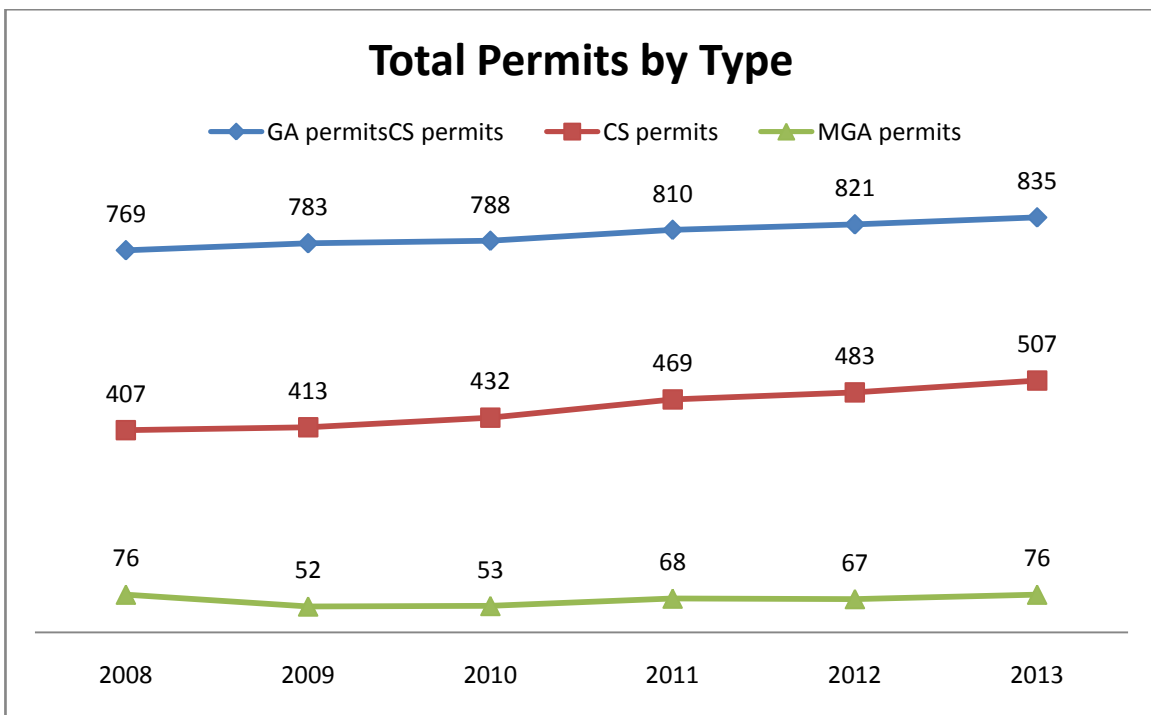
Dr. Whitcher will provide a verbal explanation of the information provided.





Number of evaluations needed to stay current

GA	CS	MGA
165	80	11



Note: GA evaluations are done every 5 years; CS evaluations are done every 6 years. A small number of evaluators do most of the evaluations. There are regional differences with more evaluators in every category in Southern CA than in the North, about 25% more reflecting the larger population in Southern CA.



MEMORANDUM

DATE	February 14, 2014
TO	Dental Board Members
FROM	Bruce Whitcher, Board Member Dental Board of California
SUBJECT	LCP 6: Discussion and Possible Action Regarding the Board's General Anesthesia and Conscious Sedation Evaluation Program

Background

The Dental Board is responsible for the issuance and maintenance of general anesthesia, conscious sedation, and pediatric and adult oral conscious sedation permits. Permits are issued to qualified applicants who have completed specified educational requirements and are subject to renewal every two years.

The first bill regulating the use of general anesthesia by dentists was enacted in 1979 followed by laws regulating conscious sedation in 1986, oral conscious sedation for minors in 1998 and for adult patients only in 2006. These laws and regulations have been periodically updated, most recently in 2006.

Maintenance of general anesthesia and parenteral conscious sedation permits requires completion of an onsite office inspection and evaluation every 5 years for general anesthesia permit holders and six years for conscious sedation permit holders. The process includes an inspection of the facility, emergency drugs and equipment, demonstration of ability to manage 13 simulated emergencies, and observation of a clinical case utilizing either general anesthesia or conscious sedation. No inspection or evaluation is required for an oral conscious sedation permit, but permit holders are required to maintain specified facilities and equipment, and must be capable of managing sedation related emergencies.

Anesthesia and sedation administered in physician practices is also tightly regulated. California law prohibits physicians from performing surgical procedures that require anesthesia to be administered in doses that have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes unless the surgery is performed in an accredited, licensed, or certified setting. A physician anesthesiologist is required to obtain a general anesthesia permit from the Dental Board prior to administering anesthesia in a dental office and must undergo an onsite inspection and evaluation every 6 years.

Evaluators who perform the onsite inspection must have held a permit for at least 3 years, be experienced in the techniques utilized, and have completed a calibration course. Evaluators serve as subject matter experts employed by the board, are reimbursed for travel and provided with a per diem.

Scheduling the onsite inspection and evaluation is a complex process. An evaluation requires the permit holder to provide board staff with 3 dates at least 2-3 months in advance. Staff must then find two site evaluators who are available on the assigned dates. The permit holder must identify a patient willing to schedule treatment on that date. Scheduling can take as many as 10-15 contacts with evaluators.

Between 2010 and 2013 the Board began to experience a shortage of evaluators. The now Board tracks evaluations postponed due to rescheduling or unavailability of an evaluator and this has increased. Calibration courses have been held every year from 2007 until 2012 in an effort to recruit evaluators but the response has been limited with the addition of only 1 or two per year. Outreach efforts to the professional community have yielded a limited response.

Challenges

The emerging trends affecting the Onsite Inspection and Evaluation Program include:

- Increasing numbers of permit holders
- A declining number of evaluators due to retirement and other causes

Possible Options

1. Limit the issuance of new anesthesia and sedation permits

The Board has the discretion to issue sedation and anesthesia permits following an inspection and evaluation, but doing so would place a substantial burden on licensees entering the workforce and would limit the availability of sedation services to patients.

2. Utilize an outside contractor to schedule the evaluations

An executive decision in 2009 brought the scheduling of the evaluations back in house. CALAOMS scheduled the evaluations from 2003 to 2009 with results comparable to those achieved by the DBC. Research would need to be done to determine if contracting out would be a viable option. The costs of contracting out the scheduling are unknown at this time.

3. Reduce the number of evaluators from two to one

Current regulations require two evaluators. This greatly increases the difficulty of scheduling the evaluations. Office accreditation site visits utilize a single evaluator. Utilizing one evaluator would require a regulatory amendment that could take up to two years to complete.

4. Increase the time interval between evaluations

The time between evaluations was reduced from 6 years to 5 years for GA permit holders in 2006 to comply with national standards. Changing this interval would require a regulatory amendment.

5. Change the evaluation to a simulator based examination given at specified locations.

The American Dental Association sponsored development of an airway course designed to serve as an evaluation tool. This approach would require development of an examination and training of highly skilled evaluators as well as a regulatory change to implement the program

6. Continue the program without change

In the near term, continue recruiting evaluators and scheduling evaluations using both established and innovative methods.



MEMORANDUM

DATE	February 27, 2014
TO	Dental Board Members
FROM	Jessica Olney, Associate Governmental Program Analyst
SUBJECT	Agenda Item LCP 7: Update on General Anesthesia/Conscious Sedation Calibration Webinar

Dr. Witcher is currently in the development process of the webinar for General Anesthesia/Conscious Sedation Calibration Course. Staff plans to begin testing the webinar in the spring of 2014. Although staff intended to host a webinar in 2013 due to operational needs of the Board the webinar was postponed until further notice.



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 8(A): Discussion and Possible Action Regarding Comments Received During the 45-Day Public Comment Period for the Board's Proposed Rulemaking to Amend §§ 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036, Add §§ 1032.7, 1032.8, 1032.9, 1032.10, and Repeal §§ 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements

Background:

At its August 2013 meeting, the Dental Board of California (Board) approved proposed regulatory language relative to the Portfolio Examination Requirements and directed staff to initiate the rulemaking. Board staff filed the initial rulemaking documents with the Office of Administrative Law (OAL) on Tuesday, October 29th and the proposal was published in the California Regulatory Notice Register on Friday, November 8, 2013. The 45-day public comment period began on Friday, November 8, 2013 and ended on Monday, December 23, 2013. The Board held a regulatory hearing in Sacramento on Monday, January 6, 2014.

The Board received written comments from: (1) Bruce Sims; (2) the California Dental Association (CDA); (3) Steven W. Friedrichsen, DDS, Professor and Dean, College of Dental Medicine, Western University of Health Sciences; and (4) Avishai Sadan, DMD, Dean, Ostrow School of Dentistry, University of Southern California. Additionally, the Board received verbal testimony from Sharon Golightly, representing the California Dental Hygiene Association (CDHA), at the regulatory hearing.

Pursuant to Government Code Section 11346.9(a)(3), adopted regulations submitted to OAL are required have a final statement of reasons which includes a summary of each objection or recommendation made regarding the specific adoption, amendment, or repeal process, together with an explanation of how the proposed action has been changed to accommodate each objection or recommendation, or the reasons for making no change. This requirement applies to objections or recommendations specifically directed at the agency's proposed action or to the procedures followed by the agency in proposing or adopting the action. For the purposes of Government Code

Section 11346.9(a)(3), a comment is "irrelevant" if it is not specifically directed at the agency's proposed action or to the procedures followed by the agency in proposing or adopting the action.

Staff has reviewed the comments received and has developed recommended responses in consultation with the Board's Portfolio Examination subcommittee and Board Legal Counsel. The Board may take action to accept, reject, or modify staff's recommended response to comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale to demonstrate necessity for inclusion in the rulemaking's final statement of reasons.

Staff has drafted modified text (attached) for the Board's consideration. The proposed amendments to the text coincide with the staff recommended responses to the comments. Recommended changes to the originally proposed text are indicated with double-strikeout for deletions (e.g. ~~portfolio examination~~) and double-underline for additions (e.g. portfolio examination).

If the Board accepts the staff recommendations, and votes to modify the text, staff is prepared to notice the text for a 15-day public comment period on March 3, 2014. The modified text would be posted on the Board's web site and mailed to those parties who commented on the initial proposed text. The public comment period would begin on March 4th and would end on March 18th.

In the event the Board receives adverse comments in response to the modified text, staff recommends the Board hold a special teleconference meeting to respond to the comments to expedite the adoption of these regulations. If no adverse comments are received after the 15-day public comment period, there will be no need for the Board to hold a special teleconference meeting, since the Board would have already adopted the modified text as the final text at the February Board meeting. Board staff would then prepare the final rulemaking documents and submit the package for the necessary approvals from the Director of the Department of Consumer Affairs, the Secretary of the Business, Consumer Services, and Housing Agency, and the Director of the Department of Finance. Once those approvals are obtained, the final rulemaking file will be submitted to the OAL. The OAL has thirty (30) working-days to issue its determination of approval of a regulatory file. If approved, the OAL will file with the Secretary of State. Beginning January 1, 2013, new quarterly effective dates for regulations will be dependent upon the timeframe an OAL approved rulemaking is filed with the Secretary of State, as follows:

- The regulation would take effect on January 1 if the OAL approved rulemaking is filed with the Secretary of State on September 1 to November 30, inclusive.
- The regulation would take effect on April 1 if the OAL approved rulemaking is filed with the Secretary of State on December 1 to February 29, inclusive.
- The regulation would take effect on July 1 if the OAL approved rulemaking is filed with the Secretary of State on March 1 to May 31, inclusive.
- The regulation would take effect on October 1 if the OAL approved regulation is filed on June 1 to August 31, inclusive.

At this time, staff anticipates the portfolio examination requirements will become effective on October 1, 2014.

Comments Received from Bruce Sims:

Summary of Comments:

Mr. Bruce Sims submitted an email commenting that the phrase “established standards of care” was used in the proposal, and yet consumers cannot find out what such standards are. Mr. Sims commented that he had an experience where a dentist’s business manager falsely claimed that a procedure was required by such ‘standards of care’, and that if there is a document specifying such ‘standards of care’ for the common dental practices associated with cleaning, repair, and restoration, that document should be available for consumers to reference.

Mr. Sims also commented on the Board’s regulatory action titled “Consumer Protection Enforcement Initiative” from 2011. Mr. Sims commented that he saw nothing in the rules and regulations that hold a dentist accountable for the behavior of employees though such accountability exists in law. He commented that dentists must be made aware of their responsibilities in regards to their employee’s behavior and that the Board would seem to have that responsibility.

Staff Recommended Response:

Staff recommends rejection of Mr. Sims comments. Legally, the established standards of care in dentistry are indefinable and cannot be found in textbooks. The *Journal of the American Dental Association* featured an article from Joseph P. Graskemper, DDS, JD, in October 2004 that touched on the standard of care in dentistry and how it has evolved. Dr. Graskemper explained that “the standard of care actually is found in the definition of negligence, which is said to have four elements, all of which must be met to allow negligence to be found in a malpractice lawsuit. Those four elements are as follows: that a duty of care was owed by the dentist to the patient; that the dentist violated the applicable standard of care; that the plaintiff suffered a compensable injury; and, that such injury was caused in fact and proximately caused by substandard conduct.” Dr. Graskemper cites that a definition of the standard of care was best stated in *Blair v. Eblen* (461 S.W. 2d370, 370 (Ky 1970)): “[A dentist is] under a duty to use that degree of care and skill which is expected of a reasonably competent [dentist] acting in the same or similar circumstances.” Because the standard of care evolves due to court rulings, advances in dental research, continuing education, and the progression of the practice of dentistry, there is no possible way for the Board to define it as it relates to this proposal.

Mr. Sims second comment regarding the regulatory action titled “Consumer Protection Enforcement Initiative” is not relevant to this regulatory proposal, as this was a previous Board rulemaking that became effective in March 2012.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

Comments Received from the California Dental Association:

The California Dental Association (CDA) submitted a letter to the Board in response to the Board's rulemaking proposal. The CDA commented that it appreciates the opportunity to provide comment on the proposed regulatory package to implement portfolio licensure in California and has been proud to work with the Board these last few years on what is being looked to across the nation as a milestone in the history of dental licensure examination.

The CDA commented that it has participated in many stakeholder meetings and discussions regarding the details of the portfolio process, and has appreciated the openness of the Dental Board and the six California dental schools to their thoughts and perspectives as these regulations and the accompanying manuals have been developed. The letter stated that the level of consensus that has been reached between all parties is remarkable given the complexity and unprecedented nature of the task. Because of that effort, the CDA had few broad policy concerns; however, the CDA addresses a few areas where the CDA feels additional clarification may be appropriate.

CDA Comment #1 - Section 1028(b)(6):

The CDA questioned if Section 1028 (b)(6) should say something like "proof that the applicant has passed the California Law and Ethics written examination," rather than simply "information as to whether the applicant has taken" the exam.

Staff Recommended Response:

Staff recommends rejection of this comment. It is not necessary for the Board to obtain proof that an applicant has passed the California Law and Ethics written examination as the Board receives the examination results directly from the vendor. Rather, it is important for staff to have information as to whether an applicant has taken the examination so that staff may determine if there is an existing applicant file or not because applicants may take the Law and Ethics exam well in advance of submitting a portfolio examination application. If there is not an existing file, staff would know to issue eligibility to an applicant and establish a file.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #2 - Section 1028(e):

The CDA commented that subsections (e)(1), (2), and (3) all use the word "examinee" to refer to the final submittal of the portfolio to the Board. It would seem to be more accurate to consistently use the word "applicant" here, since once they are submitting their completed portfolios to the Board they are no longer being "examined;" the Board's role is simply to verify completion of the portfolio requirements.

Staff Recommended Response:

Staff recommends rejection of the term "applicant"; however, staff does recommend modifying the text to replace "examinee" with "candidate". The term "candidate" is synonymous with the terms "applicant" and "examinee" as a student participating in the portfolio examination pathway to licensure is always

considered a “candidate” for licensure throughout the examination and application processes. Additionally, staff recommends adding a definition to clarify the meaning of “candidate”.

Staff does not agree that the Board’s role would be to simply verify completion of the portfolio requirements. Rather, the Board is charged with the responsibility of administering the portfolio examination, via cooperation with California dental schools, and is responsible for making the ultimate decision as to whether a candidate was assessed properly via the examination and has fulfilled the requirements for licensure.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #3 - Section 1028(e):

The CDA commented that the regulations are somewhat unclear about the respective timing and review process for the portfolio itself and the application for licensure. In discussions with board staff, CDA believed the intent is that the portfolio would be submitted and reviewed first, and once the portfolio was determined to be complete, the applicant would be notified and could then submit the licensure application. To make that process clearer in the regulations, CDA suggested the following amendments, commencing after the first paragraph of subsection (e):

(e) Prior to submitting the “Application for Determination of Licensure Eligibility (Portfolio)”, the Board shall have completed its review of the applicant’s submitted portfolio and notified the applicant that he/she has met the requirements for Licensure by Portfolio Examination and is eligible to submit the application.

- (1) The earliest date upon which an ~~examinee~~ applicant may submit their portfolio for review by the board shall be within 90 days of anticipated graduation. The latest date upon which an ~~examinee~~ applicant may submit their portfolio for review by the board shall be no more than 90 days after graduation.
- (2) The ~~examinee~~ applicant shall arrange with the dean of his or her dental school for the school to submit the completed portfolio materials to the Board.
- ~~(3) The Board shall review the submitted portfolio materials to determine if it is complete and the examinee has met the requirements for Licensure by Portfolio Examination.~~

Staff Recommended Response:

Staff recommends rejection of this comment. The Board would be notified of a candidate’s readiness to have their portfolio examination reviewed once the Board receives the “Application for Determination of Licensure Eligibility (Portfolio)” Form 33A-22P (New 08/2013). The dental school is still responsible for submitting the candidate’s completed portfolio materials to the Board. Once the Board reviews the “Application for Determination of Licensure Eligibility

(Portfolio)” Form 33A-22P (New 08/2013) and determines that the candidate is eligible for licensure, the Board will subsequently send the candidate the “Application for Issuance of License Number and Registration of Place of Practice,” (Rev. 11-07). The candidate would submit this form with the applicable initial licensure fee to the Board to be issued a license number. Staff does not believe it’s necessary to add the term “anticipated” as it relates to graduation as it does not provide an added benefit or add substance to the proposed language.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #4 - Section 1032:

The CDA commented that the last sentence of this section states: “The student shall have the approval of his or her clinical faculty prior to beginning the portfolio examination process.” The word “approval” implies that a dental school would have the authority to deny a student’s request to participate in the portfolio process, thereby forcing him or her to take the WREB exam instead, which does not seem appropriate as a matter of policy. All methods of licensure examination in California are expected to be equivalent and equally available to applicants who meet the necessary requirements. The CDA suggested the following amendment:

“The student shall notify ~~have the approval of~~ his or her clinical faculty prior to beginning the portfolio examination process.”

Staff Recommended Response:

Staff recommends rejection of this comment. The requirement for a student to seek approval prior to beginning the portfolio examination process was intended to ensure that a candidate was ready to begin clinical experiences on patients, thus ensuring patient safety. The Board understands that clinical experiences in dental schools typically begin at the end of the second year; however, seeking prior clinical faculty approval will allow for adequate patient protection in the event there is future reshuffling of curriculum sequencing and clinical experiences happen earlier. However, staff recommends modifying the text to delete this provision from section 1032 and specify this requirement for each individual competency examination for the sake of clarity.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #4 - Section 1032.1

In reviewing the draft regulations in their entirety, the CDA found a number of instances in which the distinction between clinical experiences and competency examinations is not clear and could be confused. Throughout the draft there are references to “completion” or “successful completion” of clinical experiences, which implies that the procedures are completed entirely by the student. Clarifying the definitions here,

including providing a definition of “competency examination,” may help prevent confusion later on. Based on prior discussions, it seems to CDA that the clearest distinction is that clinical experiences can include faculty intervention, while competency examinations cannot. CDA suggested adding the following definition of “competency examination,” along with amendments to the definition of “clinical experiences:”

(b) “Clinical experiences” means the procedures, performed with or without faculty intervention, that the ~~examinee~~ applicant must complete to the satisfaction of his or her clinical faculty prior to submission of his or her portfolio examination application.

(c) “Competency examination” means an examinee’s final assessment in a portfolio examination competency, performed without faculty intervention and graded by competency examiners registered with the board.

The CDA also suggested that subsection (e) be deleted, since the term “independent performance” does not appear in the proposed regulations, and thus a definition is not needed.

Staff Recommended Response:

Staff recommends acceptance of this comment with the exception of replacing “applicant” with “candidate” for reasons previously specified.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #5 - Section 1032.2:

The CDA suggested several structural/grammatical amendments which they believe will clarify the level of information that needs to be provided to the Board in each applicant’s portfolio:

(a) Each ~~examinee~~ applicant shall complete at least the minimum number of clinical experiences in each of the competencies prior to submission of their portfolio to the Board. ~~Clinical experiences have been determined as a minimum number in order to provide an examinee with sufficient understanding, knowledge and skill level to reliably demonstrate competency. All clinical experiences shall be performed on patients under the supervision of school faculty and shall be included in the portfolio submitted to the Board. Clinical experiences shall be performed at the dental school clinic, or at an extramural dental facility or a mobile dental clinic approved by the Board. The portfolio shall contain documentation certification that the examinee has satisfactorily completed the minimum number of clinical experiences as follows:~~

(1) ~~The documentation of~~ oral diagnosis and treatment planning (ODTP) clinical experiences shall include a minimum of twenty (20) patient cases. Clinical experiences for ODTP include: comprehensive oral evaluations, limited (problem-focused) oral evaluations, and periodic

oral evaluation.

- (2) ~~The documentation of~~ direct restorative clinical experiences shall include a minimum of sixty (60) restorations. The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including: amalgams, composites, crown build-ups, direct pulp caps, and temporizations.
- (3) ~~The documentation of~~ indirect restorative clinical experiences shall include a minimum of fourteen (14) restorations. The restorations completed in the clinical experiences may be a combination of the following procedures: inlays, onlays, crowns, abutments, pontics, veneers, cast posts, overdenture copings, or dental implant restorations.
- (4) ~~The documentation of~~ removable prosthodontic clinical experiences shall include a minimum of five (5) prostheses. One of the five prostheses may be used as a portfolio competency provided that it is completed in an independent manner with no faculty intervention. A ~~prosthesis is defined to~~ may include any of the following: full denture, partial denture (cast framework), partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth), immediate treatment denture, or overdenture retained by a natural or dental implants.
- (5) ~~The documentation of~~ endodontic clinical experiences on patients shall include five (5) canals or any combination of canals in three separate teeth.
- (6) ~~The documentation of~~ periodontal clinical experiences shall include a minimum of twenty-five (25) cases. A periodontal experience shall include the following: An adult prophylaxis, treatment of periodontal disease such as scaling and root planing, any periodontal surgical procedure, and assisting on a periodontal surgical procedure when performed by a faculty or an advanced education candidate in periodontics. The combined clinical periodontal experience shall include a minimum of five (5) quadrants of scaling and root planing procedures.

- (b) ~~Evidence of successful~~ ~~Completion of all required~~ clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion: Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be ~~maintained~~ included in the examinee's portfolio submitted to the Board.

Staff Recommended Response:

Staff recommends acceptance of these comments with the following exceptions:

- Replace the term "applicant" with "candidate";
- Include the following in the definition for "clinical experiences" in Section 1032.1: "Clinical experiences have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge, and skill level to reliably demonstrate competency." Staff believes that this information will add clarity to the definition.
- Reject the modification to delete the requirement for clinical experiences to be included in the portfolio submitted to the Board. The schools are

responsible for maintaining the complete portfolio which includes the documentation of clinical experiences. The portfolio must include the documentation of clinical experiences in order for the Board to issue approval.

- Reject the modification that the portfolio would contain “certification” rather than “documentation” of the completed minimum number of clinical experiences for reasons previously specified.
- Reject the modification to the removable prosthodontic clinical experiences which define a prosthesis in a permissive manner with “may” rather than a definitive manner with “shall”. Staff recommends using “shall”.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #6 - Section 1032.3:

As a general comment that applies to the subsequent sections as well, since the specifics of the clinical experience requirements for all competencies are contained in the preceding section 1032.2, for the sake of clarity the CDA suggested deleting redundant references to clinical experiences in Section 1032.3 and making the section entirely about the competency examination. Thus, the CDA suggested changing the title to “Portfolio Competency Examination: Oral Diagnosis and Treatment Planning (ODTP),” and modifying (a) as follows:

~~(a) The portfolio shall contain the following documentation of the minimum ODTP clinical experiences and documentation of ODTP portfolio competency examination:~~

~~(1) Evidence of successful completion of the ODTP clinical experiences shall be certified by the director of the school’s clinical education program on the “Portfolio Examination Certification of Clinical Experience Completion” Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the examinees portfolio.~~

~~(2) Documentation providing proof of satisfactory completion of a final assessment in the ODTP competency examination. For purpose of this section, satisfactory proof means the ODTP competency examination has been approved by the designated dental school faculty~~

For the sake of further clarity, the CDA suggested switching the current subsections (b) and (c), so that “Acceptable Patient Criteria” comes before “Competency Examination Requirements.” This seems to make logical sense, since the patient must be chosen before the exam can be taken. The CDA offered a similar suggestion for the remaining competency examination sections.

Staff Recommended Response:

Staff recommends rejection of these comments. Section 1032.3 was not intended to address only the competency examination requirements; rather, it

was intended to explain all of the requirements of the candidate's portfolio in relation to the specified competency. A complete portfolio submitted to the Board must contain documentation of the relevant clinical experiences and the competency examinations for each required competency. Including the numerical requirements for clinical experiences in Section 1032.2 was intended to eliminate the potential duplication that the proposed language would have had if the clinical experience requirements had been distributed amongst each applicable competency section. Additionally, staff does not believe it is necessary or would provide further clarity by moving "Acceptable Patient Criteria" before "Competency Examination Requirements" as there does not seem to be any added benefit. Staff recommends clarifying the language in subdivision (a) to clarify that it is applicable to the portfolio examination in its entirety.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #7 - Section 1032.3:

The CDA commented that in reviewing the entirety of the current subdivision (b), it is not clear to the CDA how many different patients can be included in the ODTP competency examination. Subsection (b)(2) states that there shall be "one" multidisciplinary portfolio competency exam, but (b)(2) states that "the treatment plan shall involve at least three...disciplines...", and subsequent subsections make reference to "treatment provided to clinical patients." The CDA questioned if this section should more clearly spell out the number of patient treatment plans that can make up this competency examination.

Staff Recommended Response:

Staff recommends rejection of this comment. Staff believes that the language is clear that the oral diagnosis and treatment planning competency examination would be initiated and completed on one patient and requires a treatment plan involving at least three of the six competency disciplines. Staff does not believe modifications to the text are necessary as this was the agreed upon terminology developed by the focus groups from the dental schools involved in the development of the portfolio examination criteria.

However, staff does recommend some grammatical and technical amendments to clean up the language and correct the inadvertent pluralizing of "patient".

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #8 - Section 1032.4:

The CDA suggested that changes to the title and to subsection (a) be made here that are equivalent to those suggestions for Section 1032.3, and for the same reason.

Staff Recommended Response:

Staff recommends rejection of these comments. Section 1032.4 was not intended to address only the competency examination requirements; rather, it was intended to explain all of the requirements of the candidate's portfolio in relation to the specified competency. A complete portfolio submitted to the Board must contain documentation of the relevant clinical experiences and the competency examinations for each required competency. Including the numerical requirements for clinical experiences in Section 1032.2 was intended to eliminate the potential duplication that the proposed language would have had if the clinical experience requirements had been distributed amongst each applicable competency section. Additionally, staff does not believe it is necessary or would provide further clarity by moving "Acceptable Patient Criteria" before "Competency Examination Requirements" as there does not seem to be any added benefit.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #9 - Section 1032.4:

The CDA found some ambiguity here as to how many patients are to be included in the competency exam, and exactly which restorative procedures are required to be performed, and would defer to the developers of these criteria as to the intent. Specifically, subsection (b) states that the examinee shall document competency "to perform a Class II, Class III, and Class IV direct restoration..." (underline added for emphasis). However, the wording of (b)(2) appears to give the examinee the option to perform two Class II amalgam restorations, with a Class III/IV composite as an option for one of the restorations but not a requirement. This discrepancy may need to be clarified.

Staff Recommended Response:

Staff recommends acceptance of this comment. The examination should only include two restorations consisting of: (1) one Class II amalgam or composite, maximum one slot preparation; and, (2) one Class III or IV composite. Staff recommends modifying the text accordingly.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #10 - Section 1032.5:

The CDA makes the same comment and suggestions regarding the title and subsection (a) made for previous sections.

Staff Recommended Response:

Staff recommends rejection of these comments. Section 1032.5 was not intended to address only the competency examination requirements; rather, it

was intended to explain all of the requirements of the candidate's portfolio in relation to the specified competency. A complete portfolio submitted to the Board must contain documentation of the relevant clinical experiences and the competency examinations for each required competency. Including the numerical requirements for clinical experiences in Section 1032.2 was intended to eliminate the potential duplication that the proposed language would have had if the clinical experience requirements had been distributed amongst each applicable competency section. Additionally, staff does not believe it is necessary or would provide further clarity by moving "Acceptable Patient Criteria" before "Competency Examination Requirements" as there does not seem to be any added benefit.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #11 - Section 1032.6:

The CDA makes the same comment and suggestions regarding the title and subsection (a) made for previous sections.

Staff Recommended Response:

Staff recommends rejection of these comments. Section 1032.6 was not intended to address only the competency examination requirements; rather, it was intended to explain all of the requirements of the candidate's portfolio in relation to the specified competency. A complete portfolio submitted to the Board must contain documentation of the relevant clinical experiences and the competency examinations for each required competency. Including the numerical requirements for clinical experiences in Section 1032.2 was intended to eliminate the potential duplication that the proposed language would have had if the clinical experience requirements had been distributed amongst each applicable competency section. Additionally, staff does not believe it is necessary or would provide further clarity by moving "Acceptable Patient Criteria" before "Competency Examination Requirements" as there does not seem to be any added benefit.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #12 - Section 1032.6:

The CDA commented that for each prosthetic option, the examination standards include a reference to follow-up care [i.e. "(5)(H) Evidence the examinee provided the patient post insertion care including adjustment, relines and patient counseling"]. The CDA commented that such open-ended references to follow-up/post insertion care leave it unclear how it will be determined when this competency examination has been completed and a final score can be issued. The CDA questioned if it needs to be clarified in the regulations.

Staff Recommended Response:

Staff recommends acceptance of this comment and recommends adding “within the established standard of care” to the text.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #13 - Section 1032.7:

The CDA makes the same comment and suggestions regarding the title and subsection (a) made for previous sections.

Staff Recommended Response:

Staff recommends rejection of these comments. Section 1032.7 was not intended to address only the competency examination requirements; rather, it was intended to explain all of the requirements of the candidate’s portfolio in relation to the specified competency. A complete portfolio submitted to the Board must contain documentation of the relevant clinical experiences and the competency examinations for each required competency. Including the numerical requirements for clinical experiences in Section 1032.2 was intended to eliminate the potential duplication that the proposed language would have had if the clinical experience requirements had been distributed amongst each applicable competency section. Additionally, staff does not believe it is necessary or would provide further clarity by moving “Acceptable Patient Criteria” before “Competency Examination Requirements” as there does not seem to be any added benefit.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #14 - Section 1032.7:

The CDA commented that subsection (b)(2) states that the endodontic competency exam will consist of “one (1) clinical case.” However, the subsequent subsection (b)(3) uses the word “cases” twice. For the sake of clarity, the Board may wish to change those to “case.”

Staff Recommended Response:

Staff recommends acceptance of this comment.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

CDA Comment #15 - Section 1032.8:

The CDA makes the same comment and suggestions regarding the title and subsection (a) made for previous sections.

Staff Recommended Response:

Staff recommends rejection of these comments. Section 1032.8 was not intended to address only the competency examination requirements; rather, it was intended to explain all of the requirements of the candidate's portfolio in relation to the specified competency. A complete portfolio submitted to the Board must contain documentation of the relevant clinical experiences and the competency examinations for each required competency. Including the numerical requirements for clinical experiences in Section 1032.2 was intended to eliminate the potential duplication that the proposed language would have had if the clinical experience requirements had been distributed amongst each applicable competency section. Additionally, staff does not believe it is necessary or would provide further clarity by moving "Acceptable Patient Criteria" before "Competency Examination Requirements" as there does not seem to be any added benefit.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment # 16 - Section 1032.9:

The CDA commented that since this section is itself establishing the criteria for competency examiner qualifications, the suggested the following amendment to (a):

- (a) Portfolio competency examiners shall meet the following criteria established by the board:

Staff Recommended Response:

Staff recommends acceptance of this comment.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment # 17 - Section 1032.9:

The CDA commented that subsection (b) requires schools to submit to the Board the names and qualifications of the faculty members "to be approved or disapproved by the Board as portfolio competency examiners," and to certify that they meet the standards of the school and of these regulations. The CDA commented that the regulations provide no criteria by which the Board would "approve or disapprove" any individual examiner put forth by a school. The CDA questioned on what basis the Board could disapprove examiners if the dental school dean has certified the qualifications. The CDA also questioned if the Board's review of competency examiners should be left to the periodic auditing process.

Staff Recommended Response:

Staff recommends rejection of this comment. The portfolio examination is administered by the Board; and as such the Board maintains its authority to approve or disapprove portfolio competency examiners. Such approval by the Board would be based on the required documentation of qualifications provided to the Board as specified in subdivisions (a), (b), and (c). It is important for the Board to maintain its authority to approve or disapprove competency examiners at any time; if the Board only reviewed competency examiners during the periodic auditing process, the Board would risk losing its ability to disapprove competency examiners that are not grading appropriately, which could lead to the Board issuing licenses to candidates who may pose a risk to patient protection.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment # 18 - Section 1032.9:

The CDA commented that subsection (c) appears redundant and could be deleted; and, subsection (b) already requires the deans to certify that each examiner has met the requirements of (a)(3), which is the calibration requirement described again in (c).

Staff Recommended Response:

Staff recommends rejection of this comment. Staff does not believe the language exhibits redundancy. Subdivision (a) provides the qualifications for the competency examiners; subdivision (b) specifies that the schools must submit the names, credentials, and qualifications, and a certifying letter from the dean that the examiner satisfies the criteria and standards to conduct the competency examination for the faculty to be considered by the Boards; and, subdivision (c) provides that the dean must submit documentation that the appointed examiners have satisfied the Board's competency examiner training requirements.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #19 - Section 1032.10:

The CDA commented that they have a concern that subsection (d), as drafted, lacks clarity about the respective roles of the dental school and the Board in determining whether an examiner should be disqualified due to problems in calibration. Because the Board is not envisioned to be involved in the day-to-day operations of this process, the CDA believes their responsibility for making these determinations should lie in the periodic auditing process, and that the schools should maintain the ongoing responsibility to dismiss examiners. The CDA suggested the following clarifying amendments:

(c) Calibration of Examiners. The calibration of portfolio competency examiners shall be conducted to maintain common standards as an ongoing process. Portfolio competency examiners shall be provided feedback about their performance and how their scoring varies from their fellow examiners. Portfolio competency examiners whose error rate exceeds psychometrically accepted standards for reliability shall be re-calibrated. If at any time a school determines that a portfolio competency examiner is unable to be meet the board's re-calibrated standards, the school shall disapprove remove the portfolio competency examiner from further participation in the portfolio examination process. In addition, the Board may through its auditing process require a school to remove an examiner based on findings that the examiner does not meet the Board's calibration standards.

Staff Recommended Response:

Staff recommends rejection of this comment. The portfolio examination is administered by the Board; and as such the Board maintains its authority to approve or disapprove portfolio competency examiners. It is important for the Board to maintain its authority to approve or disapprove competency examiners at any time; if the Board only reviewed competency examiners during the periodic auditing process, the Board would risk losing its ability to disapprove competency examiners that are not grading appropriately, which could lead to the Board issuing licenses to candidates who may pose a risk to patient protection.

However, staff does recommend adding language to subdivision (c) to specify that the school is required to notify the Board if at any time a school determines that a competency examiner is unable to meet the Board's calibration standards.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #20 - Section 1034:

The CDA commented that subsection (c) states: "An examinee shall be deemed to have passed the portfolio examination if his or her overall score is at least 75 in each of the portfolio competency examinations." Taken out of context, this could imply that this is the sole condition for being awarded a license via portfolio. The CDA suggested the following clarifying amendments:

Along with the requirements of Section 1028, an examinee shall be deemed to have passed the portfolio examination eligible for licensure via portfolio only if his or her overall scaled score is at least 75 in each of the portfolio competency examinations.

Staff Recommended Response:

Staff recommends rejection of this comment. The contents of this section are specific to the grading of the competency examinations, not the portfolio examination in its entirety. Therefore, staff recommends modifying the title of the section to "Portfolio Competency Examination Grading".

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #21 - Section 1034:

The CDA commented that subsection (d) as drafted states: "The executive officer shall notify examinees who have passed or failed the portfolio examination." Given that the entire process for the Board's review of portfolios and licensure applications is contained in Section 1028, this subsection is not needed and could cause confusion, especially since this section is about competency examinations. Under the portfolio process, the Board really is not determining whether someone has "passed or failed" the examination; rather, its role is to determine whether the portfolio is complete as submitted by the school, and to issue a license once that determination has been made and all other requirements have been met.

Staff Recommended Response:

Staff recommends rejection of this comment. The Board still has to verify scoring accuracy and the Board maintains the final approval, as this is a Board administered examination.

However, staff recommends modifying the text to replace "executive officer" with "Board" so that it is clearly understood as a Board-administered examination. The Board delegates authority to staff to review examination results and applications to determine eligibility for initial licensure via the portfolio examination.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #22 - Section 1034:

The CDA commented that subsection (f) in its entirety appears to be redundant and unnecessary, since the scoring factors already are included in the sections for each competency examination.

Staff Recommended Response:

Staff recommends acceptance of the comment. Staff recommends modifying the language to only reference the relevant subsections of each competency so that the competency examination grading criteria may be clearly understood.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #23 - Section 1035:

The CDA commented that this section as a whole appears to be a throwback to the days when the Board was administering its own clinical examination, and thus it does not seem to fit comfortably within either the WREB or the portfolio process. In each of those cases, the CDA's assumption would be that appeals at least initially should be directed to the examining entity (WREB or the dental school) and not to the Board. We do, nevertheless, believe that there should be built-in the ability for an applicant to make a secondary appeal to the Board if he or she is dissatisfied with the due process received by the examining entity. Therefore, the CDA suggested the following amendments:

- (a) An examinee who has failed an examination shall be provided with notice, upon written request to the examining body, of those areas in which he/she is deficient ~~in the clinical and restorative laboratory phases of such examination.~~
- (b) An unsuccessful examinee who has been informed of the areas of deficiency in his/her performance ~~on the clinical and restorative laboratory phases of the examination~~ and who has determined that one or more of the following errors was made during the course of his/her examination and grading may appeal to the ~~board~~ examining body within sixty (60) days following receipt of his/her examination results:
 - (1) Significant procedural error in the examination process;
 - (2) Evidence of adverse discrimination;
 - (3) Evidence of substantial disadvantage to the examinee

After completion of the examining body's appeal process, the examinee may submit an appeal to the Board within 30 days of the examining body's decision.

Such appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The board shall respond to the appeal in writing and may request a personal appearance by the examinee. The board shall thereafter take such action as it deems appropriate.

~~(c) This section shall not apply to the portfolio examination of an examinee's competence to enter the practice of dentistry.~~

Staff Recommended Response:

Staff recommends rejection of this comment. This section is not applicable to the Board's portfolio examination as exempted in subdivision (c). Additionally, the CDA proposed modifications would adversely impact the Board's California Law and Ethics examination.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

CDA Comment #24 - Section 1036:

The CDA commented that similar to the preceding section, by grafting language on to old regulatory language that pertained more to the Board's own clinical examination, and which now applies to the WREB exam, these amendments are somewhat confusing. For example, subsection (a) would appear to allow a portfolio licensure

applicant to obtain remedial education at a dental school other than the one he/she is currently attending, which doesn't make much sense. In addition, the proposed amendments to subsection (b)(1) create similar ambiguity by adopting a portfolio-specific form (seemingly leaving no equivalent form for WREB examinees), but then implying that the form should be submitted to the Board (not to the school) prior to retaking a competency examination, which makes little sense given that the Board would otherwise not be involved with an individual portfolio examinee at that stage of the process. The CDA commented that the Board may want to consider creating a separate remedial education section specific to the portfolio process.

Staff Recommended Response:

Staff recommends acceptance of this comment and recommends modification of the text to differentiate between the remedial education process for the Board's portfolio examination and the WREB examination.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

Comments Received from Steven W. Friedrichsen, DDS, Professor and Dean, College of Dental Medicine, Western University of Health Sciences

The Board received a letter from Steven W. Friedrichsen, DDS, Professor and Dean at Western University of Health Sciences College of Dental Medicine (CDM). Dr. Friedrichsen commented that the faculty and student leadership of the CDM reviewed the proposal and the feedback from both leadership groups was used to develop their comments. The letter stated that the concerns and potential solutions were offered in the spirit of full support of the Portfolio Examination, while at the same time encouraging the Board to consider modification of the Portfolio Examination to address concerns prior to implementation. A copy of the letter is included in the meeting materials.

The CDM stated that it is highly supportive of the Portfolio Examination as one of the pathways to licensure in California and believes it is a long overdue bold step forward in the initial licensing process. The CDM hopes that the collective feedback from the six California dental schools and other interested parties will lead to modifications that produce a smooth initial implementation and successful administration of the Portfolio Examination.

Concern #1 - Impact to Schools:

The CDM commented that the original intent was that the Portfolio Examination process would fit within the curriculum and patient care processes of the dental schools; the estimated impact to the schools was envisioned to be "minor and absorbable". While the school understands the original intent, they wanted it to be recognized that as the portfolio examination has grown in complexity through the design process, it no longer meets that intent.

The letter commented that portfolio was anticipated to logistically include a set of uniform, collaboratively developed competency examinations that would be seamlessly integrated into each of the schools assessment systems. In order to achieve the collaborative buy-in of the six dental schools, it appears the rubrics are overly

generalized and there is a lack of uniformity in the grading between the various competencies. The faculty who would serve as portfolio competency examiners determined the portfolio competencies would not function as a wholesale replacement for similar competencies that are integrated into the CDM's clinical assessment systems. The letter stated that it appears that the CDM would either have to provide additional definition to the portfolio rubrics and devise a conversion matrix for their grading system, or use the portfolio competencies in parallel with the CDM's. Dr. Friedrichsen noted that either of those options would require a significant added investment of time and personnel to support two systems – the portfolio competencies and the CDM's current assessment practices.

The letter stated that each component of the portfolio has an associated cost. The recordkeeping for audits, inter-institutional calibration processes, separate tracking for numerical requirements and logistics of scheduling multiple faculty for competency examinations, collectively represents a significant cost; and as designed, that cost would be borne by the schools. The letter provided that those costs would most likely accrue to the students of schools that choose to participate. These imbedded costs would be amortized among all students in a school – even those taking other licensure exams.

The letter illustrated that an example of how costs can quickly accumulate is readily seen by reviewing the *Impact on the Board* that is outlined on page 7 of the *Notice*. The projected impact to the Board's budget exceeds \$100,000 per year and includes both administrative and adjudication costs. The CDM noted that it should be recognized that for each and every expense incurred by the Board, there is a parallel costs to the dental schools. The CDM expects that the projected costs for the administration of the portfolio exam are not minor and will be difficult to absorb without passing the expense along to the students. The CDM's students and faculty alike are concerned that significant implementation costs would affect the tuition or fees.

Staff Recommended Response:

Staff recommends rejection of this comment. The Board worked collaboratively with the six California dental schools to design the portfolio examination. The examination was developed to fit seamlessly into the existing school curriculum by using the existing resources. Each competency component of the exam was developed by focus groups composed of representatives from each of the six California dental schools. These regulations are implementing the findings and collaborative work of those focus groups. Participation of the California dental schools in the Board's portfolio examination is entirely voluntary; and no other school has expressed similar concerns. Additionally, the projected impact to the Board of \$100,000 was in regards to revenue from applications and not an expense.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

Concern #2 - Portability:

The CDM commented that they are concerned that the anticipated lack of portability to other states will detract from student participation. An examination that does not qualify for licensure in other states could deter student participation. In the current dental practice environment, dental graduates frequently find that employment opportunities often cross state borders. The CDM notes that it will be critical to investigate and communicate how the portfolio examination will be viewed by other states in their licensure decisions, both in initial licensure and when applying for licensure by credentials. The CDM anticipates that students would most likely choose a regional examination that offers the opportunity for licensure in a number of states rather than risk the geographic restriction to California.

As a private institution, the CDM acknowledges that a significant percentage of their students will seek licensure in other states and the investment of supporting two examination processes (both WREB and the portfolio examination) will have to be carefully weighed by the CDM once the final processes and procedures are in place. If the lack of portability drives the interest rate in students below a critical threshold, the CDM would likely need to reluctantly not participate in the portfolio examination.

Staff Recommended Response:

Staff recommends rejection of this comment. The portability of the Board's portfolio examination is not relevant to this rulemaking. The portfolio examination was not designed to be portable across states; however, the Board understands that other states are considering adding a portfolio type examination to their pathways to licensure. The Board hopes that portability will be available some time in the future. Additionally, taking the Board's portfolio examination would not preclude a candidate from taking the WREB examination.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

Concern #3 - Liability Coverage for Faculty and Patients:

The CDM commented that they have two significant liability concerns related to the integrated format with portfolio competency exams.

First, if portfolio competencies are used solely for licensure, on those dates and times when the dental school faculty is serving as the portfolio competency examiners, they are in essence acting on behalf of the Board rather than the CDM. Under those circumstances, the faculty will be conducting the portfolio competencies for the purposes of licensure in California, which is not and cannot be a graduation requirement of the CDM. It is nearly inevitable that at some point a student will not pass the portfolio competencies. When that occurs, it is also inevitable that the student will consider seeking legal recourse. Because the portfolio competencies are not a component of the CDM curriculum required for graduation, Western University's liability coverage for their faculty will not extend to the administration of the exam on behalf of the Board. If the portfolio examination is administered at Western University of Health Sciences as proposed, the Board would need to provide appropriate coverage for the actions of the faculty.

Second, a similar situation can be forecast on behalf of the patients who are involved in the competency examinations. On those dates and times, the patients are in essence being treated for the purposes of an examination process. If the patient encounters a substantive issue requiring correction or remediation, our University's liability carrier is likely to consider the event uncovered – again California licensure is not a graduation requirement for their students, and therefore, not a component of the curriculum. If the portfolio examination is administered at Western University of Health Sciences as designed, the Board (or students) would need to provide appropriate coverage for the relevant patient care process.

Additionally, if the portfolio examination process extends beyond commencement, the CDM would need to construct a specific mechanism to allow students to participate in the requisite competency exams, completion of requirements, or remediation.

Staff Recommended Response:

Staff recommends rejection of this comment. This comment is based on speculation and is not relevant to the proposed regulations concerning examination requirements. The Board worked collaboratively with the six California dental schools to design the portfolio examination. The examination was developed to fit seamlessly into the existing school curriculum by using the existing resources. Each competency component of the exam was developed by focus groups composed of representatives from each of the six California dental schools. These regulations are implementing the findings and collaborative work of those focus groups. Participation of the California dental schools in the Board's portfolio examination is entirely voluntary; and no other school has expressed similar concerns. The schools would administer the Board's exam, but would not be working for the Board. Since the student's would be performing the procedures as part of their curriculum, and it is key that the patient is a patient of record within the school receiving treatment through a normal sequence, it was assumed that the liability would be assumed by the school. Staff believes Western University's concern is only an individual concern that is unique to their particular education model.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

Concern #4 - Numerical Requirements:

The CDM commented that they are concerned that the use of numerically based requirements is not in alignment with competency based outcome measures.

The Commission on Dental Accreditation (CODA), as well as most contemporary assessment systems, has moved the educational processes to competency-based outcomes. The numerical requirements of the portfolio process run counter to the design of the CDM dental education program and CODA standards for accreditation. As a result of changing disease patterns, treatment procedures and demographics, it is likely that the CDM would be challenged to provide all students with sufficient numbers

of procedures in some areas (i.e. removable prosthodontics) on a consistent basis to meet the numerical requirements outlined as well as the competencies.

Reaching specific targeted numbers of requirements could put the students and the CDM in untenable positions. The CDM would need to either preferentially direct patient care experiences selectively to the portfolio examination participants to meet the numerical requirements or deny students the opportunity to participate in the portfolio licensure pathway. The use of specific numbers of procedures has served as an ethical pitfall for decades – students “make” patient care fit the requirements in order to achieve a goal. The CDM encourages the Board to revisit this component of the portfolio examination.

Staff Recommended Response:

Staff recommends rejection of this comment. The Board worked collaboratively with the six California dental schools to design the portfolio examination. The examination was developed to fit seamlessly into the existing school curriculum by using the existing resources. Each competency component of the exam was developed by focus groups composed of representatives from each of the six California dental schools. These focus groups established the number of clinical experiences required as part of the examination. These regulations are implementing the findings and collaborative work of those focus groups. If it becomes necessary in the future, the Board may need to reevaluate the number of required clinical experiences if there are changes in the population of individuals seeking dental treatment at dental schools; however, this is not necessary at this point in the examination’s development. Participation of the California dental schools in the Board’s portfolio examination is entirely voluntary; and no other school has expressed similar concerns.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

Potential Solutions – Allow the Use of Existing Systems:

The CDM would like the Board to consider an option that would allow the schools to request the Board review existing competency examinations and processes as equivalent alternatives to the portfolio competencies and requirements.

The Board may want to consider providing schools with the option of using the existing competency-based assessments conducted by the individual schools. This would potentially solve several key concerns. The schools that want to exercise this option could submit a copy of their competency assessment rubrics, grading scale and faculty calibration plan for the identified portfolio competencies. The Board would then review the submission to assure that it was equivalent to the portfolio competencies. All students who completed the Board approved plan of competencies and other requirements would be considered for licensure.

Developing this option would allow schools to use their existing assessment systems and outcomes reporting processes which already support the CODA Standards for accreditation, college outcome and assessment plans and institutional learning

objectives. Using existing systems and processes in lieu of the proposed competencies and requirements would help the portfolio examination meet the intent of “minor and absorbable” impact. The liability concerns would also evaporate through the utilization of existing graduation requirements.

The same option process should be considered for the requirements. Schools with existing requirements processes could modify them to equate to the portfolio requirements. Those schools that have a competency-based curriculum could submit their overarching competency assessment process for review by the Board for approval in lieu of submitting numerical requirements.

Staff Recommended Response:

Staff recommends rejection of this comment. The Board worked collaboratively with the six California dental schools to design the portfolio examination. The examination was developed to fit seamlessly into the existing school curriculum by using the existing resources. Each competency component of the exam was developed by focus groups composed of representatives from each of the six California dental schools. These regulations are implementing the findings and collaborative work of those focus groups. Participation of the California dental schools in the Board’s portfolio examination is entirely voluntary; and no other school has expressed similar concerns.

Board Action Requested:

The Board may take action to accept, reject, or modify staff’s recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking’s final statement of reasons.

Comments Received from Avishai Sadan, DMD, Dean, Ostrow School of Dentistry of the University of Southern California:

Summary of Comments:

Dr. Sadan submitted a letter in response to the proposed rulemaking thanking the Board for the documentation concerning the portfolio examination requirements. The letter stated that the faculty at the Ostrow School of Dentistry of USC has welcomed the opportunity to participate in the integration process of merging the portfolio evaluation of candidate competency within their clinical education program. The school feels their students will be able to comply with the minimum required experiences as outlined in the initial rulemaking documents; although, the school may need additional time to provide a more detailed response in regards to a timeline for implementation and clinical faculty calibration with the portfolio criteria and standards.

Staff Recommended Response:

There is no need to respond to this comment as there are no comments in response to the language that was proposed. Board staff will be working with the dental schools closely through the implementation and calibration processes, once the regulations become effective.

Board Action Requested:

There is no action necessary.

Comments Received from Sharon Golightly, California Dental Hygiene Association, at the Regulatory Hearing Held on January 6, 2014 in Sacramento, CA:

Summary of Comments:

Sharon Golightly, representing the California Dental Hygiene Association, stated that there was concern that the examination did not include testing of a dentist's skills and competency relating to the administration of local anesthesia and nitrous oxide. Ms. Golightly commented that this concern stemmed from the fact that the use of local anesthesia and nitrous oxide has led to citations and deaths occurring during dental treatment. Ms. Golightly noted that the administration of local anesthesia and nitrous oxide was included as components of the proposed competency examinations, but felt that they should be tested as a separate stand-alone competency examination. She stated that this is a competency that sees a lot of lawsuits, especially in the field of pedodontics, as children may easily be overdosed. She commented that it should be examined in an educational institution.

Ms. Golightly explained that the Western Regional Examination Board (WREB) Examination for hygiene candidates has a separate examination to test a candidate's competence in the application of local anesthesia and that she felt there should be the same standard in the practice of dentistry to provide public protection as it is an area where she felt the skills and competency are inadequate.

Staff Recommended Response:

Staff recommends rejection of this comment. The competencies assessed as part of the Board's proposed Portfolio Examination requirements include more than adequate training and competency evaluation in pain management. While pain management using local anesthesia and nitrous oxide is not a separate competency that is assessed as part of the Portfolio Examination, these pain management options are embedded within the competencies for direct restoration, indirect restoration, periodontics, endodontics, and removable prosthodontics. Additionally, it is not in the best interest of a patient to administer anesthetic agents for the simple purpose of assessing the administration of a drug without patient treatment.

Board Action Requested:

The Board may take action to accept, reject, or modify staff's recommended response to the comments. If staff recommendations are rejected or modified, staff requests that the Board provide a rationale for inclusion in the rulemaking's final statement of reasons.

Additional Staff Recommendations:

Staff recommends modifying the text to correct technical and grammatical errors.

PROPOSED MODIFIED TEXT

**TITLE 16. DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS**

MODIFIED TEXT

Changes made to the originally proposed text are indicated with double-strikethrough for deletions and double-underline for additions.

Amend California Code of Regulations, Title 16, Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036; Adopt California Code of Regulations, Title 16, Sections 1032.7, 1032.8, 1032.9, 1032.10; and, Repeal California Code of Regulations, Title 16, Sections 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039; as follows:

**CHAPTER 1. GENERAL PROVISIONS APPLICABLE TO ALL LICENSEES
ARTICLE 6. FEES**

§ 1021. Examination, Permit and License Fees for Dentists

The following fees are set for dentist examination and licensure by the board~~__~~^{**}:

- | | |
|---|--------|
| (a) Initial application for the board clinical and written examination pursuant to Section 1632(c)(1) of the code, initial application for those applicants qualifying pursuant to Section 1632(c)(2) and those applicants qualifying pursuant to Section 1634.1 | \$100 |
| (b) Initial application for restorative technique examination | \$250 |
| (c) Applications for reexamination | \$75 |
| (d) Board clinical and written examination or pursuant to Section 1632(c)(1) of the code | \$450 |
| <u>(ed)</u> Restorative technique examination or reexamination | \$250 |
| <u>(fe)</u> Fee for application for licensure by credential | \$283 |
| <u>(gf)</u> Initial license | \$365 |
| <u>(hg)</u> Biennial license renewal fee | \$365. |
| <u>(ih)</u> Biennial license renewal fee for those qualifying pursuant to Section 1716.1 of the code shall be one half of the renewal fee prescribed by subsection (h). | |
| <u>(ji)</u> Delinquency fee - license renewal - The delinquency fee for license renewal shall be the amount prescribed by section 163.5 of the code. | |
| <u>(kj)</u> Substitute certificate | \$50 |

(k) Application for an additional office permit	\$100
(l) Biennial renewal of additional office permit	\$100
(m) Late change of practice registration	\$50
(n) Fictitious name permit The fee prescribed by Section 1724.5 of the Code	
(o) Fictitious name renewal	\$150
(p) Delinquency fee-fictitious name renewal	
The delinquency fee for fictitious name permits shall be one-half of the fictitious name permit renewal fee.	
(q) Continuing education registered provider fee	\$250
(r) General anesthesia or conscious sedation permit or adult or minor oral conscious sedation certificate	\$200
(s) Oral Conscious Sedation Certificate Renewal	\$75
(t) General anesthesia or conscious sedation permit renewal fee	\$200
(u) General anesthesia or conscious sedation on-site inspection and evaluation fee	\$250

*Fee pro-rated based on applicant's birth date.

** Examination, licensure, and permit fees for dentistry may not all be included in this section, and may appear in the Business and Professions Code.

Note: Authority cited: Sections 1614, 1635.5, 1634.2(c), 1724 and 1724.5, Business and Professions Code. Reference: Sections 1632, 1634.1, 1646.6, 1647.8, 1647.12, 1647.15, 1715, 1716.1, 1718.3, 1724 and 1724.5, Business and Professions Code.

CHAPTER 2. DENTISTS

ARTICLE 2. APPLICATION FOR LICENSURE

§ 1028. Application for Licensure.

(a) An applicant for licensure as a dentist shall submit an "Application for Licensure to Practice Dentistry" (WREB) Form 33A-22W (Revised 11/06), which is hereby incorporated by reference, or "~~Application for Examination for Licensure to Practice Dentistry~~Determination of Licensure Eligibility (Portfolio)" Form 33A-22P (New 08/2013), which are hereby incorporated by reference, ~~which are forms prescribed by the board and the application shall be accompanied by the following information and fees:~~

(b) Applications for licensure shall be accompanied by the following information and fees:

- (1) The application and examination(s) fees as set by Section 1021;
- (2) Satisfactory evidence that the applicant has met all applicable requirements in Sections 1628 and 1632 of the Code;
- (3) ~~Two classifiable sets of fingerprints or a LiveScan form and applicable fee~~The applicant shall furnish two classifiable sets of fingerprints or submit a Live Scan inquiry to establish the identity of the applicant and to permit the Board to conduct a criminal history record check. The applicant shall pay any costs for furnishing the fingerprints and conducting the criminal history record check;
- (4) Where applicable, a record of any previous dental practice and ~~verification~~certification of license status in each state or jurisdiction in which licensure as a dentist has been attained;
- (5) ~~Except for applicants qualifying pursuant to Section 1632(c)(2), satisfactory evidence of liability insurance or of financial responsibility in accordance with Section 1628(c) of the code. For purposes of that subsection:~~
 - (A) ~~Liability insurance shall be deemed satisfactory if it is either occurrence type liability insurance or claims made type liability insurance with a minimum five year reporting endorsement, issued by an insurance carrier authorized by the Insurance Commissioner to transact business in this State, in the amount of \$100,000 for a single occurrence and \$300,000 for multiple occurrences, and which covers injuries sustained or claimed to be sustained by a dental patient in the course of the licensing examination as a result of the applicant's actions.~~
 - (B) ~~"Satisfactory evidence of financial responsibility" means posting with the board a \$300,000 surety bond.~~
- (65) Applicant's name, social security number, address of residency, mailing address if different from address of residency, date of birth, and telephone number, and gender of applicant;
- (76) Applicant's preferred examination site(s) in California unless the applicant has passed the Western Regional Examining Board examination Information as to whether the applicant has ever taken the California Law and Ethics written examination;
- (87) Any request for accommodation pursuant to the Americans with Disabilities Act;

~~(98)~~ A 2-inch by 2-inch passport style photograph of the applicant, submitted with the “Application for Licensure to Practice Dentistry (WREB)” Form 33A-22W (Revised 11/06), or “Application for Determination of Licensure Eligibility (Portfolio)” Form 33A-22P (New 08/2013);

(409) Information regarding applicant's education including dental education and postgraduate study, if applicable;

(4410) Certification from the dean of the qualifying dental school attended by the applicant to certify the date the applicant graduated;

~~(11) Certification from the dean of the qualifying dental school attended by the applicant to certify the applicant has graduated with no pending ethical issues;~~

(4211) Information regarding whether the applicant has any pending or had in the past any charges filed against a dental license or other healing arts license;

(4312) Information regarding any prior disciplinary action(s) taken against the applicant regarding any dental license or other healing arts license held by the applicant including actions by the United States Military, United States Public Health Service or other federal government entity. “Disciplinary action” includes, but is not limited to, suspension, revocation, probation, confidential discipline, consent order, letter of reprimand or warning, or any other restriction or action taken against a dental license. If an applicant answers “yes”, he or she shall provide the date of the effective date of disciplinary action, the state where the discipline occurred, the date(s), charges convicted of, disposition and any other information requested by the board;

(4413) Information as to whether the applicant is currently the subject of any pending investigation by any governmental entity. If the applicant answers “yes,” he or she shall provide any additional information requested by the board;

(4514) Information regarding any instances in which the applicant was denied a dental license, denied permission to practice dentistry, or denied permission to take a dental board examination. If the applicant answers “yes”, he or she shall provide the state or country where the denial took place, the date of the denial, the reason for denial, and any other information requested by the board;

(4615) Information as to whether the applicant has ever surrendered a license to practice dentistry in another state or country. If the applicant answers “yes,” additional information shall be provided including state or country of surrender, date of surrender, reason for surrender, and any other information requested by the board;

(4716) Information as to whether the applicant has ever been convicted of any crime including infractions, misdemeanors and felonies unless the conviction was

~~for an infraction with a fine of less than \$300. "Conviction" for purposes of this subparagraph includes a plea of no contest and any conviction that has been set aside pursuant to Section 1203.4 of the Penal Code. Therefore, applicants shall disclose any convictions in which the applicant entered a plea of no contest and any convictions that were subsequently set aside pursuant to Section 1203.4 of the Penal Code. violation of the law in this or any other state, the United States, or other country, omitting traffic infractions under \$1,000 not involving alcohol, dangerous drugs, or controlled substances. For the purposes of this section, "conviction" means a plea or verdict of guilty or a conviction following a plea of nolo contendere or "no contest" and any conviction that has been set aside or deferred pursuant to Sections 1000 or 1203.4 of the Penal Code, including infractions, misdemeanors, and felonies;~~

~~(1817) Information as to whether the applicant is in default on a United States Department of Health and Human Services education loan pursuant to Section 685 of the Code; and~~

~~(19) Any other information the board is authorized to consider when determining if an applicant meets all applicable requirements for examination and licensure; and~~

~~(2018) A certification, under the penalty of perjury, by the applicant that the information on the application is true and correct;_~~

~~(b) Completed applications shall be filed with the board not later than 45 days prior to the date set for the beginning of the examination for which application is made. An application shall not be deemed incomplete for failure to establish compliance with educational requirements if the application is accompanied by a certification from an approved school that the applicant is expected to graduate from that school prior to such examination and if the approved school certifies not less than 15 days prior to examination that the applicant has in fact graduated from that school.~~

~~(c) In addition to complying with the applicable provisions contained in subsections (a) through (b) above, an applicant submitting an "Application for Licensure to Practice Dentistry" (WREB) Form 33A-22W (Revised 11/06), for licensure as a dentist upon passage of Western Regional Examining Board ("WREB") examination shall also furnish evidence of having successfully passed, on or after January 1, 2005, the WREB examination.~~

~~(d) In addition to complying with the applicable provisions contained in subsections (a) through (b) above, an applicant submitting an "Application for Determination of Licensure Eligibility (Portfolio)" Form 33A-22P (New 08/2013) shall also furnish certification from the dean of the qualifying dental school attended by the applicant to certify the applicant has graduated with no pending ethical issues;~~

~~(e) An "Application for Determination of Licensure Eligibility (Portfolio)" Form 33A-22P~~

(New 08/2013) may be submitted prior to graduation, if the application is accompanied by a certification from the school that the applicant is expected to graduate. The Board shall not issue a license, until receipt of a certification from the dean of the school attended by the applicant, certifying the date the applicant graduated with no pending ethical issues on school letterhead.

(1)The earliest date upon which ~~an examinee~~ a candidate may submit their portfolio for review by the board shall be within 90 days of graduation. The latest date upon which ~~an examinee~~ a candidate may submit their portfolio for review by the board shall be no more than 90 days after graduation. ‘

(2) The ~~examinee~~ candidate shall arrange with the dean of his or her dental school for the school to submit the completed portfolio materials to the Board.

(3) The Board shall review the submitted portfolio materials to determine if it is complete and the ~~examinee~~ candidate has met the requirements for Licensure by Portfolio Examination.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1628, ~~and 1628.5,~~ and 1632, Business and Professions Code.

§ 1030. Theory Examination.

An applicant shall successfully complete the ~~National Board of Dental Examiners' National Board Dental Examinations of the Joint Commission on National Dental Examinations~~ examination prior to taking the California examination and shall submit confirmation thereof to the board prior to submission of the "Application for Issuance of License Number and Registration of Place of Practice," (Rev. 11-07). ~~Such confirmation must be received in the board office not less than 30 days prior to the examination date requested.~~

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and ~~1633.5~~ 1634.1, Business and Professions Code.

ARTICLE 3. EXAMINATIONS

§ 1031. Supplemental Examinations in California Law and Ethics.

Prior to issuance of a license, an applicant shall successfully complete supplemental written examinations in California law and ethics.

(a) The examination on California law shall test the applicant's knowledge of California law as it relates to the practice of dentistry.

(b) The examination on ethics shall test the applicant's ability to recognize and apply ethical principles as they relate to the practice of dentistry.

(c) ~~An examinee candidate~~ shall be deemed to have passed the examinations if his/her score is at least 75% in each examination.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632 and ~~4633.5~~1634.1, Business and Professions Code.

§ 1032. Demonstrations of Skill Portfolio Examination: Eligibility.

~~Each applicant shall complete written examinations in endodontics and removable prosthodontics. Clinical examinations consisting of periodontics, an amalgam restoration and a composite resin restoration will be completed on patients. In addition, each applicant shall be required to complete a simulation examination in fixed prosthetics.~~

The portfolio examination shall be conducted while the examinee candidate is enrolled in a Board-approved dental school located in California. A student may elect to begin the portfolio examination process during the clinical training phase of their dental education. The student shall have the approval of his or her clinical faculty prior to beginning the portfolio examination process.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.

§ 1032.1. Endodontics Portfolio Examination: Definitions.

~~The written endodontics diagnosis and treatment planning examination shall test the applicant's ability to diagnose, treatment plan, interpret radiographs and evaluate treatment strategies for pulpal and periapical pathoses and systemic entities.~~

As used in this Article, the following definitions shall apply:

(a) "Candidate" means a dental student who is taking the examination for the purpose of applying to the Board for licensure.

(ab) "Case" means a dental procedure which satisfies the required clinical experiences.

(bc) "Clinical experiences" means the procedures, performed with or without faculty intervention, that the examinee candidate must complete to the satisfaction of his or her clinical faculty prior to submission of his or her portfolio examination application. Clinical experiences have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge, and skill level to reliably demonstrate competency.

(d) "Competency examination" means a candidate's final assessment in a portfolio examination competency, performed without faculty intervention and graded by competency examiners registered with the Board.

(ee) "Critical error" means a gross error that is irreversible or may impact the patient's safety and wellbeing.

~~(d) "Examinee" means the dental student who is taking the examination.~~

~~(e) "Independent performance" means an examinee actually involved in the delivery of dental treatment by him or herself. This shall not include observing treatment or being guided by a faculty clinician.~~

~~(f) "Patient management" means the interaction between patient and examinee candidate from initiation to completion of treatment, including any post-treatment complications that may occur.~~

~~(g) "Portfolio" means the cumulative documentation of clinical experiences and competency examinations submitted to the Board.~~

~~(h) "Portfolio competency examiner" means the dental school faculty examiner. The portfolio competency examiner shall be a faculty member chosen by the school, registered with the Board, and shall be trained and calibrated to conduct and grade the portfolio competency examinations.~~

~~(i) "School" means a Board-approved dental school located in California.~~

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632, Business and Professions Code.

§ 1032.2. Removable Prosthodontics Evaluation Examination Portfolio Examination: Requirements for Demonstration of Clinical Experience.

~~The written removable prosthodontics evaluation examination shall be conducted in a laboratory setting and test the applicant's knowledge, understanding and judgement in the diagnosis and treatment of complete denture, partial denture and implant cases.~~

~~(a) Each examinee candidate shall complete at least the minimum number of clinical experiences in each of the competencies prior to submission of their portfolio to the Board. Clinical experiences have been determined as a minimum number in order to provide an examinee with sufficient understanding, knowledge and skill level to reliably demonstrate competency. All clinical experiences shall be performed on patients under the supervision of school faculty and shall be included in the portfolio submitted to the Board. Clinical experience shall be performed at the dental school clinic, an extramural dental facility or a mobile dental clinic approved by the Board. The portfolio shall contain documentation that the examinee candidate has satisfactorily completed the minimum number of clinical experiences as follows:~~

~~(1) The documentation of eOral diagnosis and treatment planning (ODTP) clinical experiences shall include a minimum of twenty (20) patient cases. Clinical experiences for ODTP include: comprehensive oral evaluations, limited (problem-focused) oral evaluations, and periodic oral evaluation.~~

(2) The documentation of dDirect restorative clinical experiences shall include a minimum of sixty (60) restorations. The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including: amalgams, composites, crown build-ups, direct pulp caps, and temporizations.

(3) The documentation of iIndirect restorative clinical experiences shall include a minimum of fourteen (14) restorations. The restorations completed in the clinical experiences may be a combination of the following procedures: inlays, onlays, crowns, abutments, pontics, veneers, cast posts, overdenture copings, or dental implant restorations.

(4) The documentation of rRemovable prosthodontic clinical experiences shall include a minimum of five (5) prostheses. One of the five prostheses may be used as a portfolio competency examination provided that it is completed in an independent manner with no faculty intervention. A prosthesis is defined to shall include any of the following: full denture, partial denture (cast framework), partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth), immediate treatment denture, or overdenture retained by a natural tooth or dental implants.

(5) The documentation of eEndodontic clinical experiences on patients shall include five (5) canals or any combination of canals in three separate teeth.

(6) The documentation of pPeriodontal clinical experiences shall include a minimum of twenty-five (25) cases. A periodontal experience shall include the following: An adult prophylaxis, treatment of periodontal disease such as scaling and root planing, any periodontal surgical procedure, and assisting on a periodontal surgical procedure when performed by a faculty or an advanced education candidate in periodontics. The combined clinical periodontal experience shall include a minimum of five (5) quadrants of scaling and root planning procedures.

(b) Evidence of successful eCompletion of all required clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained-included in the examineecandidate's portfolio.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1032.3. Clinical Periodontics ExaminationPortfolio Examination: Oral Diagnosis and Treatment Planning (ODTP).

(a) The clinical periodontics examination shall include a clinical periodontal examination and diagnosis and hand scaling of a quadrant(s) as assigned or approved by the board.

~~The term "scaling" means the complete removal of explorer-detectable calculus, soft deposits and plaque, and smoothing of the unattached tooth surfaces. Unattached tooth surface means the portion of the crown and root surface to which no tissue is attached. Ultrasonic, sonic, handpiece-drive or other mechanical scaling devices may be used only at the direction of the board.~~

~~Additionally, the clinical periodontics examination shall include a written exercise using projected slides depicting clinical situations which shall test the applicant's ability to recognize, diagnose and treat periodontal diseases.~~

~~(b) One patient shall be provided by the applicant for the clinical periodontal examination and diagnosis and scaling portions of the examination. The applicant shall provide full mouth radiographs of the patient, which shall consist of 18 radiographs of which at least four must be bite-wings. Radiographs must be of diagnostic quality and must depict the current condition of the patient's mouth. If a patient is deemed unacceptable by the examiners, it is the applicant's responsibility to provide another patient who is acceptable. An acceptable patient shall meet the criteria set forth in Section 1033.1 and the following additional criteria:~~

~~(1) Have a minimum of 20 natural teeth, of which at least four must be molar teeth.~~

~~(2) Have at least one quadrant with the following:~~

~~(A) At least six natural teeth;~~

~~(B) At least one molar, one bicuspid and one anterior tooth which are free of conditions which would interfere with evaluation including, but not limited to, gross decay, faulty restorations, orthodontic bands, overhanging margins, or temporary restorations with subgingival margins. (Crowns with smooth margins are acceptable);~~

~~(C) Interproximal probing depths of three to six millimeters, of which at least some must exceed three millimeters. A deviation of one millimeter from the above range is permissible;~~

~~(D) Explorer-detectable moderate to heavy interproximal subgingival calculus must be present on at least 50 percent of the teeth. Calculus must be radiographically evident.~~

~~(c) If an applicant is unable to find a patient with one quadrant which meets the requirements of subsection (b)(2) above, the applicant may provide a patient in which those requirements can be found somewhere in two quadrants on the same side of the mouth rather than in one quadrant. However, an applicant who presents such a patient shall be required to scale all teeth in both quadrants in the same time allotted for scaling one quadrant.~~

(a) The portfolio examination shall contain the following documentation of the minimum ODTP clinical experiences and documentation of ODTP portfolio competency examination:

(1) Evidence of successful completion of the ODTP clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the examinee candidate's portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the ODTP competency examination. For purpose of this section, satisfactory proof means the ODTP competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements: The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The ODTP competency examination shall include:

(1) Fifteen (15) scoring factors:

(A) Medical Issues That Impact Dental Care;

(B) Treatment Modifications Based on Medical Conditions;

(C) Patient Concerns/Chief Complaint;

(D) Dental History;

(E) Significant Radiographic Findings;

(F) Clinical Findings;

(G) Risk Level Assessment;

(H) Need for Additional Diagnostic Tests/Referrals;

(I) Findings From Mounted Diagnostic Casts;

(J) Comprehensive Problem List;

(K) Diagnosis and Interaction of Problems;

(L) Overall Treatment Approach;

(M) Phasing and Sequencing of Treatment;

(N) Comprehensiveness of Treatment Plan; and

(O) Treatment Record.

(2) Initiation and completion of one (1) multidisciplinary portfolio competency examination.

(3) The treatment plan shall involve at least three (3) of the following six disciplines: periodontics, endodontics, operative (direct and indirect restoration), fixed and removable prosthodontics, orthodontics, and oral surgery.

(4) ~~Medical history for dental treatment provided to patients.~~ Patient's Medical History: The medical history shall include: an evaluation of past illnesses and conditions, hospitalizations and operations, allergies, family history, social history, current illnesses and medications, and their effect on dental condition.

(5) ~~Dental history for dental treatment provided to clinical patients.~~ Patient's Dental History: The dental history shall include: age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts.

(6) Documentation of a comprehensive examination of patient's current oral health condition and vital signs ~~for dental treatment provided to patients.~~ The documentation shall include:

(A) Interpretation of radiographic series;

(B) Performance of caries risk assessment;

(C) Determination of periodontal condition;

(D) Performance of a head and neck examination, including oral cancer screening;

(E) Screening for temporomandibular disorders;

(F) Assessment of vital signs;

(G) Performance of a clinical examination of dentition; and

(H) Performance of an occlusal examination.

(7) Documentation the ~~examinee candidate~~ evaluated data to identify problems. The documentation shall include:

- (A) Chief complaint;
- (B) Medical problem;
- (C) Stomatognathic problems; and
- (D) Psychosocial problems.

(8) Documentation the ~~examinee~~ candidate worked-up the problems and developed a tentative treatment plan. The documentation shall include:

- (A) Problem definition, e.g., severity/chronicity and classification;
- (B) Determination if additional diagnostic tests are needed;
- (C) Development of a differential diagnosis;
- (D) Recognition of need for referral(s);
- (E) Pathophysiology of the problem;
- (F) Short term needs;
- (G) Long term needs;
- (H) Determination interaction of problems;
- (I) Development of treatment options;
- (J) Determination of prognosis; and
- (K) Patient information regarding informed consent.

(9) Documentation the ~~examinee~~ candidate developed a final treatment plan. The documentation shall include:

- (A) Rationale for treatment;
- (B) Problems to be addressed, or any condition that puts the patient at risk in the long term; and
- (C) Determination of sequencing with the following framework:
 - (i) Systemic: medical issues of concern, medications and their effects, effect of diseases on oral condition, precautions, treatment modifications;

(ii) Urgent: Acute pain/infection management, urgent esthetic issues, further exploration/additional information, oral medicine consultation, pathology;

(iii) Preparatory: Preventive interventions, orthodontic, periodontal (Phase I, II), endodontic treatment, caries control, other temporization;

(iv) Restorative: operative, fixed, removable prostheses, occlusal splints, implants;

(v) Elective: esthetic (veneers, etc.) any procedure that is not clinically necessary, replacement of sound restoration for esthetic purposes, bleaching; and

(vi) Maintenance: periodontic recall, radiographic interval, periodic oral examination, caries risk management.

(c) Acceptable Patient Criteria for ODTP Competency Examination. The patient used for the competency examination shall meet the following criteria:

(1) Maximum of ASA II, as defined by the American Society of Anesthesiologists (ASA) Physical Status Classification System;

(2) Missing or will be missing two or more teeth, not including third molars; and

(3) At least moderate periodontitis with probing depths of 5 mm or more.

(d) Competency Examination Scoring: The scoring system used for the ODTP competency examination is defined as follows:

(1) A score of 0 is unacceptable; ~~examinee-candidate~~ exhibits a critical error.

(2) A score of 1 is unacceptable; major deviations that are correctable

(3) A score of 2 is acceptable; minimum competence

(4) A score of 3 is adequate; less than optimal

(5) A score of 4 is optimal

A score rating of “2” shall be deemed the minimum competence level performance.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1 Business and Professions Code.

§ 1032.4. Clinical Amalgam Restoration and Composite Resin Restoration
Portfolio Examination: Direct Restoration.

~~(a) Amalgam restoration. Each applicant shall complete to the satisfaction of the board one Class II amalgam restoration in a vital posterior tooth, excluding the mandibular first bicuspid. The tooth involved in the restoration must have caries which penetrates the dento-enamel junction and must be in occlusion. Proximal caries must be in contact with at least one adjacent tooth. The tooth selected may have one existing single-surface restoration or sealant on the occlusal, buccal or lingual surfaces.~~

~~(b) Composite resin restoration. Each applicant shall complete to the satisfaction of the board, one Class III or IV composite resin cavity preparation and restoration of a permanent incisor or canine. The tooth to be restored with a Class III or IV restoration must have proximal caries which penetrates the dento-enamel junction and the caries must be in contact with an adjacent tooth.~~

~~(c) Radiographic requirements. Each applicant shall provide satisfactory periapical and bite-wing radiographs of the tooth to be treated for the amalgam restoration and a satisfactory periapical radiograph of the tooth to be treated for the composite resin restoration. All radiographs shall have been taken not more than six months prior to the examination at which they are presented and must depict the current condition of the patient's tooth.~~

~~(d) Rubber dams. A rubber dam shall be used during the preparation of the amalgam restoration and the composite resin restoration. The Amalgam preparation and the composite resin preparation shall be presented for grading with a rubber dam in place.~~

~~(e) Altering preparations. A preparation which has been graded shall not be changed or altered by the examinee without the specific approval and signature of an examiner.~~

~~(f) Pathological exposures. In the event of a pathological exposure during the amalgam preparation or the composite resin preparation, both the preparation and the restoration will be graded.~~

~~(g) Mechanical exposures. In the event of a mechanical exposure, completion of the clinical procedure will not be allowed for either the amalgam restoration or the composite resin restoration and the applicant will receive a grade of zero.~~

(a) The portfolio examination shall contain the following documentation of the minimum direct restoration clinical experiences and documentation of the direct restoration portfolio competency examination:

(1) Evidence of successful completion of the direct restoration clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the ~~examinee candidate's~~ portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the direct restoration competency examination. For purpose of this section, satisfactory proof means the direct restoration competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements: The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The direct restoration portfolio shall include documentation of the ~~examinee candidate's~~ clinical competency to perform a ~~Class II, Class III and Class IV~~ direct restoration on teeth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials. The case selection shall be based on minimum direct restoration criteria for any permanent anterior or posterior teeth. Each procedure may be considered a clinical experience. The direct restoration competency examination shall include:

(1) Seven (7) scoring factors:

(A) Case Presentation;

(B) Outline and Extensions;

(C) Internal Form;

(D) Operative Environment;

(E) Anatomical Form;

(F) Margins; and

(G) Finish and Function.

(2) Two (2) restorations: One (1) Class II amalgam or composite, maximum one slot preparation; and one ~~(1) Class II amalgam or composite, or Class III/IV composite.~~

(3) Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.

(4) A case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.

(5) Patient Management. The ~~examinee candidate~~ shall be familiar with the patient's medical and dental history.

(6) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(c) Acceptable Criteria for Direct Restoration Examination: The tooth used for each of the competency examinations shall meet the following criteria:

(1) A Class II direct restoration shall be performed on any permanent posterior tooth.

(A) The treatment shall be performed in the sequence described in the treatment plan.

(B) More than one test procedure shall be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments.

(C) Caries as shown on either of the two required radiographic images of an unrestored proximal surface shall extend to or beyond the dento-enamel junction.

(D) The tooth to be treated shall be in occlusion.

(E) The restoration shall have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration shall be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.

(F) The tooth shall be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.

(G) Any tooth with bonded veneer is not acceptable.

(2) A Class III/IV direct restoration shall be performed on any permanent anterior tooth.

(A) The treatment shall be performed in the sequence described in the treatment plan.

(B) Caries as shown on the required radiographic image of an unrestored proximal surface shall extend to or beyond the dento-enamel junction.

(C) Carious lesions shall involve the interproximal contact area.

(D) The restoration shall have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration shall be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.

(E) The tooth shall be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.

(F) The lesion shall not be acceptable if it is in contact with circumferential decalcification.

(G) Procedural approach shall be appropriate for the lesion on the tooth.

(H) Any tooth with bonded veneer is not acceptable.

(d) Competency Examination Scoring. The scoring system used for the direct restoration competency examination is defined as follows:

(1) A score of 0 is unacceptable; ~~examinee candidate~~ exhibits a critical error.

(2) A score of 1 is unacceptable; multiple major deviations that are correctable.

(3) A score of 2 is unacceptable; one major deviation that is correctable.

(4) A score of 3 is acceptable; minimum competence.

(5) A score of 4 is adequate; less than optimal.

(6) A score of 5 is optimal.

A score rating of "3" shall be deemed the minimum competence level performance.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, ~~and 1632,~~ and 1632.1, Business and Professions Code.

§ 1032.5. Clinical Simulated Fixed Prosthetics Examination Portfolio Examination: Indirect Restoration.

~~(a) Each applicant shall prepare two abutments to retain a three-unit posterior fixed partial denture and a crown preparation on an anterior tooth. The two abutment preparations of the three-unit posterior fixed partial denture shall be a metal-ceramic retainer and/or complete metal crown retainer and/or a 3/4 crown retainer. Assignment~~

of abutment preparations will be made at start of the prosthetics examination. The crown preparation on an anterior tooth shall be a metal-ceramic preparation.

(b) Each applicant shall provide an articulated dentoform typodont which has 32 synthetic teeth and soft rubber gingivae. The typodont shall be an articulated Columbia typodont No.s 560, 660, 860, 1360, or 1560 or Kilgore typodont D-95S-200 series or an equivalent in all respects.

(c) The typodont shall be mounted in a manikin. The manikin must be mounted in a simulated patient position and kept in a correct operating position while performing examination procedures. The manikin will be provided at the test site and will be mounted either on a dental chair with a headrest bar or mounted on a simulator. The type of manikin mounted on a dental chair shall be a Columbia Aluminum head with metal checks, model number AH-1C-1 or its equivalent. The type of manikin mounted on a simulator shall be a Frasco phantom head P-5 with face mask or its equivalent.

(d) Minimum equipment to be supplied with the dental chair or simulator at the test site shall be a dental operatory light, a high-speed air handpiece hose with water and airspray, a low-speed air handpiece hose, a three-way air-water dental syringe and an evacuation system.

(a) The portfolio examination shall contain the following documentation of the minimum indirect restoration clinical experiences and documentation of the indirect restoration portfolio competency examination:

(1) Evidence of successful completion of the indirect restoration clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the examinee candidate's portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the indirect restoration competency examination. For purpose of this section, satisfactory proof means the indirect restoration competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements: The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The indirect restoration competency examination shall include documentation of the examinee candidate's competency to complete a ceramic onlay or more extensive, a partial gold restoration onlay or more extensive, a metal-ceramic restoration, or full gold restoration. The indirect restoration competency examination shall include:

(1) Seven (7) scoring factors:

(A) Case Presentation;

(B) Preparation;

(C) Impression;

(D) Provisional;

(E) ~~Examinee~~Candidate Evaluation of Laboratory Work;

(F) Pre-Cementation

(G) Cementation and Finish.

(2) One (1) indirect restoration which may be a combination of any of the following procedures.

(A) Ceramic restoration shall be onlay or more extensive;

(B) Partial gold restoration shall be onlay or more extensive;

(C) Metal ceramic restoration; or

(D) Full gold restoration.

(3) A case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.

(4) Patient Management. The ~~examinee~~ candidate shall be familiar with the patient's medical and dental history.

(5) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(c) Acceptable Criteria for Indirect Restoration Examination: The tooth used for the competency examination shall meet the following criteria:

(1) Treatment shall be performed in the sequence described in the treatment plan.

(2) The tooth shall be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment.

(3) The tooth selected for restoration, shall have opposing occlusion that is stable.

(4) The tooth shall be in occlusal contact with a natural tooth or a permanent

restoration. Occlusion with a full or partial denture is not acceptable.

(5) The restoration shall include at least one cusp.

(6) The restoration shall have an adjacent tooth to be able to restore a proximal contact; proximal surface of the tooth adjacent to the planned restoration shall be either an enamel surface or a permanent restoration; temporary restorations or removable partial dentures are not acceptable adjacent surfaces.

(7) The tooth selected shall require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns.

(8) The ~~examinee~~ candidate shall not perform any portion of the crown preparation in advance.

(9) The direct restorative materials which are placed to contribute to the retention and resistance form of the final restoration may be completed in advance, if needed.

(10) The restoration shall be completed on the same tooth and same patient by the same ~~examinee~~ candidate.

(11) A validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of the existing crown.

(12) Teeth with cast post shall not be allowed.

(13) A facial veneer is not acceptable documentation of the ~~examinee~~ candidate's competency to perform indirect restorations.

(d) Competency Examination Scoring. The scoring system used for the indirect restoration competency examination is defined as follows:

(1) A score of 0 is unacceptable; ~~examinee~~ candidate exhibits a critical error

(2) A score of 1 is unacceptable; multiple major deviations that are correctable

(3) A score of 2 is unacceptable; one major deviation that is correctable

(4) A score of 3 is acceptable; minimum competence

(5) A score of 4 is adequate; less than optimal

(6) A score of 5 is optimal

A score rating of “3” shall be deemed the minimum competence level of performance.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, ~~and 1632,~~ and 1632.1, Business and Professions Code.

§ 1032.6. Removable Prosthodontics Evaluation Examination Portfolio
Examination: Removable Prosthodontics.

(a) The portfolio examination shall contain the following documentation of the minimum removable prosthodontic clinical experiences and documentation of the removable prosthodontic portfolio competency examination:

(1) Evidence of successful completion of the removable prosthodontic clinical experiences shall be certified by the director of the school’s clinical education program on the “Portfolio Examination Certification of Clinical Experience Completion” Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the ~~examinee~~ candidate’s portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the removable prosthodontic competency examination. For purpose of this section, satisfactory proof means the removable prosthodontic competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements. The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The removable prosthodontic competency examination shall include:

(1) One (1) of the following prosthetic treatments from start to finish on the same patient:

(A) Denture or overdenture for a single edentulous arch; or

(B) Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch.

(2) Scoring factors on prosthetic treatments for denture or overdenture for a single edentulous arch or scoring factors on prosthetic treatments for cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch, as follows:

(A) Nine (9) scoring factors on prosthetic treatments for denture or overdenture for a single edentulous arch, as follows:

(i) Patient Evaluation and Diagnosis

(ii) Treatment Plan and Sequencing

- (iii) Preliminary Impressions
- (iv) Border Molding and Final Impressions
- (v) Jaw Relation Records
- (vi) Trial Dentures
- (vii) Insertion of Removable Prosthesis
- (viii) Post-Insertion
- (ix) Laboratory Services for Prosthesis

(B) Twelve (12) scoring factors on prosthetic treatments for cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch, as follows:

- (i) Patient Evaluation and Diagnosis
- (ii) Treatment Plan and Sequencing
- (iii) Preliminary Impressions
- (iv) RPD Design
- (v) Tooth Modification
- (vi) Border Molding and Final Impressions
- (vii) Framework Try-in
- (viii) Jaw Relation Records
- (ix) Trial Dentures
- (x) Insertion of Removable Prosthesis
- (xi) Post-Insertion
- (xii) Laboratory Services for Prosthesis

(3) Documentation the ~~examinee~~ candidate developed a diagnosis, determined treatment options and prognosis for the patient to receive a removable prosthesis. The documentation shall include:

(A) Evidence the ~~examinee~~ candidate obtained a patient history, (e.g. medical, dental and psychosocial).

(B) Evaluation of the patient's chief complaint.

(C) Radiographs and photographs of the patient.

(D) Evidence the ~~examinee~~ candidate performed a clinical examination, (e.g. hard/soft tissue charting, endodontic evaluation, occlusal examination, skeletal/jaw relationship, VDO, DR, MIP).

(E) Evaluation of existing prosthesis and the patient's concerns.

(F) Evidence the ~~examinee~~ candidate obtained and mounted a diagnostic cast.

(G) Evidence the ~~examinee~~ candidate determined the complexity of the case based on ACP classifications.

(H) Evidence the patient was presented with treatment plan options and assessment of the prognosis, (e.g. complete dentures, partial denture, overdenture, implant options, FPD).

(I) Evidence the ~~examinee~~ candidate analyzed the patient risks/benefits for the various treatment options.

(J) Evidence the ~~examinee~~ candidate exercised critical thinking and made evidence based treatment decisions.

(4) Documentation of the ~~examinee~~ candidate's competency to successfully restore edentulous spaces with removable prosthesis. The documentation shall include:

(A) Evidence the ~~examinee~~ candidate developed a diagnosis and treatment plan for the removable prosthesis.

(B) Evidence the ~~examinee~~ candidate obtained diagnostic casts.

(C) Evidence the ~~examinee~~ candidate performed diagnostic wax-up/survey framework designs.

(D) Evidence the ~~examinee candidate~~ performed an assessment to determine the need for pre-prosthetic surgery and made the necessary referral.

(E) Evidence the ~~examinee candidate~~ performed tooth modifications and/or survey crowns, when indicated.

(F) Evidence the ~~examinee candidate~~ obtained master impressions and casts.

(G) Evidence the ~~examinee candidate~~ obtained occlusal records.

(H) Evidence the ~~examinee candidate~~ performed a try-in and evaluated the trial dentures.

(I) Evidence the ~~examinee candidate~~ inserted the prosthesis and provided the patient with post-insertion care.

(J) Documentation the ~~examinee candidate~~ followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

(5) Documentation of the ~~examinee candidate~~'s competency to manage tooth loss transitions with immediate or transitional prostheses. The documentation shall include:

(A) Evidence the ~~examinee candidate~~ developed a diagnosis and treatment plan that identified teeth that could be salvaged and or teeth that needed extraction.

(B) Evidence the ~~examinee candidate~~ educated the patient regarding the healing process, denture experience, and future treatment need.

(C) Evidence the ~~examinee candidate~~ developed prosthetic phases which included surgical plans.

(D) Evidence the ~~examinee candidate~~ obtained casts (preliminary and final impressions).

(E) Evidence the ~~examinee candidate~~ obtained the occlusal records.

(F) Evidence the ~~examinee candidate~~ did try-ins and evaluated trial dentures.

(G) Evidence the ~~examinee candidate~~ competently managed and coordinated the surgical phase.

(H) Evidence the ~~examinee-candidate~~ provided the patient post insertion care including adjustment, relines and patient counseling within the established standards of care.

(I) Documentation the ~~examinee-candidate~~ followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

(6) Documentation of the ~~examinee-candidate~~'s competency to manage prosthetic problems. The documentation shall include:

(A) Evidence the ~~examinee-candidate~~ competently managed real or perceived patient problems.

(B) Evidence the ~~examinee-candidate~~ evaluated existing prosthesis.

(C) Evidence the ~~examinee-candidate~~ performed uncomplicated repairs, relines, re-base, re-set or re-do, if needed.

(D) Evidence the ~~examinee-candidate~~ made a determination if specialty referral was necessary.

(E) Evidence the ~~examinee-candidate~~ obtained impressions/records/information for laboratory use.

(F) Evidence the ~~examinee-candidate~~ competently communicated needed prosthetic procedure to laboratory technician.

(G) Evidence the ~~examinee-candidate~~ inserted the prosthesis and provided the patient follow-up care.

(H) Evidence the ~~examinee-candidate~~ performed in-office maintenance, (e.g. prosthesis cleaning, clasp tightening and occlusal adjustments).

(7) Documentation the ~~examinee-candidate~~ directed and evaluated the laboratory services for the prosthesis. The documentation shall include:

(A) Complete laboratory prescriptions sent to the dental technician.

(B) Copies of all communications with the laboratory technicians.

(C) Evaluations of the laboratory work product, (e.g. frameworks, processed dentures).

(8) Prosthetic treatment for the examination shall include an immediate or interim denture.

(9) Patients shall not be shared or split between examination ~~examinee~~ candidates.

(10) Patient Management. The ~~examinee candidate~~ shall be familiar with the patient's medical and dental history.

(11) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(12) Case complexity shall not exceed the American College of Prosthodontics Class II for partially edentulous patients.

(c) Acceptable Criteria for Removable Prosthodontics Examination. Prosthetic procedures shall be performed on patients with supported soft tissue, implants, or natural tooth retained overdentures.

(d) Competency Examination Scoring. The scoring system used for the removable prosthodontics competency examination is defined as follows:

(1) A score of 1 is unacceptable with gross errors

(2) A score of 2 is unacceptable with major errors

(3) A score of 3 is minimum competence with moderate errors that do not compromise outcome

(4) A score of 4 is acceptable with minor errors that do not compromise outcome

(5) A score of 5 is optimal with no errors evident

A score rating of "3" shall be deemed the minimum competence level of performance.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§1032.7 Portfolio Examination: Endodontics.

(a) The portfolio examination shall contain the following documentation of the minimum endodontic clinical experiences and documentation of the endodontic portfolio competency examination:

(1) Evidence of successful completion of the endodontic clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-

23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the ~~examinee~~ candidate's portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the endodontic competency examination. For purpose of this section, satisfactory proof means the endodontic competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements. The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The endodontic examination shall include:

(1) Ten (10) scoring factors:

(A) Pretreatment Clinical Testing and Radiographic Imaging;

(B) Endodontic Diagnosis;

(C) Endodontic Treatment Plan;

(D) Anesthesia and Pain Control;

(E) Caries Removal, Removal of Failing Restorations, Evaluation of Restorability, Site Isolation;

(F) Access Opening;

(G) Canal Preparation Technique;

(H) Master Cone Fit;

(I) Obturation Technique;

(J) Completion of Case.

(2) One (1) clinical case.

(3) Documentation the ~~examinee~~ candidate applied case selection criteria for endodontic cases. The portfolio shall contain evidence the cases selected met the American Association of Endodontics case criteria for minimum difficulty such that treated teeth have uncomplicated morphologies, have signs and symptoms of swelling and acute inflammation and have not had previously completed or initiated endodontic therapy. The documentation shall include:

(A) The determination of the diagnostic need for endodontic therapy;

(B) Charting and diagnostic testing;

(C) A record of radiographs performed on the patient and an interpretation of the radiographs pertaining to the patient's oral condition;

(D) Evidence of a pulpal diagnosis within approved parameters, including consideration and determination following the pulpal diagnosis that it was within the approved parameters. The approved parameters for pulpal diagnosis shall be normal pulp, reversible pulpitis, irreversible pulpitis, and necrotic pulp.

(E) Evidence of a periapical diagnosis within approved parameters, including consideration and determination following the periapical diagnosis that it was within the approved parameters. The approved parameters for periapical diagnosis shall be normal periapex, asymptomatic apical periodontitis, symptomatic apical periodontitis, acute apical abscess, and chronic apical abscess.

(F) Evidence of development of an endodontic treatment plan that included trauma treatment, management of emergencies, and referrals when appropriate. An appropriate treatment plan may include an emergency treatment due to a traumatic dental injury or for relief of pain or acute infection. The endodontic treatment may be done at a subsequent appointment.

(4) Documentation the ~~examinee candidate~~ performed pretreatment preparation for endodontic treatment. The documentation shall include:

(A) Evidence the patient's pain was competently managed.

(B) Evidence the caries and failed restorations were removed.

(C) Evidence of determination of tooth restorability.

(D) Evidence of appropriate isolation with a dental dam.

(5) Documentation the ~~examinee candidate~~ competently performed access opening. The documentation shall include:

(A) Evidence of creation of the indicated outline form.

(B) Evidence of creation of straight line access.

(C) Evidence of maintenance of structural integrity.

(D) Evidence of completion of un-roofing of pulp chamber.

(E) Evidence of identification of all canal systems.

(6) Documentation the ~~examinee~~ candidate performed proper cleaning and shaping techniques. The documentation shall include:

(A) Evidence of maintenance of canal integrity.

(B) Evidence of preservation of canal shape and flow.

(C) Evidence of applied protocols for establishing working length.

(D) Evidence of demonstration of apical control.

(E) Evidence of applied disinfection protocols.

(7) Documentation of performance of proper obturation protocols, including selection and fitting of master cone, determination of canal condition before obturation, and verification of sealer consistency and adequacy of coating.

(8) Documentation of demonstrated proper length control of obturation, including achievement of dense obturation of filling material and obturation achieved to a clinically appropriate height for the planned definitive coronal restoration.

(9) Documentation of a competently completed endodontic case, including evidence of an achieved coronal seal to prevent recontamination and creation of diagnostic, radiographic, and narrative documentation.

(10) Documentation of provided recommendations for post-endodontic treatment, including evidence of recommendations for final restoration alternatives and recommendations for outcome assessment and follow-up.

(11) Patient Management. The ~~examinee~~ candidate shall be familiar with the patient's medical and dental history.

(12) Implementation of any treatment modifications needed that are consistent with the patient's medical history.

(c) Acceptable Criteria for Endodontics Competency Examination. The procedure shall be performed on any tooth to completion by the same ~~examinee~~ candidate on the same patient. A "completed case" means a tooth with an acceptable and durable coronal seal.

(d) Competency Examination Scoring. The scoring system used for the endodontics competency examination is defined as follows:

(1) A score of 0 is unacceptable; ~~examinee~~ candidate exhibits a critical error.

(2) A score of 1 is unacceptable; major deviations that are correctable.

(3) A score of 2 is acceptable; minimum competence.

(4) A score of 3 is adequate; less than optimal.

(5) A score of 4 is optimal.

A score rating of “2” shall be deemed the minimum competence level performance.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1032.8 Portfolio Examination: Periodontics.

(a) The portfolio examination shall contain the following documentation of the minimum periodontic clinical experiences and documentation of the periodontic portfolio competency examination:

(1) Evidence of successful completion of the periodontic clinical experiences shall be certified by the director of the school’s clinical education program on the “Portfolio Examination Certification of Clinical Experience Completion” Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the ~~examinee~~ candidate’s portfolio.

(2) Documentation providing proof of satisfactory completion of a final assessment in the periodontic competency examination. For purpose of this section, satisfactory proof means the periodontic competency examination has been approved by the designated dental school faculty.

(b) Competency Examination Requirements. The candidate shall have the approval of his or her clinical faculty prior to beginning the competency examination. The periodontic competency examination shall include:

(1) One (1) case to be scored in three parts, as follows:

(A) Part A: Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, and treatment plan;

(B) Part B: Calculus detection and effectiveness of calculus removal; and

(C) Part C: Periodontal re-evaluation.

(2) Nine (9) scoring factors:

(A) Review Medical and Dental History (Part A);

- (B) Radiographic Findings(Part A);
- (C) Comprehensive Periodontal Data Collection (Part A);
- (D) Evaluate Periodontal Etiology/Risk Factors (Part A);
- (E) Comprehensive Periodontal Diagnosis (Part A);
- (F) Treatment Plan (Part A);
- (G) Calculus Detection (Part B);
- (H) Effectiveness of Calculus Removal (Part B); and
- (I) Periodontal Re-evaluation (Part C).

(3) All three parts of the examination shall be performed on the same patient. In the event the patient does not return for periodontal re-evaluation (Part C), the student shall use a second patient for the completion of the periodontal re-evaluation (Part C) portion of the periodontic competency examination.

(4) Documentation the ~~examinee candidate~~ performed a comprehensive periodontal examination. The documentation shall include:

- (A) Evidence that the patient's medical and dental history was reviewed.
- (B) Evidence that the patient's radiographs were evaluated.
- (C) Evidence of performance of an extra-oral and intra-oral examination on the patient.
- (D) Evidence of performance of comprehensive periodontal data collection. Evidence shall include evaluation of patient's plaque index, probing depths, bleeding on probing, suppurations, cemento-enamel junction to the gingival margin (CEJ-GM), clinical attachment, furcations, and tooth mobility.
- (E) Evidence of performance of an occlusal assessment.

(5) Documentation the ~~examinee candidate~~ diagnosed and developed a periodontal treatment plan. The documentation shall include:

- (A) Evidence of determination of periodontal diagnosis.
- (B) Evidence of formulation of an initial periodontal treatment plan that demonstrates

(i) Determination of periodontal diagnosis.

(ii) Formulation an initial periodontal treatment plan that demonstrates the following:

(a) Determination to treat or refer patient to periodontist or periodontal surgery;

(b) Discussion with patient regarding etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient-specific oral hygiene instructions;

(c) Determination on non-surgical periodontal therapy;

(d) Determination of re-evaluation need; and

(e) Determination of recall interval.

(6) Documentation of performance of non-surgical periodontal therapy. The documentation shall include:

(A) Detected supragingival and subgingival calculus;

(B) Performance of periodontal instrumentation, including:

(i) Removed calculus;

(ii) Removed plaque; and

(iii) Removed stains;

(C) Demonstration that excessive soft tissue trauma was not inflicted; and

(D) Demonstration that anesthesia was provided to the patient.

(7) Documentation of performance of periodontal re-evaluation. The documentation shall include:

(A) Evidence of evaluation of effectiveness of oral hygiene;

(B) Evidence of assessment of periodontal outcomes, including:

(i) Review of the patient's medical and dental history;

(ii) Review of the patient's radiographs;

(iii) Performance of comprehensive periodontal data collections (e.g. evaluation of plaque index, probing depths, bleeding on probing, suppurations, cemento-enamel junction to the gingival margin (CEJ-GM), clinical attachment level, furcations, and tooth mobility.

(C) Evidence of discussion with patient regarding current periodontal status as compared to the pre-treatment status, patient-specific oral hygiene instructions, and modifications of specific risk factors;

(D) Evidence of determination of further periodontal needs including the need for referral to a periodontist and periodontal surgery; and

(E) Evidence of establishment of a recall interval for periodontal treatment.

(c) Acceptable Patient Criteria for Periodontics Competency Examination:

(1) The examination, diagnosis, and treatment planning shall include:

(A) A patient with a minimum of twenty (20) natural teeth, with at least four (4) molars;

(B) At least one probing depth of five (5) mm or greater shall be present on at least four (4) of the teeth, excluding third molars, with at least two of these teeth with clinical attachment loss of 2 mm or greater;

(C) A full mouth assessment or examination

(D) The patient shall not have had previous periodontal treatment at the dental school where the examination is being conducted. Additionally, the patient shall not have had previous non-surgical or surgical periodontal treatment within the past six (6) months.

(2) Calculus detection and periodontal instrumentation (scaling and root planing) shall include:

(A) A patient with a minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which shall be a molar. Third molars may be used if they are fully erupted.

(B) At least one probing depth of five (5) mm or greater shall be present on at least two (2) of the teeth that require scaling and root planing.

(C) A minimum of six (6) surfaces of clinically demonstrable subgingival calculus shall be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus shall be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual. If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.

(3) Re-evaluation shall include:

(A) A thorough knowledge of the patient's case;

(B) At least two (2) quadrants of scaling and root planing on the patient being reevaluated.

(C) At least two documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing shall be completed within an interval of 6 weeks or less.

(D) A patient with a minimum twenty (20) natural teeth with at least four (4) molars.

(E) Baseline probing depth of at least five (5) mm on at least four (4) of the teeth, excluding third molars.

(d) Competency Examination Scoring. The scoring system used for the periodontics competency examination is defined as follows:

(1) A score of 0 is unacceptable; ~~examinee candidate~~ exhibits a critical error

(2) A score of 1 is unacceptable; major deviations that are correctable

(3) A score of 2 is acceptable; minimum competence

(4) A score of 3 is adequate; less than optimal

(5) A score of 4 is optimal

A score rating of "2" shall be deemed the minimum competence level performance.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

1032.9 Portfolio Examination: Competency Examiner Qualifications.

(a) Portfolio competency examiners shall meet the following criteria established by the board:

(1) An examiner shall be full-time or part-time faculty member of a Board-approved California dental school.

(2) An examiner shall have a minimum of one (1) year of previous experience in administering clinical examinations.

(3) An examiner shall undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods as established in section 1032.10. Portfolio competency examiners are required to attend Board-approved standardized calibration training sessions offered at their schools prior to administering a competency examination and annually thereafter.

(b) At the beginning of each school year, each school shall submit to the Board the names, credentials and qualifications of the dental school faculty to be approved or disapproved by the Board as portfolio competency examiners. Documentation of qualifications shall include a letter from the dean of the California dental school stating that the dental school faculty satisfies the criteria and standards established by the dental school to conduct portfolio competency examinations in an objective manner, and has met the requirements of subdivision (a)(1) through (a)(3) of this section.

(c) In addition to the names, credentials and qualifications, the dean of the California dental school shall submit documentation that the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements established in section 1032.10.

(d) Any changes to the list of portfolio competency examiners shall be reported to the Board within thirty (30) days, including any action taken by the school to replace an examiner.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1032.10 Portfolio Examination: Competency Examiner Training Requirements.

(a) Portfolio competency examiners are required to attend Board-approved standardized calibration training sessions offered at their schools prior to administering a competency examination. Each of the schools will designate faculty who have been approved by the Board to serve as competency examiners and is responsible for administering the Board approved calibration course for said examiners. Examiners may grade any competency examination in which they have completed the required calibration. Each training session shall be presented by designated Portfolio competency examiners at their respective schools and require the prospective examiners to participate in both didactic and hands-on activities.

(b) Didactic Training Component. During didactic training, designated Portfolio competency examiners shall present an overview of the examination and its evaluation (grading) system through lecture, review of examiner training materials, including slide presentations, sample documentation, and sample cases.

(c) Hands-On Component. Training shall include multiple examples of performance that clearly relate to the specific judgments that examiners are expected to provide during the portfolio competency examinations. Hands-on training sessions include an overview of the rating process, clear examples of rating errors, examples of how to mark the grading forms, a series of several sample cases for examiners to hone their skills, and opportunities for training staff to provide feedback to individual examiners.

(d) Calibration of Examiners. The calibration of portfolio competency examiners shall be conducted to maintain common standards as an ongoing process. Portfolio competency examiners shall be provided feedback about their performance and how their scoring varies from their fellow examiners. Portfolio competency examiners whose error rate exceeds psychometrically accepted standards for reliability shall be re-calibrated. A school shall notify the Board if, at any time, it is determined that a competency examiner is unable to meet the Board's calibration standards. If any portfolio competency examiner is unable to be re-calibrated, the Board shall disapprove the portfolio competency examiner from further participation in the portfolio examination process.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, 1632, and 1632.1, Business and Professions Code.

§ 1033. General Procedures for Law and Ethics Written and Laboratory Dental Licensure Examinations.

The following rules, which are in addition to any other examination rules set forth elsewhere in this chapter, are adopted for the uniform conduct of all written and laboratory dental licensure examinations:

(a) The ability of an examineecandidate to read and interpret instructions and examination material is a part of the examination.

~~(b) No person shall be admitted to an examination room or laboratory unless he or she is wearing the appropriate identification badge.~~

~~(c) An examineecandidate may be dismissed from the entire examination, and a statement of issues may be filed against the examineecandidate, for acts which interfere with the board's objective of evaluating professional competence. Such acts include, but are not limited to, the following:~~

~~(1) Allowing another person to take the examination in the place of, and under the identity of, the examineecandidate.~~

- (2) Copying or otherwise obtaining examination answers from other persons during the course of the written examination.
- (3) Bringing any notes, textbooks, unauthorized models, or other informative data into an examination room ~~or laboratory~~.
- (4) Assisting another ~~examinee~~ examinee candidate during the examination process.
- (5) Copying, photographing or in any way reproducing or recording examination questions or answers.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630, ~~and 1632~~, and 1632.1, Business and Professions Code.

§ 1033.1. General Procedures and Policies for ~~Clinical Dental Licensure~~ Portfolio Examination.

The following rules, which are in addition to any other examination rules set forth elsewhere in this chapter, are adopted for the uniform conduct of the ~~clinical dental licensure portfolio~~ portfolio examination.

~~(a) Each examinee shall furnish patients, instruments, handpieces and materials, necessary to carry the procedures to completion. The board will provide operatory lights, dental delivery units and chairs or simulators.~~

(a) The ~~examinee~~ examinee candidate shall be able to read and interpret instructions and examination material as part of the examination.

~~(b) A patient provided by an examinee shall be in a health condition acceptable for dental treatment. If conditions indicate a need to consult the patient's physician or for the patient to be premedicated (e.g. high blood pressure, heart murmur, rheumatic fever, heart condition, prosthesis), the ~~examinee~~ examinee candidate must obtain the necessary written medical clearance and/or, evidence of premedication before the patient will be accepted. The examiners may, in their discretion, reject a patient who in the opinion of at least two examiners has a condition which interferes with evaluation or which may be hazardous to the patient, other patients, applicants or examiners. A hazardous condition includes, but is not limited to, acute symptomatic hepatitis, active herpetic lesions, acute periodontal or periapical abscesses, or necrotizing ulcerative gingivitis. In addition, a patient may be rejected when, in the opinion of at least two examiners, the proposed treatment demonstrates improper patient management, including but not necessarily limited to, contraindicating medical status of the patient, grossly pathologic or unhygienic oral conditions such as extremely heavy calculus deposits, other pathology related to the tooth to be treated, or selection of a restoration that is not suited to the patient's biological or cosmetic requirements. Whenever a patient is rejected, the reason for such rejection shall be noted on the examination record and shall be signed by both rejecting examiners. If the patient's well-being is put into jeopardy at any time during the portfolio competency examination, the examination shall be terminated. The~~

examineecandidate shall fail the examination, regardless of performance on any other part of the examination.

~~(c) No person shall be admitted to the clinic unless he or she is wearing the appropriate identification badge.~~

~~(dc) The use of local anesthetics shall be administered according to the school's protocol and standards of care. The type and amount of anesthetics shall be consistent with the patient's medical history and current condition not be permitted until the patient has been approved by an examiner.~~

~~(e) Only the services of registered dental assistance or dental assistants shall be permitted.~~

~~(f) An assignment which has been made by the board shall not be changed by an examinee without the specific approval of the board.~~

~~(gd) An examineecandidate may be dismissed from the entire examination, and a statement of issues may be filed against the examineecandidate, for acts which interfere with the board's objective of evaluating professional competence. Such acts include, but are not limited to the following:~~

~~(1) Allowing another person to take the portfolio examination in the place of, and under the identity of, the examineecandidate.~~

~~(2) Presenting purported carious lesions which are artificially created, whether or not the examineecandidate created the defect.~~

~~(3) Presenting radiographs which have been altered, or contrived to represent other than the patient's true condition, whether or not the misleading radiograph was created by the examineecandidate.~~

~~(4) Bringing any notes, textbooks, unauthorized models, periodontal charting information or other informative data into the clinic during any portfolio competency examination.~~

~~(5) Assisting another examineecandidate during the portfolio examination process.~~

~~(6) Failing to comply with the board's infection control regulations. Examinee Candidates shall be responsible for maintaining all of the standards of infection control while treating patients. This shall include the appropriate sterilization and disinfection of the cubicle, instruments and handpieces, as well as, the use of barrier techniques (including glasses, mask, gloves, proper attire, etc.) as required by the California Division of Occupational Safety and Health (Cal/OSHA) and California Code of Regulations, Title 16, Section 1005.~~

~~(7) Failing to use an aspirating syringe for administering local anesthesia.~~

~~(8) Utilizing the services of a licensed dentist, dental school graduate, dental school student, registered dental hygienist in extended functions, registered dental hygienist, dental hygiene graduate, dental hygiene student, or registered dental assistant in extended functions, or student or graduate of a registered dental assistant in extended functions program.~~

~~(9) Treating a patient, or causing a patient to receive treatment outside the designated examination settings and timeframes.~~

~~(10) Premedicating a patient for purposes of sedation.~~

~~(11) Dismissing a patient without the approval and signature of an examiner.~~

~~(h) An examinee may be declared by the board to have failed the entire examination for demonstration of gross incompetence in treating a patient.~~

(e) Examinee Candidates shall wear personal protective equipment (PPE) during the portfolio competency examinations. PPE shall include masks, gloves, and eye protection during each portfolio competency examination.

(f) Radiographs for each of the portfolio competency examinations shall be of diagnostic quality. Digital or conventional radiographs may be used.

(g) Dental dams shall be used during endodontic treatment and the preparation of amalgam and composite restorations. Finished restorations shall be graded without the dental dam in place.

(h) Examinee Candidates shall provide clinical services upon patients of record of the dental school who fulfill the acceptable criteria for each of the six (6) portfolio competency examinations.

(i) Examinee Candidates shall be allowed three (3) hours and thirty (30) minutes for each patient treatment session.

(j) Each portfolio competency examination shall be performed by the examinee candidate without faculty intervention. Completion of a successful portfolio competency examination may be counted as a clinical experience for the purpose of meeting the requirements of section 1032.2.

(k) ~~Examinee~~Candidates who fail a portfolio competency examination three (3) times shall not be permitted to retake the portfolio competency examination until remediation has been completed as specified in section 1036.

(l) Readiness for an ~~examinee~~-candidate to take a portfolio competency examination shall be determined by the dental school's clinical faculty.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630,~~and~~1632, and 1632.1, Business and Professions Code.

§ 1034. Grading of Examinations Administered by the Board Portfolio Competency Examination Grading.

This section shall apply to the clinical and written examination administered by the board pursuant to Section 1632(c)(1) of the code. This section shall apply, in addition to any other examination rules set forth in this Chapter, for the purpose of uniform conduct of the portfolio examination grading.

(a) Each examiner shall grade independently. Examinations shall be anonymous. An anonymous examination is one conducted in accordance with procedures, including but not limited to those set forth below, which ensure and preserve the anonymity of examinees. The board shall randomly assign each examinee a number, and said examinee shall be known by that number throughout the entire examination. The grading area shall be separated from the examination area by barriers that block the grading examiners' view of examinees during the performance of the examination assignments. There shall be no communication between grading examiners and clinical floor examiners except for oral communications conducted in the presence of board staff. Each portfolio competency examination shall be graded by two (2) independent portfolio competency examiners and shall use the Board's standardized scoring system as specified in subdivision (f) of this section. There shall be no communication between grading examiners and examinees except written communications on board approved forms.

(b) The final grade of each examinee shall be determined by averaging the grades obtained in:

- (1) Endodontics;
- (2) Removable prosthodontics evaluation examination;
- (3) Periodontics;
- (4) Amalgam restoration;
- (5) Composite resin restoration; and
- (6) Clinical simulated fixed prosthetics preparations.

~~(c) An examinee shall be deemed to have passed the examination if his or her overall average for the entire examination is at least 75% and the examinee has obtained a grade of 75% or more in at least four sections of the examination, except that an examinee shall not be deemed to have passed the examination if he or she receives a score of less than 75% in more than one section of the examination in which a patient is treated. An examinee candidate shall be deemed to have passed the portfolio examination if his or her overall scaled score is at least 75 in each of the portfolio competency examinations.~~

~~(d) The ~~executive officer~~ Board shall compile and summarize the grades attained by each examinee and establish the overall average of each examinee. He or she shall indicate on the records so compiled the names of notify those examinee candidates who have passed or failed the portfolio examination and shall so notify each examinee.~~

~~(e) Each portfolio competency examination shall be signed by the school portfolio competency examiners who performed the grading.~~

~~(f) Competency Examination Scoring: The portfolio competency examiners shall use the following scoring system for each of the competency examinations:~~

~~(1) The scoring system used for the ODTP competency examination as specified in Section 1032.3(d), is defined as follows:~~

~~(A) A score of 0 is unacceptable; examinee exhibits a critical error.~~

~~(B) A score of 1 is unacceptable; major deviations that are correctable.~~

~~(C) A score of 2 is acceptable; minimum competence.~~

~~(D) A score of 3 is adequate; less than optimal.~~

~~(E) A score of 4 is optimal.~~

~~A score rating of "2" shall be deemed the minimum competence level performance.~~

~~(2) The scoring system used for the direct restoration competency as specified in Section 1032.4(d), examination is defined as follows:~~

~~(A) A score of 0 is unacceptable; examinee exhibits a critical error.~~

~~(B) A score of 1 is unacceptable; multiple major deviations that are correctable.~~

~~(C) A score of 2 is unacceptable; one major deviation that is correctable.~~

~~(D) A score of 3 is acceptable; minimum competence.~~

~~(E) A score of 4 is adequate; less than optimal.~~

~~(F) A score of 5 is optimal.~~

~~A score rating of "3" shall be deemed the minimum competence level performance.~~

~~(3) The scoring system used for the indirect restoration competency examination as specified in Section 1032.5(d) is defined as follows:~~

~~(A) A score of 0 is unacceptable; examinee exhibits a critical error~~

~~(B) A score of 1 is unacceptable; multiple major deviations that are correctable~~

~~(C) A score of 2 is unacceptable; one major deviation that is correctable~~

~~(D) A score of 3 is acceptable; minimum competence~~

~~(E) A score of 4 is adequate; less than optimal~~

~~(F) A score of 5 is optimal~~

~~A score rating of "3" shall be deemed the minimum competence level of performance.~~

~~(4) The scoring system used for the removable prosthodontics competency examination as specified in Section 1032.6(d) is defined as follows:~~

~~(A) A score of 1 is unacceptable with gross errors~~

~~(B) A score of 2 is unacceptable with major errors~~

~~(C) A score of 3 is minimum competence with moderate errors that do not compromise outcome~~

~~(D) A score of 4 is acceptable with minor errors that do not compromise outcome~~

~~(E) A score of 5 is optimal with no errors evident~~

~~A score rating of "3" shall be deemed the minimum competence level of performance.~~

(5) The scoring system used for the endodontics competency examination as specified in Section 1032.7(d), is defined as follows:

(A) A score of 0 is unacceptable; examinee exhibits a critical error.

(B) A score of 1 is unacceptable; major deviations that are correctable.

(C) A score of 2 is acceptable; minimum competence.

(D) A score of 3 is adequate; less than optimal.

(E) A score of 4 is optimal.

A score rating of "2" shall be deemed the minimum competence level performance.

(6) The scoring system used for the periodontics competency examination as specified in Section 1032.8(d), is defined as follows:

(A) A score of 0 is unacceptable; examinee exhibits a critical error

(B) A score of 1 is unacceptable; major deviations that are correctable

(C) A score of 2 is acceptable; minimum competence

(D) A score of 3 is adequate; less than optimal

(E) A score of 4 is optimal

A score rating of "2" shall be deemed the minimum competence level performance.

(g) If an examinee candidate commits a critical error, the examinee candidate shall not proceed with the portfolio competency examination. If the examinee candidate makes a critical error at any point during a portfolio competency examination, a score of "0" shall be assigned and the portfolio competency examination shall be terminated immediately.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1614, 1615, 1630, 1632, 1632.1, 1633 and 1634, Business and Professions Code.

§ 1034.1. Passing Score of Examination Administered by the Western Regional Examining Board (WREB) (§ 1632(c)(2) of the Code).

The board ~~will~~shall accept as a passing score for Western Regional Examining Board examination the passing score as determined by the Western Regional Examining Board.

Note: Authority cited: Sections 1614 and 1632, Business and Professions Code.

Reference: Sections 139 and 1632, Business and Professions Code.

§ 1035. Examination Review Procedures; Appeals.

(a) An ~~examinee~~examinee candidate who has failed an examination shall be provided with notice, upon written request, of those areas in which he/she is deficient ~~in the clinical and restorative laboratory phases of such examination.~~

(b) An unsuccessful ~~examinee~~examinee candidate who has been informed of the areas of deficiency in his/her performance ~~on the clinical and restorative laboratory phases of the examination~~ and who has determined that one or more of the following errors was made during the course of his/her examination and grading may appeal to the board within sixty (60) days following receipt of his/her examination results:

- (1) Significant procedural error in the examination process;
- (2) Evidence of adverse discrimination;
- (3) Evidence of substantial disadvantage to the ~~examinee~~examinee candidate.

Such appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The board shall respond to the appeal in writing and may request a personal appearance by the ~~examinee~~examinee candidate. The board shall thereafter take such action as it deems appropriate.

(c) This section shall not apply to the portfolio examination of an ~~examinee~~examinee candidate's competence to enter the practice of dentistry.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630-1632, Business and Professions Code.

~~§ 1035.1. Clinical Periodontics Examination. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632, Business and Professions Code.~~

~~§ 1035.2. Clinical Cast Restoration and Amalgam. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.~~

§ 1036. Remedial Education: Law and Ethics; WREB

~~An applicant, who fails to pass the examination after three attempts, or who fails to pass a portfolio competency examination after three attempts, shall not be eligible for further re-examination until the applicant has successfully completed the required additional education as specified in Section 1633(b) of the Business and Professions Code.~~

(a) The course work shall be taken at a dental school approved by the Commission on Dental Accreditation or a comparable organization approved by the Board, and shall be completed within a period of one year from the date of notification of the applicant's third failure.

(1) The course of study must be didactic, laboratory or a combination of the two. Use of patients is optional.

(2) Instruction must be provided by a faculty member of a dental school approved by the Commission on Dental Accreditation or a comparable organization approved by the Board.

(3) Pre-testing and post-testing must be part of the course of study.

(b) When an applicant applies for reexamination, he or she shall furnish evidence of successful completion of the remedial education requirements for reexamination.

(1) Evidence of successful completion must be on the ~~“Certification of Successful Completion of Remedial Education for Portfolio Competency Re-Examination requirements for re-examination Eligibility” (Form New 08/13rev. 1)~~ “Certification of Successful Completion of Remedial Education Requirements for Re-Examination Eligibility” (Form Rev. 1), that is hereby incorporated by reference, ~~form that is provided by the board and submitted prior to the examination.~~

(2) The form must be signed and sealed by the Dean of the dental school providing the remedial education course.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632.5, Business and Professions Code.

§ 1036.01. Remedial Education: Portfolio Competency Examinations.

A candidate, who fails to pass a portfolio competency examination after three attempts, shall not be eligible for further re-examination until the candidate has successfully completed the required additional education as specified in Section 1633(b) of the Business and Professions Code.

(a) The course work shall be taken at a dental school approved by the Commission on Dental Accreditation or a comparable organization approved by the Board, and shall be

completed within a period of one year from the date of notification of the applicant's third failure.

(1) The course of study must be didactic, laboratory or a combination of the two. Use of patients is optional.

(2) Instruction must be provided by a faculty member of a dental school approved by the Commission on Dental Accreditation or a comparable organization approved by the Board.

(3) Pre-testing and post-testing must be part of the course of study.

(b) When an applicant applies for reexamination, he or she shall furnish evidence of successful completion of the remedial education requirements for reexamination.

(1) Evidence of successful completion must be on the "Certification of Successful Completion of Remedial Education for Portfolio Competency Re-Examination requirements for re-examination Eligibility" (Form New 08/13), that is hereby incorporated by reference, that is submitted prior to the examination.

(2) The form must be signed and sealed by the Dean of the dental school providing the remedial education course.

Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632.5, Business and Professions Code.

~~§ 1036.1. Amalgam -Restorative Laboratory. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.~~

~~§ 1036.2. Fixed Prosthetics -Restorative Laboratory. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.~~

~~§ 1036.3. Removable Prosthetics -Restorative Laboratory. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630 and 1632, Business and Professions Code.~~

~~§ 1037. Grading of Examinations. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1614, 1615, 1632, 1633 and 1634, Business and Professions Code.~~

~~§ 1038. Examination Review Procedures; Appeals. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Sections 1630-1632, Business and Professions Code.~~

~~§ 1039. Remedial Education. [REPEAL]~~

~~Note: Authority cited: Section 1614, Business and Professions Code. Reference: Section 1632.5, Business and Professions Code.~~



December 19, 2013

Ms. Sarah Wallace
Legislative and Regulatory Analyst
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

SUBJECT: Proposed Regulations – Portfolio Examination

Dear Ms. Wallace,

The California Dental Association (CDA) appreciates the opportunity to provide comment on the proposed regulatory package to implement portfolio licensure in California. CDA has been proud to work with the board these last few years on what is being looked to across the nation as a milestone in the history of dental licensure examination.

CDA has participated in many stakeholder meetings and discussions regarding the details of the portfolio process, and has appreciated the openness of the Dental Board and the six California dental schools to our thoughts and perspectives as these regulations and the accompanying manuals have been developed. The level of consensus that has been reached between all parties is remarkable given the complexity and unprecedented nature of the task. Because of that effort, CDA has few if any broad policy concerns with these draft regulations. In looking at them in detail, though, we do see a few areas where we feel additional clarification may be appropriate. Our hope is that these will be relatively easy issues to address that will not unduly delay the process.

Section 1028

Shouldn't subsection (b)(6) say something like "proof that the applicant has passed the California Law and Ethics written examination," rather than simply "information as to whether the applicant has taken" the exam?

Subsections (e)(1), (2), and (3) all use the word "examinee" to refer to the final submittal of the portfolio to the board. It would seem to be more accurate to consistently use the word "applicant" here, since once they are submitting their completed portfolios to the board they are no longer being "examined;" the board's role is simply to verify completion of the portfolio requirements.

Currently, the regulations are somewhat unclear about the respective timing and review process for the portfolio itself and the application for licensure. In discussions with board staff, the intent is that the portfolio would be submitted and reviewed first, and once the portfolio was determined to be complete, the applicant would be notified and could then submit the licensure application. To make that process clearer in the regulations, we suggest the following amendments, commencing after the first paragraph of subsection (e):

(f) Prior to submitting the "Application for Determination of Licensure Eligibility (Portfolio)", the Board shall have completed its review of the applicant's submitted portfolio and notified the applicant that he/she has met the requirements for Licensure by Portfolio Examination and is eligible to submit the application.

- (1) The earliest date upon which an ~~examinee~~ applicant may submit their portfolio for review by the board shall be within 90 days of anticipated graduation. The latest date upon which an ~~examinee~~ applicant may submit their portfolio for review by the board shall be no more than 90 days after graduation.
- (2) The ~~examinee~~ applicant shall arrange with the dean of his or her dental school for the school to submit the completed portfolio materials to the Board.
- (3) ~~The Board shall review the submitted portfolio materials to determine if it is complete and the examinee has met the requirements for Licensure by Portfolio Examination.~~

Section 1032

The last sentence of this section states: "The student shall have the approval of his or her clinical faculty prior to beginning the portfolio examination process." The word "approval" implies that a dental school would have the authority to deny a student's request to participate in the portfolio process, thereby forcing him or her to take the WREB exam instead, which does not seem appropriate as a matter of policy. All methods of licensure examination in California are expected to be equivalent and equally available to applicants who meet the necessary requirements. We would suggest the following amendment:

"The student shall notify ~~have the approval of~~ his or her clinical faculty prior to beginning the portfolio examination process."

Section 1032.1

In reviewing the draft regulations in their entirety, we find a number of instances in which the distinction between clinical experiences and competency examinations is not clear and could be confused. Throughout the draft there are references to "completion" or "successful completion" of clinical experiences, which implies that the procedures are completed entirely by the student. Clarifying the definitions here, including providing a definition of "competency examination," may help prevent confusion later on. Based on our prior discussions, it seems to us that the clearest distinction is that clinical experiences can include faculty intervention, while competency examinations cannot. To that end, we suggest adding the following definition of "competency examination," along with amendments to the definition of "clinical experiences:"

(b) "Clinical experiences" means the procedures, performed with or without faculty intervention, that the examinee applicant must complete to the satisfaction of his or her clinical faculty prior to submission of his or her portfolio examination application.

(c) "Competency examination" means an examinee's final assessment in a portfolio examination competency, performed without faculty intervention and graded by competency examiners registered with the board.

We would also suggest that subsection (e) be deleted, since the term "independent performance" does not appear in the proposed regulations, and thus a definition is not needed.

Section 1032.2

We would like to suggest several structural/grammatical amendments which we believe will clarify the level of information that needs to be provided to the board in each applicant's portfolio:

(a) Each examinee applicant shall complete at least the minimum number of clinical experiences in each of the competencies prior to submission of their portfolio to the Board. Clinical experiences have been determined as a minimum number in order to provide an examinee with sufficient understanding, knowledge and skill level to reliably demonstrate competency. All clinical experiences shall be performed on patients under the supervision of school faculty and shall be included in the portfolio submitted to the Board. Clinical experiences shall be performed at the dental school clinic, or at an

extramural dental facility or a mobile dental clinic approved by the Board. The portfolio shall contain ~~documentation~~ certification that the examinee has ~~satisfactorily~~ completed the minimum number of clinical experiences as follows:

- (1) ~~The documentation of~~ oral diagnosis and treatment planning (ODTP) clinical experiences shall include a minimum of twenty (20) patient cases. Clinical experiences for ODTP include: comprehensive oral evaluations, limited (problem-focused) oral evaluations, and periodic oral evaluation.
- (2) ~~The documentation of~~ direct restorative clinical experiences shall include a minimum of sixty (60) restorations. The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including: amalgams, composites, crown build-ups, direct pulp caps, and temporizations.
- (3) ~~The documentation of~~ indirect restorative clinical experiences shall include a minimum of fourteen (14) restorations. The restorations completed in the clinical experiences may be a combination of the following procedures: inlays, onlays, crowns, abutments, pontics, veneers, cast posts, overdenture copings, or dental implant restorations.
- (4) ~~The documentation of~~ removable prosthodontic clinical experiences shall include a minimum of five (5) prostheses. One of the five prostheses may be used as a portfolio competency provided that it is completed in an independent manner with no faculty intervention. ~~A prosthesis is defined to~~ may include any of the following: full denture, partial denture (cast framework), partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth), immediate treatment denture, or overdenture retained by a natural or dental implants.
- (5) ~~The documentation of~~ endodontic clinical experiences on patients shall include five (5) canals or any combination of canals in three separate teeth.
- (6) ~~The documentation of~~ periodontal clinical experiences shall include a minimum of twenty-five (25) cases. A periodontal experience shall include the following: An adult prophylaxis, treatment of periodontal disease such as scaling and root planing, any periodontal surgical procedure, and assisting on a periodontal surgical procedure when performed by a faculty or an advanced education candidate in periodontics. The combined clinical periodontal experience shall include a minimum of five (5) quadrants of scaling and root planing.

procedures.

- ~~(b) Evidence of successful completion of all required clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion: Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained included in the examinee's portfolio submitted to the Board.~~

Section 1032.3

As a general comment that applies to the subsequent sections as well, since the specifics of the clinical experience requirements for all competencies are contained in the preceding section 1032.2, for the sake of clarity we suggest deleting redundant references to clinical experiences in Section 1032.3 and making the section entirely about the competency examination. Thus, we suggest changing the title to "Portfolio Competency Examination: Oral Diagnosis and Treatment Planning (ODTP)," and modifying (a) as follows:

- ~~(a) The portfolio shall contain the following documentation of the minimum ODTP clinical experiences and documentation of ODTP portfolio competency examination:~~

- ~~(1) Evidence of successful completion of the ODTP clinical experiences shall be certified by the director of the school's clinical education program on the "Portfolio Examination Certification of Clinical Experience Completion" Form 33A-23P (New 08/13), which is hereby incorporated by reference, and shall be maintained in the examinees portfolio.~~
- ~~(2) Documentation providing proof of satisfactory completion of a final assessment in the ODTP competency examination. For purpose of this section, satisfactory proof means the ODTP competency examination has been approved by the designated dental school faculty.~~

For the sake of further clarity, we suggest switching the current subsections (b) and (c), so that "Acceptable Patient Criteria" comes before "Competency Examination Requirements." This seems to make logical sense, since the patient must be chosen before the exam can be taken. We would offer a similar suggestion for the remaining competency examination sections.

Finally, in reviewing the entirety of the current (b), it is not clear to us how many different

patients can be included in the ODTP competency examination. Subsection (b)(2) states that there shall be “one” multidisciplinary portfolio competency exam, but (b)(2) states that “the treatment plan shall involve at least three...disciplines...”, and subsequent subsections make reference to “treatment provided to clinical patients.” Should this section more clearly spell out the number of patient treatment plans that can make up this competency examination? We do not offer an answer to this question, but would defer to the faculty and consultants who developed these criteria as to what was intended.

Section 1032.4

For the sake of brevity, we will simply suggest that changes to the title and to subsection (a) be made here that are equivalent to those we have suggested for Section 1032.3 above, and for the same reason.

As with the previous section, we find some ambiguity here as to how many patients are to be included in the competency exam, and exactly which restorative procedures are required to be performed, and would defer to the developers of these criteria as to the intent. Specifically, subsection (b) states that the examinee shall document competency “to perform a Class II, Class III, and Class IV direct restoration...” (underline added for emphasis). However, the wording of (b)(2) appears to give the examinee the option to perform two Class II amalgam restorations, with a Class III/IV composite as an option for one of the restorations but not a requirement. This discrepancy may need to be clarified.

Section 1032.5

Here, we would only make the same comment and suggestions regarding the title and subsection (a) made for previous sections.

Section 1032.6

Here, we would again make the same comment and suggestions regarding the title and subsection (a) made for previous sections.

For each prosthetic option, the examination standards include a reference to follow-up care [i.e. “(5)(H) Evidence the examinee provided the patient post insertion care including adjustment, relines and patient counseling”]. Such open-ended references to follow-up/post insertion care leave it unclear how it will be determined when this competency examination has been completed and a final score can be issued. Does that need to be clarified in the regulations?

Section 1032.7

Here, we would again make the same comment and suggestions regarding the title and subsection (a) made for previous sections.

We have just one other technical comment. Subsection (b)(2) states that the endodontic competency exam will consist of "one (1) clinical case." However, the subsequent subsection (b)(3) uses the word "cases" twice. For the sake of clarity, the board may wish to change those to "case."

Section 1032.8

Here, we would only offer the same comment and suggestions regarding the title and subsection (a) made for previous sections.

Section 1032.9

Since this section is itself establishing the criteria for competency examiner qualifications, we suggest the following amendment to (a):

- (a) Portfolio competency examiners shall meet the following criteria established by the board:

Subsection (b) requires schools to submit to the Board the names and qualifications of the faculty members "to be approved or disapproved by the Board as portfolio competency examiners," and to certify that they meet the standards of the school and of these regulations. However, the regulations provide no criteria by which the board would "approve or disapprove" any individual examiner put forth by a school. If the dental school dean has certified the qualifications of the examiners, on what basis could the board disapprove them? Should board review of competency examiners be left to the periodic auditing process?

Subsection (c) appears redundant and could be deleted. Subsection (b) already requires the deans to certify that each examiner has met the requirements of (a)(3), which is the calibration requirement described again in (c).

Section 1032.10

We have a concern that subsection (d), as drafted, lacks clarity about the respective roles of the dental school and the Board in determining whether an examiner should be

disqualified due to problems in calibration. Because the Board is not envisioned to be involved in the day-to-day operations of this process, we believe their responsibility for making these determinations should lie in the periodic auditing process, and that the schools should maintain the ongoing responsibility to dismiss examiners. We suggest the following clarifying amendments:

- (c) Calibration of Examiners. The calibration of portfolio competency examiners shall be conducted to maintain common standards as an ongoing process. Portfolio competency examiners shall be provided feedback about their performance and how their scoring varies from their fellow examiners. Portfolio competency examiners whose error rate exceeds psychometrically accepted standards for reliability shall be re-calibrated. If at any time a school determines that a portfolio competency examiner is unable to be meet the board's re-calibration standards, the school shall disapprove remove the portfolio competency examiner from further participation in the portfolio examination process. In addition, the Board may through its auditing process require a school to remove an examiner based on findings that the examiner does not meet the Board's calibration standards.

Section 1034

Subsection (c) states: "An examinee shall be deemed to have passed the portfolio examination if his or her overall score is at least 75 in each of the portfolio competency examinations." Taken out of context, this could imply that this is the sole condition for being awarded a license via portfolio. We suggest the following clarifying amendments:

Along with the requirements of Section 1028, an examinee shall be deemed to have passed the portfolio examination eligible for licensure via portfolio only if his or her overall scaled score is at least 75 in each of the portfolio competency examinations.

Subsection (d) as drafted states: "The executive officer shall notify examinees who have passed or failed the portfolio examination." Given that the entire process for the board's review of portfolios and licensure applications is contained in Section 1028, this subsection is not needed and could cause confusion, especially since this section is about competency examinations. Under the portfolio process, the board really is not determining whether someone has "passed or failed" the examination; rather, its role is to determine whether the portfolio is complete as submitted by the school, and to issue a license once that determination has been made and all other requirements have been met.

Subsection (f) in its entirety appears to be redundant and unnecessary, since the scoring factors already are included in the sections for each competency examination.

Section 1035

This section as a whole appears to be a throwback to the days when the board was administering its own clinical examination, and thus it does not seem to fit comfortably within either the WREB or the portfolio process. In each of those cases, our assumption would be that appeals at least initially should be directed to the examining entity (WREB or the dental school) and not to the board. We do, nevertheless, believe that there should be built-in the ability for an applicant to make a secondary appeal to the board if he or she is dissatisfied with the due process received by the examining entity. Therefore, we suggest the following amendments:

- (a) An examinee who has failed an examination shall be provided with notice, upon written request to the examining body, of those areas in which he/she is deficient ~~in the clinical and restorative laboratory phases of such examination.~~
- (b) An unsuccessful examinee who has been informed of the areas of deficiency in his/her performance ~~on the clinical and restorative laboratory phases of the examination~~ and who has determined that one or more of the following errors was made during the course of his/her examination and grading may appeal to the ~~board~~ examining body within sixty (60) days following receipt of his/her examination results:
 - (1) Significant procedural error in the examination process;
 - (2) Evidence of adverse discrimination;
 - (3) Evidence of substantial disadvantage to the examinee

After completion of the examining body's appeal process, the examinee may submit an appeal to the Board within 30 days of the examining body's decision. Such appeal shall be made by means of a written letter specifying the grounds upon which the appeal is based. The board shall respond to the appeal in writing and may request a personal appearance by the examinee. The board shall thereafter take such action as it deems appropriate.

~~(c) This section shall not apply to the portfolio examination of an examinee's competence to enter the practice of dentistry.~~

Section 1036

Similar to the preceding section, by grafting language on to old regulatory language that

pertained more to the board's own clinical examination, and which now applies to the WREB exam, these amendments are somewhat confusing. For example, subsection (a) would appear to allow a portfolio licensure applicant to obtain remedial education at a dental school other than the one he/she is currently attending, which doesn't make much sense. In addition, the proposed amendments to subsection (b)(1) create similar ambiguity by adopting a portfolio-specific form (seemingly leaving no equivalent form for WREB examinees), but then implying that the form should be submitted to the Board (not to the school) prior to retaking a competency examination, which makes little sense given that the Board would otherwise not be involved with an individual portfolio examinee at that stage of the process. The Board may want to consider creating a separate remedial education section specific to the portfolio process.

Thank you again for the opportunity to comment on these proposed regulations, and we again extend our deep appreciation for the work that has gone into this historic endeavor thus far. We look forward to continuing to work with the board as you complete this process.

Sincerely,

A handwritten signature in cursive script that reads "Bill Lewis".

Bill Lewis
Manager, Regulatory Affairs

Ostrow School of Dentistry of USC

AVISHAI SADAN, D.M.D.

Dean

G. Donald and Marian James Montgomery
Professor of Dentistry

December 23, 2013

Sarah Wallace
Legislative & Regulatory Analyst
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815
Email: sarah.wallace@dca.ca.gov

VIA EMAIL

Dear Ms. Wallace:

Thank you for providing the documentation pertaining to the Information Digest/Policy Statement concerning the Dental Portfolio Examination requirements. Our faculty at the Ostrow School of Dentistry of USC have welcomed the opportunity to participate in the integration process of merging the portfolio evaluation of candidate competency within our clinical education program. We feel our students will be able to comply with the minimum required experiences as outlined in the documents provided. However, we may need additional time to provide a more detailed response in regards to a timeline for implementation and clinical faculty calibration with the portfolio criteria and standards.

If the Dental Board needs further information from the Ostrow School of Dentistry, please do not hesitate to contact me or Dr. Michael Mulvehill, Director of Student Licensure, at mulvehil@usc.edu or 213-740-2506.

Respectfully,



Avishai Sadan, D.M.D.

Dean

G. Donald and Marian James Montgomery
Professor of Dentistry

cc: Dr. Michael Mulvehill, Director of Student Licensure





The discipline of learning. The art of caring.

College of Dental Medicine

December 20, 2013

Dental Board of California
Department of Consumer Affairs
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

Re: Proposed Changes to Title 16 of the California Code of Regulations (Portfolio Examination for Initial Dental Licensure)

Thank you for the opportunity to review the proposed Portfolio Examination Requirements and Notice of Proposed Changes to implement AB1524 (Chapter 446, Statutes of 2010). It is obvious that much time and energy has been invested in developing the Portfolio Exam for initial dental licensure in California. We have anxiously awaited the compilation and synthesis of the activities of the various groups into the complete draft proposal for implementation. The faculty and student leadership of Western University of Health Sciences College of Dental Medicine (CDM) reviewed the proposed Requirements and Changes. Both leadership groups provided the feedback used to develop this letter.

The concerns and potential solutions are offered in the spirit of full support for the Portfolio. At the same time, we encourage the Board to carefully consider modification of the Portfolio Examination Requirements to address the concerns prior to implementation.

Statement of Support

WesternU CDM is highly supportive of the Portfolio Examination as one of the pathways to initial licensure in California.

WesternU College of Dental Medicine (CDM) believes the Portfolio Examination is a long overdue bold step forward in the initial licensure process. We are acutely aware that many other states and educational institutions are watching to see how the process unfolds in California. Hopefully the collective feedback from the six dental schools and other interested parties will lead to modifications that will produce a smooth initial implementation and successful administration of the Portfolio Examination.

Concerns

Impact to the Schools: The implementation costs and logistical complexity for the dental schools is underestimated.

The original intent was that the Portfolio process would fit within the curriculum and patient care processes of the schools. The estimated impact to the schools was envisioned to be “minor and

absorbable.” While we understand the original intent, it needs to be recognized that as the Portfolio has grown in complexity through the design process, it no longer meets that intent.

The Portfolio was anticipated to logistically include a set of uniform, collaboratively developed competency examinations that would be seamlessly integrated into each of the schools assessment systems. In order to achieve the collaborative buy-in of the six schools, it appears the rubrics are overly generalized and there is a lack of uniformity in the grading between the various competencies. The faculty who would serve as Portfolio competency examiners determined the Portfolio competencies would not function as a wholesale replacement for similar competencies that are integrated into our College’s clinical assessment systems. It appears we would either have to provide additional definition to the Portfolio rubrics and devise a conversion matrix for our grading system, or use the Portfolio competencies in parallel with ours. Either of those options would require a significant added investment of time and personnel to support two systems, the Portfolio competencies and our current assessment processes.

Each component of the Portfolio has an associated cost. The recordkeeping required for audits, inter-institutional calibration processes, separate tracking for numerical requirements and logistics of scheduling multiple faculty for competency examinations, collectively represents a significant cost. As designed, that cost would be fully borne by the school. In reality, the costs will accrue to the students of schools that choose to participate. These imbedded costs (versus the isolatable costs of a regional exam) would be amortized among all students in a school – even those taking other licensure exams.

A tangible example of how costs can quickly accumulate is readily seen by reviewing the *Impact on the Board* statement as outlined on page 7 of the *Notice*. The projected impact to the Board budget exceeds \$100,000 per year and includes both administrative and adjudication costs. It should be recognized that for each and every expense incurred by the Board, there is a parallel cost to the dental schools. We do not know about the other universities, but the projected costs for administration of the Portfolio Examination in the College of Dental Medicine are not minor and will be difficult to absorb without transfer to the students. Students and faculty alike are concerned that significant implementation costs would affect the tuition or fees.

Portability: The anticipated lack of portability to other states will detract from student participation.

In our increasingly mobile society, an examination that does not qualify for licensure in other states would deter student participation. In the contemporary dental practice environment, the recent graduate frequently finds that employment opportunities often cross state borders. It will be critical to investigate and communicate how the Portfolio Examination will be viewed by other states in their licensure decisions, both in initial licensure and when applying for licensure by credentials. Most students will likely choose a regional examination that offers the opportunity for licensure in a number of states rather than risk the geographic restriction to California.

As a private institution, a significant percentage of our students will seek licensure in other states – the investment of supporting two examination processes (both WREB and CA Portfolio) will have to be carefully weighed once the final procedures and processes are in place. If the lack of portability

drives the interest rate in students below a critical threshold, CDM would likely need to reluctantly not participate in the Portfolio option.

Liability Coverage for Faculty and Patients: There are two significant liability concerns related to the integrated format with Portfolio Competency Exams.

First, if the Portfolio competencies are used solely for licensure, on those dates and times when the dental school faculty are serving as Portfolio competency examiners, they are in essence acting on behalf of the Board rather than CDM. Under those circumstances, the faculty will be conducting the Portfolio competencies for the purposes of licensure in California, which is not and cannot be a graduation requirement for CDM. It is nearly inevitable that at some point a student will not pass the Portfolio competencies. When that occurs, it is also inevitable that the student will consider seeking legal recourse. Because the Portfolio competencies are not a component of the CDM curriculum required for graduation, WesternU's liability coverage for our faculty will not extend to the administration of the exam on behalf of the Board. If the Portfolio Examination is administered at Western University of Health Sciences as proposed, the Board would need to provide appropriate coverage for the actions of the faculty.

Second, a similar situation can be forecast on behalf of the patients who are involved in the competency examinations. On those dates and times, the patients are in essence being treated for the purposes of an examination process. If the patient encounters a substantive issue requiring correction or remediation, our University's liability carrier is likely to consider the event uncovered – again California licensure is not a graduation requirement for our students and, therefore, not a component of the curriculum. If the Portfolio Examination is administered at Western University of Health Sciences as designed, the Board (or students) would need to provide appropriate coverage for the relevant patient care processes.

Additionally, if the Portfolio Examination process extends beyond commencement, CDM would need to construct a specific mechanism to allow students to participate in the requisite competency exams, completion of requirements or remediation.

Numerical Requirements: The use of numerically based requirements is not in alignment with competency based outcomes measures.

The Commission on Dental Accreditation, as well as most contemporary assessment systems, have moved the educational processes to competency-based outcomes. The numerical requirements of the Portfolio process run counter to the design of the CDM dental education program and CODA Standards for accreditation. As a result of changing disease patterns, treatment procedures and demographics, it is likely that CDM would be challenged to provide all students with sufficient numbers of procedures in some areas (i.e., removable prosthodontics) on a consistent basis to meet the numerical requirements outlined as well as our competencies.

Reaching specific targeted numbers of requirements could put the students and CDM in untenable positions. CDM would need to either preferentially direct patient care experiences selectively to CA Portfolio participants to meet the numerical requirements or deny students the opportunity to participate in the Portfolio licensure pathway. The use of specific numbers of procedures has served

December 20, 2013

as an ethical pitfall for decades – students “make” patient care fit the requirements in order to achieve a goal. We would encourage the Board to revisit this component of the Portfolio process.

Potential Solutions

Allow the Use of Existing Systems: Consider an option that would allow the schools to request the Board review existing competency examinations and processes as equivalent alternatives to the Portfolio competencies and requirements.

The Board may want to consider providing schools with the option of using the existing competency-based assessments conducted by the individual schools. This would potentially solve several key concerns. The schools that want to exercise this option could submit a copy of their competency assessment rubrics, grading scale and faculty calibration plan for the identified Portfolio competencies. The Board would then review the submission to assure that it was equivalent to the Portfolio competencies. All students who completed the Board approved plan of competencies and other requirements for licensure would be considered for licensure.

Developing this option would allow schools to use their existing assessment systems and outcomes reporting processes which already support the CODA Standards for accreditation, college outcome assessment plans and institutional learning objectives. Using existing systems and processes in lieu of the proposed competencies and requirements would help the Portfolio Examination meet the intent of “minor and absorbable” impact. The liability concerns would also evaporate through the utilization of existing graduation requirements.

The same option process should be considered for the requirements. Schools with existing requirements processes could modify them to equate to the Portfolio requirements. Those schools that have a competency-based curriculum could submit their overarching competency assessment process for review by the Board for approval in lieu of submitting numerical requirements.

Summary

In closing, it is important to re-iterate that Western University of Health Sciences College of Dental Medicine is supportive of the implementation of the Portfolio Examination for initial dental licensure in California. The College encourages addressing the concerns outlined prior to the implementation of the proposed examination.

If there are any questions regarding our feedback, please do not hesitate to contact my office. Also, please let us know if there are ways we can be of further assistance in the implementation process.

Sincerely,



Steven W. Friedrichsen, DDS
Professor and Dean



MINUTES OF PUBLIC HEARING

January 6, 2014

2005 Evergreen Street, Hearing Room
Sacramento, CA 95815

Proposal to Amend Sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1032.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036; Adopt Sections 1032.7, 1032.8, 1032.9, 1032.10; and, Repeals Sections 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1039 of Title 16 of the California Code of Regulations Relating to Portfolio Examination Requirements

Staff Present:

Karen Fischer, Executive Officer
Sarah Wallace, Legislative and Regulatory Analyst
Dawn Dill, Licensing and Examination Unit Manager
Jessica Olney, Licensing Program Analyst
Ada Colangelo, Licensing Program Analyst

The hearing was called to order at approximately 10:00 a.m. Sarah Wallace, Legislative and Regulatory Analyst, read the opening statement explaining the hearing process and opened the hearing for testimony.

Sharon Golightly, representing the California Dental Hygiene Association, stated that there was concern that the examination did not include testing of a dentist's skills and competency relating to the administration of local anesthesia and nitrous oxide. Ms. Golightly commented that this concern stemmed from the fact that the use of local anesthesia and nitrous oxide has led to citations and deaths occurring during dental treatment. Ms. Golightly noted that the administration of local anesthesia and nitrous oxide was included as components of the proposed competency examinations, but felt that they should be tested as a separate competency stand-alone competency examination. She stated that this is a competency that sees a lot of lawsuits, especially in the field of pedodontics, as children may easily be overdosed. She commented that it should be examined in an educational institution.

Ms. Golightly explained that the Western Regional Examination Board (WREB) Examination for hygiene candidates has a separate examination to test a candidate's competence in the application of local anesthesia and that she felt there should be the same standard in the practice of dentistry to provide public protection as it is an area where she felt the skills and competency are inadequate.

The hearing was left open for twenty minutes in the event additional members of the public appeared to provide testimony. No additional public appeared. The hearing was adjourned at 10:25 a.m.

Byers, Linda@DCA

From: secundus [oddlots@cox.net]
Sent: Friday, November 08, 2013 12:55 PM
To: Wallace, Sarah@DCA; Thornburg, Jennifer@DCA
Cc: Wallace, Sarah@DCA; senator.wyland@sen.ca.gov
Subject: Re: Dental Board of California Proposed Rulemaking

Dear Ms. Wallace and Ms. Thornburg;
I offer the following comments regards the hearing listed in the email received by me.

In this PDF:
http://www.dbc.ca.gov/formspubs/1021_isr.pdf

the phrase 'established standards of care' is used and yet NOWHERE can a consumer find out what such standards are.
Given my experience where a dentist's business manager falsely claimed that a procedure was REQUIRED by such 'standards of care', IF there actually is such a document specifying such 'standards of care' for the common dental practices associated with cleaning, repair, and restoration, that document SHOULD be in the public domain for consumers to reference.

In this PDF:
http://www.dbc.ca.gov/formspubs/1018_05plang.pdf

posted on the Board's website: <http://www.dbc.ca.gov/lawsregs/index.shtml>

and dated 3 years ago and referring to "Consumer Protection Enforcement Initiative, California Code of Regulations, Title 16, Sections 1018.05 and 1020"

I see nothing in such rules and regulations that hold a dentist accountable for the behaviour of employees though such accountability exists in law. Dentists MUST be made aware of their responsibilities regards their employees behaviour. And the Board's Consumer Affairs division would seem to have that responsibility.

Bruce Sims
Escondido, CA 92027

----- Dental Board of California <sarah.wallace@DCA.CA.GOV> wrote:
> The Dental Board of California added to its Web site today the Notice of Public Hearing, Proposed Language and Incorporated Forms, and the Initial Statement of Reasons for its Portfolio Examination Requirements proposed rulemaking.
>
> Please click on this link to view the Notice of Public Hearing:
> http://www.dbc.ca.gov/formspubs/1021_notice.pdf
>
> Please click on this link to view the Proposed Language and Incorporated Forms:
> http://www.dbc.ca.gov/formspubs/1021_proposed.pdf
>
> Please click on this link to view the Initial Statement of Reasons:
> http://www.dbc.ca.gov/formspubs/1021_isr.pdf
>
> Please visit our website for a complete listing of the Dental Board of California's Proposed Regulations:
> <http://www.dbc.ca.gov/lawsregs/index.shtml>
>



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 8(B): Discussion and Possible Action Regarding Adoption of Proposed Amendment of §§ 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036, Addition of §§ 1032.7, 1032.8, 1032.9, 1032.10, and Repeal of §§ 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements

Background:

Following the Board's consideration of comments received during the required 45-day public comment period and at the January 6, 2014 regulatory hearing, the Board may hold discussion and take action to adopt the proposed amendments to sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036, proposed addition of sections 1032.7, 1032.8, 1032.9, 1032.10, and the proposed repeal of sections 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements

Action Requested:

Depending on the Board's response to the comments received, staff requests the Board take one of the following actions:

- A. If the Board rejects the comments received, and wishes to adopt the proposed text as the final text, then the Board would:

Adopt the final text as noticed and direct staff to take all steps necessary to complete the rulemaking process, including filing the final rulemaking package with the Office of Administrative Law and authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendments to sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033,

1033.1, 1034, 1034.1, 1035, and 1036, adopt the proposed addition of sections 1032.7, 1032.8, 1032.9, 1032.10, and adopt the proposed repeal of sections 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements

- B. If the Board accepts any comments received or modifies the text to include the staff's recommended changes, then the Board would:

Modify the text in response to the comments and recommendations received and direct staff to take all steps necessary to complete the rulemaking process, including preparing the modified text for a 15-day public comment period, which includes the amendments accepted by the Board at this meeting. If after the 15-day public comment period, no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendments to sections 1021, 1028, 1030, 1031, 1032, 1032.1, 1032.2, 1032.3, 1032.4, 1302.5, 1032.6, 1033, 1033.1, 1034, 1034.1, 1035, and 1036, adopt the proposed addition of sections 1032.7, 1032.8, 1032.9, 1032.10, and adopt the proposed repeal of sections 1035.1, 1035.2, 1036.1, 1036.2, 1036.3, 1037, 1038, and 1038 of Title 16 of the California Code of Regulations Relating to the Portfolio Examination Requirements as noticed in the modified text.

If the Board votes to accept the comments received or modifies the text to include recommended changes, staff will notice the modified text for 15-day public comment on March 3rd. The 15-day comment period would then end at close of business on Tuesday, March 18th. Staff recommends the Board hold a special teleconference meeting, if needed, to respond to any adverse comments that may be received during the modified text public comment period to expedite the adoption of these regulations.

If no adverse comments are received after the 15-day public comment period, there will be no need for the Board to hold a special teleconference meeting, since the Board would have adopted the modified text as the final text at the February Board meeting. Board staff would then prepare the final rulemaking documents and submit the package for the necessary approvals.



MEMORANDUM

DATE	February 18, 2014
TO	Dental Board Members
FROM	Sarah Wallace, Legislative & Regulatory Analyst
SUBJECT	Agenda Item 9: Discussion and Possible Action Regarding a Special Teleconference Meeting in April to Consider Any Adverse Comments Received Regarding the Board's Modified Text Relative to the Portfolio Examination Requirements

Background:

If the Board accepts the staff recommendations and votes to modify the text for the Portfolio Examination Requirements rulemaking in Agenda Item 8, staff will be prepared to notice the modified text for a 15-day public comment period on March 3, 2014. The modified text would be posted on the Board's web site and mailed to those parties who commented on the initial proposed text. The public comment period would begin on March 4th and would end on March 18th.

In the event the Board receives adverse comments in response to the modified text, staff recommends the Board hold a special teleconference meeting to respond to the comments to expedite the adoption of these regulations. If no adverse comments are received after the 15-day public comment period, there will be no need for the Board to hold a special teleconference meeting, since the Board would have already adopted the modified text as the final text at this Board meeting. Board staff would then prepare the final rulemaking documents.

Action Requested:

Staff requests the Board consider scheduling a tentative special teleconference for Wednesday, April 9, 2014 at 12:00 p.m. to respond to any adverse comments that may be received in response to the modified text. In the event the Board does not receive any adverse comments, the special teleconference will be cancelled. Confirmation or cancellation of the meeting would be sent to the Board members by March 19, 2014.

RECESS