STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

DENTAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1550, Sacramento, CA 95815
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DENTAL BOARD OF CALIFORNIA MEETING AGENDA
MAY 16-17, 2018

Hyatt Regency Orange County
11999 Harbor Boulevard, Pacific Room
Garden Grove, CA 92840
(844) 219-9515 (Hotel) or (916) 263-2300 (Board Office)

Members of the Board:

Thomas Stewart, DDS, President
Fran Burton, MSW, Public Member, Vice President
Yvette Chappell-Ingram, Public Member, Secretary

Steven Chan, DDS
Ross Lai, DDS
Lilia Larin, DDS
Huong Le, DDS, MA
Meredith McKenzie, Public Member
Abigail Medina, Public Member
Steven Morrow, DDS, MS
Rosalinda Olague, RDA
Joanne Pacheco, RDH, MA
James Yu, DDS
Bruce Whitcher, DDS

During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items, unless listed as informational only. 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 an item not be completed, it may be carried over and heard beginning at 9:00 a.m. on the following day. Anyone wishing to be present when the Board takes action on any item on this agenda must be prepared to attend the two-day meeting in its entirety.

Public comments will be taken on agenda items at the time the specific item is raised. 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, 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 or technical difficulties that may arise. To view the Webcast, please visit https://thedcapage.wordpress.com/webcasts/.

Thursday, May 17, 2018

8:00 A.M. FULL BOARD MEETING – OPEN SESSION

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

16. Ethics Training Presentation by Michael Santiago, Dental Board Legal Counsel

17. Executive Officer's Report
    A. Staffing Update – Vacancies and New Hires
    B. Update Substance Abuse Coordination Committee in Response to SB 796 - Review Uniform Standard #4 Relating to Frequency of Test
    C. DCA Licensing/Enforcement Performance Measures Workgroups
    D. Diversion Program Contract Update
    E. Establishment of a Dental Public Health Training and Technical Assistance Center
    F. BreEZE Maintenance Contract Update
    G. Update regarding the American Association of Dental Board (AADB) Meeting
    H. Sexual Harassment Prevention Training (SHPT) Compliance Update
    I. Update on University DeLaSalle Dental School Graduates

18. Report of Dental Hygiene Committee of California (DHCC) Activities

19. Report of Department of Consumer Affairs (DCA) Staffing and Activities

20. Discussion and Possible Action Regarding Renewal of Board's Approval of the University of DeLaSalle Bajio School of Dentistry

21. Substance Use Awareness
    A. Diversion Program Report and Statistics

    B. Update Regarding Controlled Substance Utilization Review and Evaluation System (CURES 2.0) Registration

    C. Update Regarding the February 27, 2018, Statewide Opioid Safety Workgroup Meeting

    D. Discussion and Possible Action Regarding Senate Bill 1109 (Bates) - Controlled Substances: Schedule II Drugs: Opioids

22. Dental Board of California Sunset Review Report 2018
    A. Review of Issues Identified During 2015 Legislative Oversight Hearing

    B. Discussion and Possible Action Regarding New Issues for 2019 Legislative Oversight Hearing
        i. Licensure by Credential

ii. Licensure by Residency
iii. Licensure by WREB
iv. New License to Replace Cancelled License
v. Certification of Proof of Graduation for Dental Education – Dean or Dean Delegate Signature Authority

23. Enforcement
A. Review of Enforcement Statistics and Trends

B. Review of Fiscal Year 2017-2018 First/Second/Third Quarters Performance Measures from the Department of Consumer Affairs

24. Licensing, Certifications, and Permits Committee Report on Closed Session
The Board may take action on recommendations regarding applications for issuance of new license(s) to replace cancelled license(s) and whether or not to grant, deny, or request further evaluation for a Conscious Sedation Permit as it relates to an onsite inspection and evaluation failure.

25. Public Comment on 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)).

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

27. Adjournment

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MEMORANDUM

DATE	April 30, 2018
TO	Members of the Dental Board of California
FROM	Jeri Westerfeld, Executive Assistant Dental Board of California
SUBJECT	**Agenda Item 16:** Ethics Training Presentation by Michael Santiago, Dental Board Legal Counsel

Background:
Michael Santiago, Dental Board Legal Counsel, will provide an ethics training presentation to the Board.

Action Requested:
No action requested.

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MEMORANDUM

DATE	May 4, 2018
TO	Members of the Dental Board of California
FROM	Karen Fischer, Executive Officer Dental Board of California
SUBJECT	**Agenda Item 17:** Executive Officer's Report

A. Staffing Update – Vacancies and New Hires as of May 1, 2018

OPERATIONS DIVISION
Executive Office ~ currently fully staffed

New Request (pending): Attorney III (2 year Limited Term Blanket Position) submitted for review and determination.

Administration Unit ~ currently fully staffed

Licensing & Examination Unit ~ currently fully staffed
Recently hired:
Staff Services Analyst (SSA) – Perm/FT effective 02/12/18
Program Technician II (PT II) – Perm/FT effective 05/01/18

Dental Assisting Program ~ 1 vacancy
Staff Services Manager I (SSM I) – 2-year Limited Term/FT; previous limited term appointment was terminated with the Board with separation date of 04/02/18 and recruitment has been initiated.

ENFORCEMENT DIVISION
Executive Office ~ currently fully staffed

Complaint & Compliance Unit ~ 1 vacancy
Staff Services Analyst (SSA) – Perm/FT; previous incumbent was rejected on probation with separation date of 03/30/18; recruitment has been initiated and applications are currently being screened.

Discipline Coordination Unit ~ currently fully staffed

Investigative Analysis Unit ~ currently fully staffed

Sacramento Field Office ~ 1 vacancy
Inspector I (INSP I) – Perm/FT; previous incumbent accepted a promotion with another Department with separation date of 04/30/18 and recruitment will be initiated soon.

Orange Field Office ~ 1 vacancy
Investigator (INV) – Perm/FT; previous incumbent separated as of 08/07/16 and recruitment has been initiated and conducted with a candidate in backgrounds.
Recently hired:
Special Investigator (SP INV) – Perm/FT; incumbent invoked return rights effective 02/14/18

Total number of hires/separations since February 1, 2018:
Hires – 3
Separations – 3

B. Update on Substance Abuse Coordination Committee in Response to SB 796 (Hill), Chapter 600, Statutes of 2017 – Review Uniform Standard #4 Relating to Frequency of Testing

Effective January 1, 2018, BPC Section 315 requires the Department of Consumer Affairs (DCA) to re-establish its Substance Abuse Coordination Committee comprised of executive officers of the healing arts boards for the purpose of reviewing the existing criteria for those standards governing all aspects of required (drug and alcohol) testing to determine whether the existing criteria should be updated to reflect recent developments in testing research and technology (Uniform Standard #4). This review is required to be complete by January 1, 2019.

Background: The DCA Substance Abuse Coordination Committee was established in 2009 in accordance with SB 1441; and was comprised of executive officers of the DCA healing arts boards, the executive officers of the Chiropractic Examiners and Osteopathic Medical Boards, a designee of the State Department of Alcohol and Drug Programs and was chaired by the Director of DCA. The charge of the Committee was to establish Uniform Standards for 16 specific areas related to monitoring substance-abusing diversion participants and probationers. While the standards were being established in 2009, much time was spent discussing Uniform Standard #4 which required biological drug testing be performed 104 times a year for every probationer or diversion participant, regardless of the circumstances. The standard was later revised to allow for extenuating circumstances to be considered when determining the number of required tests.

The Board adopted the Uniform Standards through regulations in 2014. The Board's Diversion program, administered by MAXIMUS utilizes all 16 standards for diversion participants. In addition, the Uniform Standards are considered by the Executive Officer in the stipulated settlement process for probation.

The first meeting of the re-established Substance Abuse Coordination Committee was held April 23, 2018. I will be actively participating in additional meetings which will be scheduled in the months ahead.

C. **DCA Licensing /Enforcement Performance Measures Workgroups**

Chris Castrillo, Deputy Director of Board and Bureau Services called a meeting of the Executive Officers on April 10th to discuss the Department of Consumer Affairs' (DCAs) formation of Licensing and Enforcement Workgroups. The goals of the workgroups will be to identify best practices and high priority areas for improvement and potential standardization of enforcement and licensing processes across boards and bureaus within DCA; and to utilize the knowledge base from Board and Bureau enforcement and licensing staff (in addition to Executive Officer's and Chief's) to develop process improvement plans. The workgroups will meet the 2nd Monday of each month and will alternate between enforcement and licensing.

D. **Diversion Program Contract Update**

California allows health care licensing boards to establish diversion programs under the auspices of the Department of Consumer Affairs (DCA) for those licensed health care professionals whose competency may be impaired due to substance abuse and/or mental illness. (Note: some boards do not include mental illness as a condition of impairment for purposes of the Diversion Program.)

MAXIMUS has operated DCA's diversion program statewide since 2003 and provides services to eight healthcare licensing boards. These eight boards include the Board of Registered Nursing, Board of Pharmacy, Dental Board, Physical Therapy Board, Physician Assistant Board, Osteopathic Medical Board, Veterinary Medical Board, Dental Hygiene Committee.

The California Diversion Program focuses on three primary mandates:

- Protect patients from being treated by impaired health care workers (protect the public).
- Create an alternative or adjunct to traditional disciplinary actions whereby health care professionals are more likely to seek help and others are more likely to identify and intervene when they suspect other health professionals needs help.
- Address the growing shortage of health care professionals in all areas by helping them to fully rehabilitate and return to their vital roles.

The DCA Diversion Program is a voluntary program that offers comprehensive referral and monitoring services to health care professionals who are impaired by substance abuse and mental illness. This is not a treatment program. Rather this is an intensive, high-touch case management and monitoring program that achieves a five-year relapse rate of just 13%. It is delivered over two phases:

- **Recovery:** Participants are removed from their roles, given a clinical assessment, and are required to fulfill a treatment plan under the oversight of case managers, who are registered nurses. During the recovery phase, participants must follow a rigorous recovery plan and demonstrate at least two

years of negative drug tests and full compliance with program requirements before they may petition their respective board to enter the transition phase.

- **Transition:** This is a period during which participants are allowed to gradually transition back to independence under a reduced level of monitoring, supervision and random drug tests. The transition phase lasts at least one year and is designed to ease participants into accepting full responsibility for their recovery.

The DCA contract is set to expire soon, so the Diversion Program Managers will be meeting to assist in the development of the Request for Proposals that will go out for bid. I will be reporting back on the progress of the new contract.

E. Establishment of a Dental Public Health Training and Technical Assistance Center

The Board recently received notification from the California Dental Director that the University of California, San Francisco (UCSF) and California Department of Public Health's Oral Health Program have established a Dental Public Health Training and Technical Assistant Center (Center) to assist Local Health Jurisdictions (LHJs) in meeting the goals outlined in the California Oral Health Plan 2018-2028. The Center's objective is to develop useful resources, provide tailored assistance, and disseminate best practices. UCSF will be focusing on five main content areas: (1) community oral health improvement plan, (2) public health services that promote local oral health programs, (3) school based or school linked dental disease prevention programs, (4) engagement of dental professionals in tobacco cessation, and (5) community water fluoridation.

F. BreEZe Maintenance Contract Update

Accenture is the vendor with whom the DCA entered into a contract to deliver maintenance and operations of the BreEZe system. Accenture utilized a Commercial Off the Shelf (COTS) program and modified it to address program needs. The contract ends April 2020 and during the next two years Accenture staff will be scaled down – ultimately leaving DCA staff to "service" the system. The DCA Office of Information Services (OIS) leadership is looking for opportunities to provide more output despite the decreasing Accenture resources over the next several years. The emphasis for the Accenture staff will be modifications to COTS and a potential software update.

Accenture's current maintenance contract provides an avenue to ask for changes to the core COTS product. After the contract ends, absent any new contract, there will not be an opportunity for core COTS product changes. OIS called a meeting of executive officers to begin discussing how to move forward with the operation and maintenance of the BreEZe system after the Accenture contract ends. Additional meetings are being scheduled.

G. Update Regarding the American Association of Dental Boards (AADB) Meeting

Dr. Bruce Whitcher attended the meeting and will give a verbal report.

H. Sexual Harassment Prevention Training (SHPT) Compliance Update

Sexual Harassment Prevention training is mandatory for rank and file employees, temporary employees (retired annuitants, proctors, seasonal employees, and student assistants), managers, supervisors, and board and commission members biennially. 2017 was a mandatory compliance year and the Department of Consumer Affairs (DCA) reported an 82% compliance rate. I am please to announce that the Dental Board is considered a Superstar by DCA because we had 100% compliance. Thanks to all board members for completing the training. A reminder to new board members that this training needs to be completed within six months of your appointment date.

I. Update on University De La Salle, Bajio School of Dentistry Graduates

In November 2017, stakeholder groups submitted questions regarding how many dental students from the University De La Salle (University) have been licensed in California and where are they practicing; and asked that the response be put on a future agenda. Since the Board approved the University in 2002, it has received 267 applications from University graduates; of that number 257 licenses have been issued. Ten applicants were not approved by the Board due deficiencies such as failure to provide a Social Security Number or Individual Taxpayer Identification Number. If deficiencies are not fulfilled within on one year of the initial filing, the application period expires and re-application is required.

In response to the question of where these licensees are practicing, please refer to the chart below which was compiled based on the Board's address of record for each licensee. There is no way of knowing whether the address of record is a home or business address, or whether the address is in an underserved area.

Number of Licensed University Graduates	Location
5	Canada: Alberta, Bumaby, Mississauga, Ontario, Toronto
230	California by county: Alameda **(4)**, Butte **(2)**, Colusa **(1)**, Contra Costa **(7)**, Fresno **(16)**, Imperial **(2),** Kern **(1)**, Kings **(2)**, Los Angeles **(47)**, Madera **(1)**, Monterey **(2)**, Merced **(1)**, Orange County **(23)**, Placer **(4)**, Riverside **(10)**, Sacramento **(10)**, San Bernardino **(21)**, San Diego **(27)**, San Francisco **(6)**, San Joaquin **(6)**, San Luis Obispo **(1)**, San Mateo **(1)**, Santa Barbara **(1)**, Santa Clara **(10)**, Santa Cruz **(1)**, Shasta **(4)**, Solano **(2)**, Sonoma **(2),** Stanislaus **(6)**, Tulare **(3),** Ventura **(3)**
4	Florida: Doral, Port St. Lucie, Wellington, and West Palm Beach
3	Georgia: Atlanta, Cumming, and Roswell
1	Iowa: Sioux City
2	Illinois: Chicago and Shaumburg
2	Michigan: Canton
1	North Carolina: Pineville
1	Nevada: Sparks
3	New York: Brooklyn, Elmhurst, Jamaica
2	Ohio: Columbus and Dublin
2	Texas: Dallas and Sugarland
1	Washington: Kent

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MEMORANDUM

DATE	April 19, 2018
TO	Members of the Dental Board of California
FROM	Jeri Westerfeld, Executive Assistant Dental Board of California
SUBJECT	**Agenda Item 18:** Report of Dental Hygiene Committee of California (DHCC) Activities

Background:
Anthony Lum, Executive Officer of the Dental Hygiene Committee of California, will provide a verbal report.

Action Requested:
None

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MEMORANDUM

DATE	April 19, 2018
TO	Members of the Dental Board of California
FROM	Jeri Westerfeld, Executive Assistant Dental Board of California
SUBJECT	**Agenda Item 19:** Report of Department of Consumer Affairs (DCA) Staffing and Activities

Background:
Patrick Le, Assistant Deputy Director of the Office of Board and Bureau Services within the Department of Consumer Affairs, will provide a verbal report.

Action Requested:
No Board action requested.

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MEMORANDUM

DATE	April 26, 2018
TO	Members of the Dental Board of California
FROM	Zachary Raske, Budget Analyst Dental Board of California
SUBJECT	**Agenda Item 20:** Discussion and Possible Action Regarding Renewal of the Dental Board of California's Approval of the University De La Salle Bajio, Dental School

Background

The Dental Board of California (Board) has the authority under Business & Professions Code Section 1636.4 to conduct evaluations of foreign dental schools and to approve those dental schools that provide an education equivalent to that of accredited institutions in the United States; and adequately prepare their students for the practice of dentistry. To date, the University of De La Salle Bajio, Dental School (University) is the only fully approved foreign dental school by the Board.

In accordance with Business and Professions Code Section 1636.4 (g), each fully approved institution is required to submit a renewal application every seven years. If a school fails to submit a renewal application, the Board's approval will automatically expire.

Update on the University De La Salle Bajio School Dentistry Application

The Board received the University's self study renewal documentation the first week of February 2018. This documentation was forwarded to subcommittee members Drs. Le and Morrow for individual review, and on April 16, 2018, the subcommittee members met in Sacramento with the Executive Officer Karen Fischer, to discuss their findings. The subcommittee noted the documentation was well organized; however, the members determined additional documents will need to be requested.

On April 25, 2018, a letter was mailed to Dr. Jorge Triana Estrada, Dean of the University's dental school, requesting additional documentation related to the University's self study renewal application. A copy of the correspondence is included in the board meeting packet.

Action Requested:

None at this time.

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April 25, 2018

DELIVERED BY EMAIL

Dr. Jorge Triana Estrada
Dean of the Dental School
Universidad De La Salle Bajio

RE: Application for Dental Board of California Re-Approval – Additional Documentation Requested

Dear Dr. Triana Estrada:

The Dental Board of California (Board) has received your application for renewal of Board approved status for the Universidad De La Salle Bajio, Dental School (University). The documentation received was very well organized, thorough, and easy to follow. This information was forwarded to a two- member subcommittee of the Board, to review for compliance with the institutional standards outlined in California Code of Regulations Section 1024.1. At this time, the subcommittee requests additional information.

Educational Standard (c)(6) requires the University to develop and maintain an ongoing process for collection and evaluation of data to support that its graduates are, in fact, competent in the clinical competencies identified in Educational Standard (c)(6) (A-N). The evaluation forms for 19 competencies were submitted in the renewal documentation. However, there was no data provided to support how the evaluation of competency was implemented. Please provide the following data:

- Conduct a random sample of 10% for each graduating class in 2016 and 2017, and provide the evaluation forms for each of the 19 competencies you have identified. For example, if your graduating class is 100 students in 2016, you would provide the evaluation forms for each of the 19 competencies for 10 students, randomly selected from the graduating class of 2016 and the same for the graduating class of 2017.

Additionally, we received information relating to Educational Standard (c)(9) that indicates that the institution has a system of ongoing curriculum review and evaluation, including a curriculum management plan that assures evaluation of all courses relative to competency objectives, elimination of outdated, unnecessary material, and incorporation of emergency information. In Supporting Document #3, the Curriculum Design Manual indicates that it is reviewed and updated every three to five years. However, the cover page references 2007 in the bottom right corner as the most recent update.

- Notify the Board if the Manual has been updated, and if so, provide a copy of the update.

In summary, the Board is requesting additional documentation relating to the two points identified in this letter. Please feel free to submit your response via email at your earliest convenience.

We continue to wish you success in your CODA review process. If you have any questions about the request for additional documentation, please contact me at (916) 263-2188 or Karen.Fischer@dca.ca.gov.

Sincerely,

Karen M. Fischer

Karen M. Fischer, MPA
Executive Officer

cc: Missy Johnson
Dental Board Subcommittee Members

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MEMORANDUM

DATE	April 27, 2018
TO	Members of the Dental Board of California
FROM	Chrystal Williams, Diversion Program Manager Dental Board of California
SUBJECT	**Agenda Item 21A:** Diversion Program Report and Statistics

The Diversion Evaluation Committee (DEC) program statistics for quarter ending March 31, 2018, 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.

Intake Referrals	**January**	**February**	**March**
Self-Referral	0	0	0
Enforcement Referral	0	0	0
Probation Referral	0	0	1
Closed Cases	0	0	0
Active Participants	13	13	14

The Board is currently recruiting for a public member position on the Northern DEC; two dental position on the Southern DEC; one physician/psychologist position on the Southern DEC; and dental auxiliary positions on both the Northern and Southern DEC.

The next DEC meeting is scheduled on July 11, 2018, in Southern California.

ACTION REQUESTED:
No action requested.

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MEMORANDUM

DATE	April 19, 2018
TO	Members of the Dental Board of California
FROM	Ryan Blonien, Supervising Investigator Dental Board of California
SUBJECT	**Agenda Item 21B: Update regarding CURES 2.0 Registration and Usage Statistics. Information Only.**

Background:

The Controlled Substance Utilization Review and Evaluation System (CURES 2.0) is a database of Schedule II, III, and IV controlled substance and prescriptions dispensed in California. The goal of the CURES 2.0 system is the reduction of prescription drug abuse and diversion without affecting the legitimate medical practice or patient care.

Prescribers were required to submit an application before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later. Registration requirements are not based on dispensing, prescribing, or administering activities but, rather, on possession of a Drug Enforcement Administration Controlled Substance Registration Certificate and valid California licensure as a Dentist, or other prescribing medical provider. The Dental Board of California currently has 34,015 active licensed dentists. The Drug Enforcement Administration has 24,633 California dentists licensed to prescribe.

Current Status:

The CURES registration statistics for the Dental Board of California are:

July 2017 7882 Registered DDS /DMD
October 2017 8064 Registered DDS/DMD
January 2018 8370 Registered DDS/DMD
April 2018 9662 Registered DDS/DMD

CURES usage from October 2017 to December 31, 2017

3943 Dentists have created Patient Activity Reports in the time frame. Patient Activity Report (PAR) Checked a patient's prescription history.

Senate Bill 482:

Senate Bill 482 established that a health care practitioner who fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

Current Status:

Pursuant to Section 11165.4 (e) of the Health and Safety Code, the Department of Justice certifies that, as of April 2, 2018, the CURES database is ready for statewide use and that the Department of Justice has adequate staff, user support, and education. Mandatory CURES consultation becomes effective on **October 2, 2018.**

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MEMORANDUM

DATE	April 20, 2018
TO	Members of the Dental Board of California
FROM	Alexander Bourdaniotis, Enforcement Manager Dental Board of California
SUBJECT	**Agenda Item 21C:** Statewide Opioid Safety Workgroup Meeting

Background:

The following information is Meeting Minutes from the February 27, 2018, Statewide Opioid Safety Workgroup Meeting.

1. Welcome and Introduction
2. Grant/Project Updates
3. Policy Framework
4. Infectious Diseases & Opioid Connections
5. Partner Announcements

The Naloxone Grant Program is a program where county health departments receive Narcan, which counteracts the life-threatening effects of opioid overdose.

- To date, 58 of 61 local health departments (LHDs) have accepted the offer of a grant to receive Narcan
- Of these, 20 have opted to receive additional Narcan in lieu of administrative cost
- It is anticipated that nearly all the Narcan will be distributed to LHDs by June 30, 2018
- According to Distribution Plans submitted to date, approximately:
  - 22 syringe exchange programs will receive 13,180 doses
  - 62 substance abuse disorder treatment services will receive 11,719 doses
  - 17 homeless programs will receive 2,505 doses
  - 57 law enforcement agencies will receive 12,730 doses
  - 5 jails will receive 260 doses

The Department of Healthcare Services (DHCS) administers the California Medication Assisted Treatment Expansion Project. On April 21, 2017, the Department of Health and Human Services (HHS) announced funding through the 21st Century Cures Act to address the national opioid crisis. California will receive $90 million over a period of two years (May 2017 through May 2019) to implement the California Medication Assisted Treatment (MAT) Expansion Project.

The MAT Expansion Project aims to serve over 20,000 individuals with Opioid Use Disorders (OUD), prevent drug overdoses, and treat OUD as a chronic disease. The project focuses on populations with limited MAT access, including rural areas.

The CDPH conducted research to determine the connection between Opioids and Infectious Diseases.

California (2015)

- 14.3% of high school students reported ever using Rx drugs without a prescription.

CDPH found an increased rate of 74.2% of newly reported Chronic Hepatitis C cases in persons ages 15-29 in California, 2011-2015. Hepatitis C related deaths are increasing, exceeding HIV deaths.

President Trump's budget request for fiscal year 2019 includes $40 million to combat the nationwide opioid crisis. The United States in experiencing an epidemic of viral hepatitis and HIV outbreaks across the nation, fueled by the opioid crisis. Partner agencies have committed to remain vigilant about prevention, testing, and treatment so that blood borne infections do not gain ground.

The next Statewide Opioid Safety Workgroup meeting is scheduled for May 31, 2018.

Action Requested:

No action requested, informational only.

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MEMORANDUM

DATE	May 4, 2018
TO	Members of the Dental Board of California
FROM	Allison Viramontes, Legislative and Regulatory Analyst Dental Board of California
SUBJECT	**Agenda Item 21D:** Discussion and Possible Action Regarding Senate Bill 1109 (Bates) - Controlled Substances: Schedule II Drugs: Opioids

BILL NUMBER: Senate Bill 1109

AUTHOR: Bates

SPONSOR: The Office of the San Diego County District Attorney

VERSION: Amended 05/02/2018

INTRODUCED: 02/13/2018

BILL STATUS: 05/02/2018 – Read second time and amended. Re-referred to Senate Appropriations Committee.

BILL LOCATION: Senate

SUBJECT: Controlled Substances: Schedule II Drugs: Opioids

RELATED BILLS: AB 1998, AB 2486, AB 2487, AB 2741, AB 2760, AB 2471

Background:

The numbers of those in the United States thought to have some kind of substance disorder are staggering. Data from the Center for Disease Control (CDC) and the National Institute on Drug Abuse (NIDA) indicate there is a greater addiction to prescription pain relievers containing some opioids than addiction to heroin. The numbers of persons who have died from overdoes of prescription painkillers is extraordinarily high in the United States and is high in California as well.

The CDC has determined that overdose deaths involving prescription opioids have quadrupled since 1999 and of those who died between 1999 and 2015, more than 183,000 people died from prescriptions containing methadone, oxycodone and hydrocodone. Schedule II drugs can be narcotic or non-narcotic. Those Schedule II

drugs containing controlled substances may include morphine, methadone, Ritalin, Demerol, Dilaudid, Percocet, Percodan and Oxycontin. NIDA reports that the largest group of users of prescription pain relievers are those between the ages of 18 and 25. In that group, death from opioid overdoses from prescriptions were higher than those from heroin and cocaine combined. According to the Journal of the American Dental Association, dentists wrote 6.4% of all opioid prescriptions in the United States in 2012. Within the population of those privately insured for the dental needs in the U.S., , the number of opioid prescriptions per 1,000 dental patients increased from the year 2010 to 2015, especially for those between 11 and 18 years of age. While these numbers are not California specific, it does begin to show the importance of focusing on prescribing.

SB 1109 addresses the addiction, misuse and overdose of prescription opioids as a public health crisis by putting some educational tools in place for patients, parents, minors and prescribers to assist them in making decisions regarding prescriptions. It codifies the Medical Board of California's Guidelines for Prescribing Controlled Substances for Pain and sets guidelines for various practice acts in the Business and Professions Code (B&PC) for healing arts boards within the Department of Consumer Affairs and requires prescribers to take continuing education courses on the risks of addiction associated with Schedule II controlled substances and sets other requirements related to practice within these boards. Only those requirements within the Dental Practice Act will be discussed and will be subject of possible action.

Analysis:

The Dental Practice Act authorizes the board, as a condition of license renewal, to require licentiates to successfully complete a portion of required continuing education (CE) hours in specific areas, including patient care, health and safety, and law and ethics. Currently, dentists must complete at least 50 hours of approved CE and dental auxiliaries must complete at least 25 units of approved CE units as a requirement of license renewal every two years. This bill would amend B&PC, Section 1645 and the board may, as a condition of license renewal, require licentiates to successfully complete a portion of the required continuing education hours in the areas above and will add the risks of addiction associated with the use of Schedule II drugs. The mandatory coursework, adopted in regulations and prescribed by the board shall not exceed fifteen hours per renewal period for dentists, and seven and one-half hours per renewal period for dental auxiliaries. For retired dentists providing only uncompensated care, the board shall not require more than 60 percent of the hours of continuing education required of other licensed dentists.

The board is to report on the outcome in its next regular sunset review process. Health and Safety Code (H&SC), beginning in Section 11150 sets forth who may prescribe and prohibits any other person from writing a prescription for a controlled substance. Section 11158.1 is added to the H&SC and requires a prescriber to discuss all of the following with the minor, the minor's parent or guardian, or another adult authorized to consent to the minor's medical treatment before dispensing or issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid:

1. The risks of addiction and overdose associated with use of opioids.

2. The increased risk of addiction to an opioid to an individual who is suffering from both mental and substance abuse disorders.
3. The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant.
4. Any other information required by law.

The board would have to adopt regulations regarding the mandatory coursework for dentists, dental auxiliaries and retired dentists providing only uncompensated care. Additionally, because failure to have a discussion with the minor, minor's parent of guardian, or another adult authorized to consent to the minor's medical treatment before dispensing or issuing a first prescription in a single course of treatment would constitute professional conduct and disciplinary action, regulations would be necessary. The board does not anticipate any significant fiscal impact in order to meet these requirements for regulatory action.

REGISTERED SUPPORT/OPPOSITION

Support
Office of the San Diego County District Attorney (sponsor)
California District Attorneys Association
McKesson Corporation

Oppose
California Medical Association
California Pharmacists Association

Action Requested:

The Board may choose to take one of the following actions regarding this bill:

Support
Support if Amended
Oppose
Watch
Neutral
No Action

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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MEMORANDUM

DATE	May 4, 2018
TO	Members of the Dental Board of California
FROM	Karen Fischer Executive Officer
SUBJECT	**Agenda Item 22A:** Dental Board of California Sunset Review Report 2018 Review of Issues Identified During 2015 Legislative Oversight Hearing

The Board will discuss the following document relating to the Oversight Committees recommendations during the prior sunset review conducted in 2014-15; and the Board's updated response to those recommendations.

Following is an update on what action the Dental Board took in response to the recommendations or findings made under the prior sunset review conducted in 2014-15.

ADMINISTRATIVE ISSUES

ISSUE #1: AUTHORITY TO COLLECT EMAIL ADDRESSES. ***Should the Board be authorized to collect and disseminate information through email addresses?***

Background: In order to improve the Board's ability to communicate with licensees, the Board will be pursuing statutory authority to allow it to require email addresses on its applications and renewal forms. Web-based communications will also reduce postage costs and provide a cost savings to the Board.

Staff Recommendation: ***The Board should advise the Committees of any statutory changes necessary to enable the Board to collect email addresses and to use email as a way to communicate with licensees and applicants.***

DBC Response: Statutory language to enable the Board to collect email addresses was submitted to the Committee and it was included in AB 179 (Chapter 510, Statutes of 2015). Business & Professions Code Section 1650.1 authorizes the Board to collect email addresses for applicants and licensees.

ISSUE #2: DENTAL ASSISTING COUNCIL (COUNCIL). ***Should the Board examine ways to increase the availability of examinations? What is the Board's relationship with the Council, and how can the Council become more effective?***

Background: SB 540 (Chapter 385, Statutes of 2011) created the Council to consider all matters relating to dental assistants. The Council is composed of seven members, including the RDA member of the Board, another member of the Board, and five RDAs who represent a broad range of dental assisting experience and education. Two of the five RDA members are required to be employed as faculty members of a registered Board-approved dental assisting educational program, one must be licensed as an RDAEF, and one must be employed clinically in private dental practice or public safety net or dental health care clinics, and must be actively licensed. The Board makes all council appointments. No council appointee shall have served previously on the dental assisting forum or have any financial interest in any registered dental assistant school. Council members serve for a term of four years, and there are no term limits. Any resulting recommendations regarding scope of practice, settings, and supervision levels are made to the Board for consideration and possible further action.

The California Association of Dental Assisting Teachers, the California Dental Assistants Association, and the Foundation for Allied Dental Education, CADAT's foundation, have raised issues relating to dental assistants, the Council, and the Board, and believe that the Council is not effectively representing the interests of the dental assisting community. Among other things, the associations assert there are not enough RDA examinations or examination sites available. According to the 2015 examination schedule, the practical examination will be offered nine times this year, with 18 possible testing dates, primarily alternating between testing sites in San Francisco and Pomona, and one scheduled test in Santa Maria. The associations also believe that the Board acted without sufficient public discussion when it recalibrated the practical examination and instituted changes relating to application processing criteria. While the Board has not changed examination criteria or any grading

criteria, the Board recently instituted a new calibration process, and pass rates declined following the change. The associations also believe the Board should exercise more regulatory oversight and prevent delays associated with program approvals and regulation development, and that the Board should rely more heavily on national dental assisting standards. Lastly, the associations assert that the Board does not adequately respond to stakeholder concerns, and that Council appointees do not accurately reflect or represent the dental assistants.

Staff Recommendation: ***The Board should explain to the Committees why it recalibrated the RDA examination, and the decline in pass rates after the practical examination was recalibrated. The Board should inform the Committees about whether it has addressed, or is in the process of addressing, any of these concerns or requests, and explain any delays relating to program approvals and regulation development. The Board should explore ways to improve its relationships with stakeholders, and to empower the Council to better serve its role in vetting and making recommendations on dental assisting issues. The Committees should consider whether it would be appropriate to transfer council appointment authority from the Board to the DCA or to the Governor's Office and the Legislature, and whether term limits should be instituted.***

DBC Response: The Board is responsible for administration of the registered dental assistant (RDA) written and practical examinations. While the written examination is computer based and offered throughout the state in multiple testing facilities through an outside vendor, board staff continued to administer the practical examination until it was suspended in 2017.

Prior to 2009, when the practical examination was administered by Committee on Dental Auxillaries (COMDA), examiners were calibrated by a dentist. However, when the program came under the Dental Board in July, 2009 the procedure changed and examiners, who themselves were RDAs, were calibrating themselves. There is no documentation as to why this procedure was changed. During 2014, Board staff observed anomalies within the grading procedure and asked that a dentist come in to calibrate the examiners. Neither the examination nor the grading criteria had changed. However, since the calibration had been conducted by a dentist rather than the RDAs, the candidate pass rate declined.

In response to the fluctuating pass rates, the Board and Dental Assisting Council (DAC) determined that an occupational analysis (OA) of the RDA profession must be conducted. In March 2015, the Office of Professional Examination Services (OPES) initiated the OA of the RDA profession at the request of the Board. Business and Professions Code (BPC) Section 139 requires that the boards and bureaus of the Department of Consumer Affairs (DCA) conduct an occupational analysis for each license classification every five to seven years. The previous OA for the RDA profession was conducted in 2010.

One purpose of the OA is to develop a description of current practice in terms of the actual job tasks that entry-level licensees must be able to perform safely and competently. The results of occupational analysis research projects are also used to ensure that the content of written, practical, and law and ethics licensing examinations reflect knowledge and skills that are critical for public protection.

While the OA was being conducted, Assembly Bill (AB)179 was passed, requiring that OPES "conduct a review to determine whether a practical examination is necessary to demonstrate competency of registered dental assistants, and if so, how this examination should be developed and administered." OPES conducted this review in conjunction with the OA. It wasn't until 2017 that OPES observed the calibration and administration of the RDA practical examination and determined that the Board should immediately suspended the practical examination until January 1, 2020 or until the Board determines an

alternative way to measure competency.

In addition to examinations, the Board is responsible for the review and approval of dental assisting educational programs and course applications. The Board receives approximately forty applications for approval from dental assisting programs and courses per year. With the transfer of responsibility for dental assisting in 2009, the board inherited a backlog of unprocessed applications for programs and courses, making it necessary for staff to direct its efforts at bringing approvals up to date. This was accomplished, and educational program and course approvals are now processed within 90 days provided there are no application deficiencies.

The Board continues to work closely with the DAC and stakeholders on the development of dental assisting educational regulations. Regulatory workshops were held during 2016 and 2017 where DAC members, stakeholders, and staff developed a working draft of proposed dental assisting educational program and course requirements that will be forwarded to the full Board for consideration.

The Board remains committed to working with the DAC and stakeholders in a supportive and collaborative manner to explore ways to improve its relationships with these groups. The Board does not believe it is necessary to transfer council appointment authority from the board to the DCA or to the Governor's Office and the Legislature. Statute already exists to limit council appointments to two full four years terms as outlined in BPC Section 1742(g).

ISSUE 3: DELAYED IMPLEMENTATION OF THE BREEZE CONTRACT. ***How does this impact the Board?***

Background: The "BreEZe Project" was designed to provide the DCA boards, bureaus, and committees with a new enterprise-wide enforcement and licensing system. The updated BreEZe system was engineered to replace the existing outdated legacy systems and multiple "work around" systems with an integrated solution based on updated technology. According to the DCA, BreEZe is intended to provide applicant tracking, licensing, renewals, enforcement, monitoring, cashiering, and data management capabilities. In addition, BreEZe is web-enabled and designed to allow licensees to complete and submit applications, renewals, and the necessary fees through the internet when fully operational. The public also will be able to file complaints, access complaint status, and check licensee information, when the program is fully operational.

According to the original project plan, BreEZe was to be implemented in three releases. The budget change proposal that initially funded BreEZe indicated the first release was scheduled for FY 2012–13, and the final release was projected to be complete in FY 2013–14. In October 2013, after a one-year implementation delay, the first ten regulatory entities were transitioned to the BreEZe system. The Board is part of Release Two, which is scheduled to go live in March 2016, three years past the initial planned release date.

The total costs of the BreEZe project are funded by regulatory entities' special funds, and the amount each regulatory entity pays is based on the total number of licenses it processes in proportion to the total number of licenses that all regulatory entities process. To date, the Board has spent approximately $265,918 between FY 09/10 and 13/14 on pro rata and other costs to prepare for the

BreEZe system transition, and is expected to spend $285,183 for FY 14/15, $541,457 for FY 15/16, and $573,193 for FY 16/17. The Dental Assisting Fund, which is also part of Release 2, has spent $199,697 on pro rata and other costs to prepare for BreEZe between FY 09/10 and FY 13/14, and is expected to spend $207,860 in FY 15/16, $401,161 in FY 215/16, and $425,365 in FY 16/17.

Some of these costs include staff costs. For example, the Board has assigned one staff services manager full time as the single point of contact for the Board's BreEZe business integration. In addition, staff has been designated as subject matter leads in different program areas, and several retired annuitants have been maintained in anticipation of the forthcoming resource demands while the system is tested, data migration is validated, and training of full time staff is conducted.

According to the Board, there are several challenges it is anticipating before successful implementation. One challenge includes the ability to schedule practical examinations for RDAs at various times and locations, because the existing off-the-shelf product that BreEZe was developed from did not contain this functionality. Another challenge is the inspection module functionality, which will be used to track the Board's inspection cases separate from its enforcement cases. Release 1 Boards chose not to use this feature, so the Board will be one of the first boards to use this module. Lastly, the Board notes that Release 2 will have an activity tracking component to track investigator time (and costs) as originally intended. In addition to these BreEZe-specific concerns, the Board noted in its report that it had existing issues with its legacy system that BreEZe was intended to solve, such as the ability to generate reports and the ability for multiple staff to have access to enforcement screens. The Board also notes that while it is in compliance with BPC § 114.5, which requires Boards to track and identify veterans, it is currently tracking this data internally while the BreEZe computer system is being developed.

Another issue of concern based on BreEZe's delayed implementation is the Board's absence of an investigative activity reporting (IAR) system. After the Board's last sunset review, it utilized the IAR, which was owned and supported by the Medical Board of California (MBC), to track the Board's cases. However, the MBC has been integrated into BreEZe and they are no longer using the IAR. In addition, the Board notes that the IAR was discontinued last spring when the Board upgraded its computers because the new operating system would not support the IAR format. As a result, investigators at the Board are manually tracking casework and supervisors are conducting regular desk audits to ensure the timeliness of casework.

Staff Recommendation: ***The Board should update the Committees on whether any of the above-mentioned concerns have been or will be addressed in Release 2. The Board should inform the Committees of any difficulties in remaining on its legacy systems, and whether any additional stop-gap technological measures are needed until BreEZe is implemented, especially in light of the loss of the IAR system and its current practice of manually tracking casework. The Board should inform the Committees of how BreEZe expenditures have affected its funds, and whether the Board will need to generate additional revenue to support BreEZe expenditures going forward.***

DBC Response: The Board went "live" on the BreEZe system on January 19, 2016. The challenges identified in the background from the prior sunset report relating to BreEZe were addressed prior to implementation. Board staff worked closely with the vendor to design a module that gave the Board the ability to schedule RDA practical examinations at various times and locations, as well as issue the results of the examination; to track inspections separate from enforcement cases; to track and identify veterans; to generate various reports; and to have the ability for multiple staff to have access to enforcement

screens.

The challenge remaining is the time tracking module that was not available in Release l. The module was intended to track investigator time and costs associated with an investigation. The module has not been utilized by other boards, however, Dental Board staff is working with DCA to develop the module to be able to track board specific items such as travel time, report writing, interviews, etc. Currently board staff tracks this information manually.

During the prior sunset review period, the increased spending associated with the implementation of BreEZe and ongoing maintenance was a stress on the Board's budget. The Board has made the appropriate adjustments and has increased licensing fees in order accommodate this expense.

ISSUE #4: PRO RATA. ***What is the impact of pro rata on the Board's functioning?***

Background: Through its various divisions, DCA provides centralized administrative services to all boards and bureaus. Most of these services are funded through a pro rata calculation that is based on "position counts" and charged to each board or bureau for services provided by personnel, including budget, contract, legislative analysis, cashiering, training, legal, information technology, and complaint mediation. DCA reports that it calculates the pro rata share based on position allocation, licensing and enforcement record counts, call center volume, complaints and correspondence, interagency agreement, and other distributions. In 2014, DCA provided information to the Assembly Business, Professions and Consumer Protection Committee, in which the Director of DCA reported that "the majority of [DCA's] costs are paid for by the programs based upon their specific usage of these services." DCA does not break out the cost of their individual services (cashiering, facility management, call center volume, etc.).

Over the past four years, the Dental Fund has spent roughly an average of 11% of its expenditures on DCA pro rata, while the Dental Assisting Fund has spent roughly 18%. The Board receives the following services from DCA for its pro rata: accounting, budget, contracts, executive assistance, information technology, investigation, legal affairs, legislative and regulatory review, personnel, and public affairs. While it appears DCA provides assistance to the Board, it is unclear how the rates are charged and if any of those services could be handled by the Board instead of DCA for a cost savings.

Staff Recommendation: ***The Board should advise the Committees about the basis upon which pro rata is calculated, and the methodology for determining what services to utilize from DCA. In addition, the Board should discuss whether it could achieve cost savings by providing some of these services in-house. The Board should inform the Committees of why the Dental Assisting Fund's pro rata costs are higher than the Dentistry Fund's pro rata costs.***

DBC Response: The Department's pro rata costs are allocated to each board and bureau based on authorized position counts, licensing and enforcement transactions, various IT related cost centers, and prior year workload volumes; there are no pro rata costs that are allocated based on a board or bureau's budget. The differences between the dental fund and dental assisting fund pro rata can be attributed, in some part, to the services used by each entity. For example, the dental assisting fund has an interagency agreement with the Office of Professional Examination Services, which is included in its pro rata budget, but the Dental Board does not.

In terms of achieving savings by providing services in house, the Board's management team has been

participating in DCA pro rata workshops to determine what services, if any, could be eliminated. The Board is also looking in to hiring its own attorney.

BUDGET AND STAFFING ISSUES

ISSUE #5: DENTAL FUND CONDITION. ***Is the Board adequately funded to cover its administrative, licensing, and enforcement costs; to continue to improve its enforcement program; and to ensure it is fully staffed?***

Background: The Dentistry Fund is maintained by the Board and includes the revenues and expenditures related to licensing for dentists. For sixteen years, the license fee for dentists was set at $365. In 2013, for the first time in 16 years, the Board increased its license fee for dentists from $365 to its statutory cap at the time of $450. These regulations went into effect on July 1, 2014. During that time, the Board also pursued an increase in statute from $450 to $525. SB 1416 (Block, Chapter 73, Statutes of 2014) raised the Board's fee for initial and renewal licenses for dentists from $450 to $525, and set fees at that level. During that time, an analysis conducted by the DCA's Budget Office determined that the license fees should be raised to $525 to ensure solvency into the foreseeable future. While fees increased have generated additional revenue, the Board expenditures, projected to be over $12M per year, continue to outpace its revenue, projected to be less than $11M per year, thus perpetuating a structural imbalance.

Part of the reason for the increase in projected and actual expenditures in recent years has been due to funding 12.5 CPEI positions; funding the diversion program; increased expenses associated with BreEZe; unexpected litigation expenses; and the general increase in the cost of doing business over the past 16 years. While the Board has expended less than what it has been authorized by the budget due to some cost savings and reimbursements, the Board emphasizes that its fund should be able to sustain expenditures without relying on estimated savings or reimbursements.

Based on data from the past five fiscal years, the Board calculated that the Dentistry Fund will be able to sustain expenditures into FY 2017/18 before facing a deficit. According to budget information presented at its February 2015, Board meeting, the Board projects it will only have 0.5 months in reserve in FY 2016/17. The Board is currently undergoing a fee rate audit to determine the appropriate fee amounts to assess and to project fee levels into the future. The fee audit will also take into account the funds necessary to establish a reserve of four to six months for economic uncertainties and unanticipated expenses, such as legislative mandates and the DCA costs. In addition, while the Dental Assisting Program has its own staff for Licensing and Examination, paid for by its fund, the rest of the functions relating to dental assisting, such as administration and enforcement, are performed by Board staff and paid for by the Dentistry Fund. As a result, the fee audit will examine the appropriate fees and costs for the Dental Assisting Fund, which currently does not pay the Dentistry Fund for any costs associated with administration or enforcement and has a very large reserve. After the results of the fee audit come out, the Board anticipates requesting an increase in the statutory fee caps, so that going forward, the Board may raise fees incrementally and within the cap, as necessary, to ensure a healthy budget. The fee audit will be available shortly.

Staff Recommendation: The Board should share the fee audit with the Committees as soon as that information is available to determine the appropriate fee caps for licensees. The Board should

consider whether it is feasible or preferable to merge the Dentistry and Dental Assisting, and to share all staff and costs. If the Board determines that funds should remain separate, the Board should ensure that the Dental Assisting Fund reimburses the Dentistry Fund for any costs incurred.

DBC Response: The final report on the Board's fee audit is available on the Board's website at http://www.dbc.ca.gov/formspubs/fear2015.pdf. The auditor made several recommendations which the Board implemented such as updating fees regularly and incrementally, and conducting a fee analysis every four to five years. This fee audit assisted the Board in determining the appropriate maximum fee ceilings that were amended through AB 179 (Chapter 510, Statutes of 2015) and became effective January 1, 2016. Since the Board raises fees through the regulatory process, raising the fee ceilings in statute gave the Board authority to move forward with promulgating regulations for appropriate fee increases when necessary in the future.

Board staff researched the feasibility of merging the dental and dental assisting funds and consulted with the Department of Consumer Affairs' Budget Office. Staff determined that the merging of the two funds will streamline certain processes. The combining of the two separate funds and two separate appropriations into one, will create efficiencies in budgeting and accounting processes in the long term and would make any budgeting issues simpler to understand. There would be a significant amount of work involved in making the switch, including requiring statutory amendments. However, the DCA Budget Office opined that the long-term benefits of merging the two funds outweigh the short-term concerns and increased workload.

At the May 2017 meeting, the Board voted to support the merging of the State Dentistry Fund and the State Dental Assisting Fund and directed staff to continue to research and identify the process by which the two funds may be merged; and to include a request to merge the funds as part of the Board's Sunset Review Report which will be developed in 2018.

LICENSING ISSUES

ISSUE #6: FOREIGN DENTAL SCHOOL APPROVAL. ***Is the process for approving foreign dental school sufficient? Should the Board consider heavier reliance on accrediting organizations for foreign school approvals if those options become available?***

Background: Since 1998, the Board has authority, under BPC § 1636.4, to conduct evaluations of foreign dental schools and to approve those who provide an education equivalent to that of accredited institutions in the United States and adequately prepare their students for the practice of dentistry. At present, the Dental Board has approved only one international dental school, De La Salle School of Dentistry, located in Leon, Guanajuato, Mexico.

In developing standards and procedures to be utilized in the evaluation and approval process of foreign dental schools, the Board has relied significantly on CODA standards. However, the Board has not updated its regulations to reflect changes that have been made to CODA standards over the years since the inception of this legislation. As a result, the Board may be assessing new programs using old standards. It is important to note the language under BPC § 1636.4 appears broad enough to reflect
any updates, for example, by stating that foreign schools should be "equivalent to that of similar

accredited institutions in the United States and adequately prepares its students for the practice of dentistry." To date, CODA has not approved any international dental schools, although it does recognize dental schools approved by the Commission on Dental Accreditation of Canada. However, CODA offers fee-based consultation and accreditation services to established international dental education programs. International programs seeking accreditation undergo a preliminary review and consultation process, after which they may be recommended to pursue accreditation through CODA. CODA has adopted the policy that international programs must be evaluated by, and comply with, the same standard as all US programs.

The Board is authorized to contract with outside consultants or a national professional organization to survey and evaluate foreign schools. The Board is required to establish a technical advisory group (TAG) to review and comment upon the survey and evaluation of the foreign dental school. The TAG is selected by the Board and consists of four dentists, two of whom shall be selected from a list of five recognized United States dental educators recommended by the foreign school seeking approval. None of the members of the TAG may be affiliated with the school seeking certification. After a complete application is sent, the Board has 60 days to approve or disapprove the application, and grants provisional approval if the school is substantially in compliance with dental school regulations. Unless otherwise agreed to, the Board appoints a site team to make a comprehensive, qualitative onsite review of the institution within six months receipt of a complete application. The school is required to pay all reasonable costs incurred by the Board staff and the site team relating to site inspection. The site team prepares and submits a report to the TAG, which will review the report and make a recommendation to the Board.

In October of 2014, the *Public Institution State University of Medicine and Pharmacy, "Nicolae Testemitanu," of the Republic of Moldova*, represented by Senator (ret.) Richard Polanco, submitted an application and the required fee for approval. This school's dental program would only serve students from the United States. This school is not CODA-approved, and has not applied for accreditation from any other state. At its November Board meeting, the Board appointed a subcommittee to review the application, and has since determined the application was not complete and provided guidance on how to improve the application. At the Board's February Board meeting, it appointed two of the school's candidates and two of its Board Members to the TAG. The Board is continuing to follow the process outlined in the statute and regulations relating to this approval.

Staff Recommendation: ***The Board should keep the Committees informed of any concerns relating to foreign school approvals. The Board should update its school approval standards, which were based on CODA standards in effect at the time, to reflect current CODA standards. The Board should inform the Committees of any advancements made by CODA with regards to foreign school approvals. If CODA, which is the national and soon-to-be international accrediting body for dental schools, is stepping into the realm of foreign dental school approvals, the Board may consider whether it should be involved in approving foreign dental schools, or whether it could rely on accrediting bodies like CODA to approve such schools.***

DBC Response: The Board is responsible for the approval of international dental schools based upon standards established pursuant to BPC Section 1636.4(d). The process for application, evaluations, and approval of international dental schools is outlined in BPC 1636.4 and Title 16, CCR 1024.3-1024.12. As mentioned in the background report, the institutional standards upon which the Board evaluates foreign dental schools were initially established based upon the Commission on Dental Accreditation (CODA) standards, used for dental schools located within the United States. At that time CODA did not have a program to evaluate international dental schools. While throughout the years CODA has

continued to review and revise its standards, the Board has not kept pace with these changes by updating its regulations to reflect current CODA standards in order to evaluate foreign dental schools. During the August 2016 meeting, the Board voted to move forward with updating the institutional standards via the regulation process.

Advancements have been made at CODA with regard to international dental school accreditation. Since 2007, CODA has had a rigorous and comprehensive international accreditation program for predoctoral dental education. Prior to applying for accreditation by the Commission, the international predoctoral dental education program must undergo consultative review by the Joint Advisory Committee on International Accreditation (JACIA). The JACIA is a joint advisory committee made up of CODA Commissioners and ADA members; its activities are separate from the Commission but supported by CODA staff and volunteers. Information about the JACIA process can be found at: http://www.ada.org/en/coda/accreditation/international-accreditation/

In essence, the JACIA process requires the following steps (details of each activity are outlined in the PDF Guidelines on the website):

1. International predoctoral dental education program submits a Preliminary Accreditation Consultation Visit Survey (PACV-Survey). The PACV-Survey is reviewed by JACIA and if a consultative visit is warranted, the program is allowed to move to step 2.
2. Observation of a CODA predoctoral site visit and individual consultation with CODA staff and site visitor. Costs incurred are at the international program's expense.
3. International dental education program completes the Preliminary Accreditation Consultation Visit Self-Study (PACV-Self-Study) and consultation visit. This is a comprehensive, fee-based site visit (PACV-Site Visit) with programmatic consultation by CODA site visitors.
4. Application for CODA accreditation. The JACIA reviews the findings and recommendations of the PACV-Site Visit and determines whether the program has potential to be successful in the Commission's accreditation process. If the preliminary determinations are favorable, the program may seek CODA accreditation.

Currently there are a number of international dental schools utilizing the CODA consultative services. However to date, no international dental school has achieved accreditation from CODA.

Upon the recommendation of legislative staff, the Board agrees that approval of foreign dental schools is best achieved by organizations such as CODA.

EXAMINATION ISSUES

ISSUE #7: OCCUPATIONAL ANALYSIS (OA) FOR RDAs AND RDAEFs. ***Should the Board conduct an OA for RDAs and RDAEFs?***

Background: At the time of the Board's last sunset review, pass rates for the RDA written examination were 53%. Since then, the Board reports that it implemented a new RDA written examination, which resulted in a pass rate that fluctuates between 62-70% depending on the candidate pool. The average pass rate for all RDA written examinees was 66% in 2012, 62.7% in 2013, and 64% in 2014. The pass rates for the RDA Practical Exam averaged roughly 83% over the past four fiscal years. However, in 2014, pass rates dropped dramatically. In August of 2014, only 47% of 498 examinees in Northern California passed, while only 24% of 486 examinees in Southern California passed. In addition, the pass rate for the RDAEF Practical Exam has shown a major decrease from 83% in FY 10/11 to just over 56% in FY 13/14. The sharp declines in pass rates occurred after the practical examinations were recalibrated, as discussed in Issue #2 above.

In FY 10/11, there was only one approved program that administered the RDAEF Practical Exam. Since that time, three additional schools have been added. Historically, retake pass rates (0% - 52%) are lower than for first time candidates. All the RDA and RDAEF schools are required to maintain the same curriculum as provided in 16 CCR Sections 1070 to 1071. The Board is authorized to determine if and when a re-evaluation is needed. Currently, the Board is looking at the need for an occupational analysis (OA) of RDA and RDAEF programs in order to validate both practical exams. The last OA for both examinations was conducted in 2009.

BPC § 139 specifies that the Legislature finds and declares that OA and examination validation studies are fundamental components of licensure programs and the DCA is responsible for the development of a policy regarding examination development and validation, and occupational analysis. Licensure examinations with substantial validity evidence are essential in preventing unqualified individuals from obtaining a professional license. To that end, licensure examinations must be developed following an examination outline that is based on a current occupational analysis; regularly evaluated; updated when tasks performed or prerequisite knowledge in a profession or on a job change, or to prevent overexposure of test questions; and reported annually to the Legislature. According to the Department's policy, an occupational analysis and examination outline should be updated at least every five years to be considered current.

At the November 2014 Board meeting, staff reported during a joint meeting of the Council and the Board's Examination Committee (Committee) that an occupational analysis may be necessary in the near future. The Council and the Committee discussed concerns relating to the RDA practical examination and the fact that the pass rate has decreased over the last year, and staff recommended that an OA of the RDA and RDAEF professions may be appropriate, especially since the Board has not had an opportunity to conduct a complete OA for the RDA and RDAEF since their licensing programs were brought under the umbrella of the Board in 2009. Such an OA is projected to be $60,000 and could take up to a year to complete. Board staff notes that the cost would be absorbable by the Dental Assisting budget.

Staff Recommendation: ***The Board should undertake the OA for the RDA and RDAEF examinations, and consider whether a practical examination is the most effective way to***

demonstrate minimal competency for those licensees. The Board should continue to monitor examination passage rates, and pursue any legislative changes necessary to reflect current practices as determined by the OA.

DBC Response: The Board determined that an occupational analysis (OA) of the RDA profession, including Registered Dental Assistants in Extended Functions (RDAEFs) must be conducted to determine how minimum competence may be best evaluated and to address concerns regarding the pass/fail rates of the currently administered RDA practical examination. An interagency agreement was made with the Department of Consumer Affairs' Office of Professional Examination Services (OPES) to conduct the OA for both registered dental assistant and registered dental assistant in extended functions. The OA for the RDA was completed in April 2016. The OA for the RDAEF was completed in January 2018. Currently the Board is starting the OA of the dental profession.

Upon completion of the OA for RDAs, OPES conducted a comprehensive review of the Practical Examination. The review was conducted with the following goals: (1) to evaluate the psychometric properties of the examination (e.g., reliability, test security, standardization) in response to ongoing concerns from the Board and industry stakeholders; (2) to determine the necessity and accuracy of the examination in response to Assembly Bill (AB) 179 (2015); and, (3) to evaluate the content validity of the RDA Practical Examination in relation to the 2016 RDA Occupational Analysis (OA) results.

OPES evaluated the practical examination with regard to reliability of measurement, examiner training and scoring, test administration, test security, and fairness. Specifically, OPES identified that the inconsistencies in different test site conditions, deficiencies in scoring criteria, poor calibration of examiners, and the lack of a clear definition of minimum acceptable competence indicated that the practical examination does not meet critical psychometric standards.

OPES recommended the Board immediately suspend the administration of the practical examination. OPES believed there was a relatively low risk of harm to the public from the suspension of the examination because of the other measures in place, i.e., passing a written examination and the fact that RDAs are required to be under general or direct supervision by a licensed dentist.

Based on OPES' experience, correcting the problems to bring the examination into compliance with technical and professional standards would have required a great deal of time, staffing and fiscal resources from the Board and the industry. Therefore, OPES recommended that the Board initiate a process to thoroughly evaluate options other than a practical examination for ensuring the competency of RDAs to perform the clinical procedures identified as a necessary component of RDA licensure.

On April 6, 2017, the Board voted to suspend the RDA practical examination as a result of the findings of the review of the practical examination conducted OPES until July 1, 2017, and directed staff to pursue legislation to amend Business and Professions Code (BPC) section 1752.1, subdivision (j), for the purpose of allowing the Board to keep the administration of the examination suspended until as such time as the Board and OPES identify options. The suspension of the RDA practical examination commenced on April 7, 2017 and remained suspended until July 1, 2017.

Since BPC Section 1752.1 reinstated the RDA practical examination requirement as of July 1, 2017, and the Board had deemed the examination to not accurately measure the competency of RDAs and could no longer administer the RDA practical examination in its current form, the Board sought urgency

legislation to extend the dates of the suspension of the examination so the Board would have adequate time to identify reasonable alternatives to measure competency and not unnecessarily create a barrier to RDA licensure in California. This urgency legislation was carried by Assembly Member Low (AB 1707) (Chapter 174, Statutes of 2017), was signed by the Governor and became effective August 7, 2017. The legislation continues the suspension of the RDA practical examination from July 1, 2017 until January 1, 2020, at which time a practical examination or an alternative means of measuring competency will be implemented.

ISSUE #8: ACCEPTANCE OF ADDITIONAL REGIONAL EXAMINATIONS. ***Should the Board consider accepting the results of the American Board of Dental Examiners, Inc. (ADEX) examination?***

Background: In August of 2014, the Senate Business, Professions and Economic Development Committee (Committee) was contacted by Mercury, a company representing the North East Regional Board of Examiners (NERB), now known as the Commission on Dental Competency Assessments (CDCA). The CDCA inquired if the Committee would consider legislation to accept the ADEX results as a pathway to licensure in California, similar to WREB, the regional examination the Board currently accepts. On August 22, 2014, AB 2750 was amended to allow applicants to satisfy examination requirements by taking an examination administered by the former-NERB or an examination developed by the American Board of Dental Examiners, Inc. (ADEX). The Committee recommended Mercury contact the Board to discuss the request for future consideration. Additionally, the Committee suggested that the Board review the issue of accepting the NERB examination results and other regional board examinations as a pathway to licensure in California during the upcoming Sunset Review process. AB 2750 was held in the Senate Rules Committee.

ADEX is a non-profit corporation comprised of state boards of dentistry focused on the development of uniform national dental and dental hygiene clinical licensure examination for sole use by state boards to assess competency. ADEX does not administer any examinations. ADEX is administered by the regional testing agencies, including CDCA (formerly NERB), the Southern Regional Testing Agency, and the Coalition of Independent Testing Agency. The content validity of the ADEX examination is based on a national independent occupational analysis (OA) completed in 2011. Currently the ADEX examination is accepted in 43 US states, 3 US territories, and Jamaica.

In accordance with BPC § 139, the Board would need to conduct examination validation studies and an occupational analysis to assess the feasibility of accepting the additional examination pathway. Any decision to accept an additional pathway will require legislative changes to the Dental Practice Act. At its November 2014 Board meeting, the Examination Committee discussed this issue, and the Board appointed a subcommittee of two Board Members~~,~~ to work with staff in researching the feasibility of accepting other regional examinations.

Staff Recommendation: ***The Board should keep the Legislature informed about the feasibility of accepting this examination, and the extent to which accepting the ADEX examination might affect licensure in the state. The Board should consult with other stakeholders, including professional associations and California-approved dental schools to understand and prepare for any consequences relating to a new examination. The Board should inform the Legislature of the cost to validate this examination, and whether accepting another examination as a path to licensure will incur any additional costs, for example, for requiring additional staff or modifying BreEZe to***

accommodate a new examination for licensure.

DBC Response: ADEX sponsored legislation, AB 2331- Dababneh (Chapter 572, Statutes of 2016) which authorizes the Board to recognize the American Dental Examining Board's (ADEX) examination as an additional pathway to licensure. Prior to recognition or acceptance of the ADEX exam, the Board must first conduct an occupational analysis of the dental profession. The Board has an interagency agreement with the DCAs Office of Professional Examination Services (OPES) to conduct this analysis and the process is currently underway. After the OA is complete, OPES will conduct a psychometric evaluation of the ADEX examination to determine compliance with the requirements of BPC Section 139. ADEX agreed to pay for the Board's occupational analysis and the psychometric evaluation. AB 2331 authorized the Department of Finance to accept funds for the purposes of reviewing and analyzing the ADEX exam.

PRACTICE ISSUES

ISSUE #9: PATIENT NOTIFICATION AND RECORD KEEPING. ***Should dentists be required to notify patients upon a change in ownership of a dental practice or upon retirement?***

Background: Consumer investigator Kurtis Ming, from "Call Kurtis," a consumer advocacy segment on Sacramento's local CBS news affiliate, reached out to the Senate Business, Professions and Economic Development Committee and the Board to determine if there were any complaints from patients about dentists selling their practice without notifying their patients, who subsequently end up harmed by the new dentists.

According to the Board, it was not aware of a trend in these cases. Although the Board noted there are no laws that require specific actions when someone is selling their dental practice, it is considered proper standard of care for dentists to notify patients when business practices change, such as bringing on an additional associate, retirement, or selling the practice. In addition, BPC § 1680(u) defines unprofessional conduct to include, "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, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions and provided the health of the patient is not jeopardized."

The Board reported that it has seen a rise in the number of cases when a licensee is no longer in possession of a patient's records. This may be related to the sale of a practice, or instances when the licensee has abandoned a practice. When a licensee fails to produce patient records within 15 days, he or she may be subject to an administrative citation. In addition, if the licensee has walked away from the practice without notifying the patients, he or she may be subject to discipline for patient abandonment. There is no general law requiring dentists to maintain records for a specific period of time. However, there may be situations when providers are required to maintain records for a certain time period, for example, for reimbursement purposes. The MBC also does not have any requirements relating to patient notification when a licensee retires or sells his or her practice, or relating to retention of patient records.

Staff Recommendation: ***The Committees should determine whether it should require dentists to***

notify patients upon a change in ownership or when a licensee retires. The Board should explore exactly what type of notification should be required, when that notice should be given, and whether a licensee should be required to keep or transfer patient records under those circumstances. The Committees may also consider whether patient notification requirements should be required not only for dental professionals, but also for other healing arts professionals.

DBC Response: As was mentioned in the background, the Board has not received a significant number of complaints from patients about dentists selling their practice without notifying their patients, and who subsequently end up harmed by the new dentists.

ISSUE #10: BPC § 726: UNPROFESSIONAL CONDUCT. ***Should dental professionals be authorized to provide treatment to his or her spouse or person with whom he or she is in a domestic relationship?***

Background: BPC § 726 prohibits, "The commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action" for any healing arts professional. BPC § 726 exempts sexual contact between a physician and surgeon and his or her spouse, or person in an equivalent domestic relationship, when providing non-psychotherapeutic medical treatment. SB 544 (Price, 2012) would have, among other things, amended BPC § 726 to provide an exemption for all licensees who provide non-psychotherapeutic medical treatment to spouses or persons in equivalent domestic relationships, instead of only exempting physicians and surgeons. This bill was held in the Senate Business, Professions and Economic Development Committee. The California Dental Association (CDA) and the California Academy of General Dentistry (CAGD) have both requested amending this section to also exempt dentists who are treating their spouses or person in an equivalent domestic relationship.

Staff Recommendation: ***The Committees should consider whether exempting dentists maintains the spirit of the law and determine whether additional conditions are necessary to ensure that spouses and domestic partners are protected.***

DBC Response: BPC Section 726 was amended and became effective January 1, 2016. The amendment included an exemption for all licensees who provide non-psychotherapeutic medical treatment to spouses or persons in equivalent domestic relationships.

ISSUE #11: ENSURING AN ADEQUATE AND DIVERSE DENTAL WORKFORCE. ***Does California have the workforce capacity to meet dental care needs, especially in underserved areas? Should the Board enhance its efforts to increase diversity in the dental profession?***

Background: According to the Office of Statewide Health Planning and Development (OSHPD), Dental Health Professional Shortage Areas (DHPSA), are designated based upon the availability of dentists and dental auxiliaries. To qualify for designation as a DHPSA, an area must have a general dentist practice ratio of 5,000:1, or 4,000:1 plus population features demonstrating "unusually high need" and a lack of access to dental care in surrounding areas because of excessive distance,

overutilization, or access barriers. According to OSHPD, over 50% of dentists (18,659) reported residing in five California counties, while the five counties with the fewest number of dentists combined had a total of 18 dentists. Approximately 5% of Californians (nearly 2 million individuals) live in a DHPSA. As a result, while California has a large number of dentists, they are not evenly distributed across the state.

In addition, due to recent changes in California law, insurance products sold under California's Health Benefit Exchange, Covered California, are required to offer pediatric dental benefits as part of their benefits package. While the Affordable Care Act (ACA) required all insurance plans to include oral care for children, the dental benefit was an optional benefit until last year, which resulted in less than one-third of the children who bought medical coverage also purchasing the dental coverage. In addition, Covered California is also offering new family dental plans to consumers who enroll in health insurance coverage in 2015. As a result, the state can expect to see the need for dental services increase. According to a 2013 Children's Partnership report, *Fix Medi-Cal Dental Coverage: Half of California's Kids Depend on It*, an estimated 1.2 million children alone will have access to dental coverage, and child enrollment in Medi-Cal's dental program alone will total 5 million. That report also notes that according to a 2005 study, nearly a quarter of California's children between the ages of 0 and 11 have never been to the dentist.

The Board has had discussions relative to increasing workforce capacity in the light of the ACA, which always include the need to increase capacity in underserved and rural areas, and monitors OSHPD data relating to workforce capacity. Last year the Board revised its Strategic Plan to highlight access to quality care in its vision statement and include diversity in our values. One objective is to identify areas where the Board can assist with workforce development, including the dental loan repayment program, and publicize such programs to help underserved populations. The Board also established an Access to Care Committee to monitor the implementation of the Affordable Care Act and to ensure that the goals and objectives outlined in its Strategic Plan are carried out. The Committee will work with interested parties, including for-profit, non-profit and stakeholder organizations, to bring increased diversity in the dental profession.

In addition, according to a 2008 report from OSHPD's Healthcare Workforce Diversity Council, *Diversifying California's Healthcare Workforce, an Opportunity to Address California's Health Workforce Shortages*, the underrepresentation of racial and ethnic groups in California's health workforce is a major issue, as these communities are less likely to have enough health providers, resulting in less access to care and poorer health. Research shows that underrepresented health professionals are more likely to serve in underserved communities and serve disadvantaged patients, so diversifying California's health workforce can significantly reduce disparities in healthcare access and outcomes, as well as help address workforce needs.

The Board reported that CODA accreditation standards, which the Board relies upon, require dental schools to have policies and procedures that promote diversity among students, faculty, and staff, and places a high value on diversity, including ethnic, geographic, and socioeconomic diversity. The Board also accepts courses in cultural competencies towards its CE requirements. In addition, the Board participates in the OSHPD project to create a health care workforce clearinghouse in accordance with SB 139 (Scott, Chapter 522, Statutes of 2007), which will allow OSHPD to deliver a report to the Legislature that addresses employment trends, supply and demand for health care workers, including geographic and ethnic diversity, gaps in the educational pipeline, and recommendations for state policy

needed producing workers in specific occupations and geographic areas to address issues of workforce shortage and distribution. Results may be found in OSHPD facts sheets on dentists and RDAs, which include information on supply, geographical distribution, age, and sex, but do not include information on ethnic or language diversity.

The Board has also been collecting workforce data pursuant to 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 Board developed a workforce survey, which licensees are required to complete upon initial licensure and license renewal. Foreign language and ethnic background questions are both optional. The online results of the survey are manually input by staff into one data file, which is downloaded annually to the Board's Web site. The current report is approximately 299 pages and posts the raw data on its Web site, since AB 269 was not accompanied with funds for staff or a computer program to work on this project and manipulate this data. However, the Board has recently partnered with the Center for Oral Health, which will take that data and put it into a useable format, which will be presented at an Access to Care Committee meeting.

Staff Recommendation: ***The Board should continue to collaborate with interested stakeholders to assist in the implementation of the ACA and enhance efforts on diversity and workforce shortages, including targeting any outreach efforts to underserved areas or communities. The Board should continue to monitor information provided by OSHPD and the industry on possible workforce shortages, and advise the Committees on workforce issues as they arise. The Board should inform the Committees of the Center for Oral Health's findings based on AB 269 data, and whether there are ways to make this data more useful.***

DBC Response: The Board continues to collaborate with interested parties to assist in the implementation of the ACA and enhance efforts on diversity and workforce shortages, including targeting any outreach efforts to underserved areas or communities. At its February 2015 Board meeting, representatives from the Center for Oral Health (COH) gave a presentation on dental workforce data and the opportunities and challenges associated with interpreting the data in a meaningful way to effect policy decisions. COH pointed out a number of challenges with the Board's data that if addressed, could yield more useful information; e.g., existing data sources are not linkable and not reliably accurate; not easily accessible, some data elements are not collected. COH recommended the Board enhance overall data capacity over time by modifying the data that exists to make it accurate, useful, and available; collaborate with partners for action and analyses, develop a data enhancement strategy for future workforce analyses, and utilize improved data to strategically improve access to care in California. When the Board converted to the BreEZe system in January 2016, additional challenges were identified and will need to be addressed.

ISSUE #12: DENTAL CORPS LOAN REPAYMENT PROGRAM. Over half of the money that has been available to this program for over a decade ago remains unused. How can the Board ensure greater participation in this program?

Background: AB 982 (Firebaugh, Chapter 1131, Statutes of 2002) established the California Dental Corps Loan Repayment Program. The dental corps program, which is administered by the DBC, assists dentists who practice in dentally underserved areas with repayment of their dental school loans.

Under the program, participants may be eligible for a total loan repayment of up to $105,000. A total of three million dollars ($3,000,000) was authorized to expend from the State Dentistry Fund for this program. SB 540 (Price, Chapter 385, Statutes of 2011) extended the program until all monies in the account are expended. To date, the Board has awarded funds to 19 participants. The practice locations are throughout the state. The facilities are located in Bakersfield, Chico, Compton, Corcoran, Los Angeles, Petaluma, Redding, San Diego, San Francisco, San Ysidro, Smith River, Vallejo, Ventura, Vista, Wasco and West Covina. The first cycle of applicants was received in January 2004, and the Board approved nine of 24 applicants, paying a total of $739,381 was paid over a three-year period. A second cycle of applicants was received in July 2006, and the Board approved six of 21 applicants, paying a total of $643,928 over a three-year period. In September 2010, the Board opened a third cycle of applications and approved the only applicant. In October 2012, the Board opened a fourth cycle of applications and approved all three applicants. Approximately $1.63 million is left in the account.

The Board promotes this program on its website and includes this information in its presentation to senior students in California dental schools. In addition, the Board has worked with stakeholders and professional associations to distribute this information through their publications. Staff is continuing to research other loan repayment programs offered by the California Dental Association, the MBC, and the OSHPD, and the Access to Care Committee is currently examining the issue to determine how to increase participation in the program.

AB 982 also established a similar program for physicians and surgeons to be administered by the MBC, which was renamed the Steven M. Thompson Physician Corps Loan Repayment Program by AB 1403 (Nunez, Chapter 367, Statutes of 2004. However, in 2005, the MBC sponsored AB 920 (Aghazarian, Chapter 317, Statutes of 2005), which transferred this program to the Health Professions Education Foundation (HPEF). At the time, the MBC noted that the transfer of the program would help both the program and the HPEF because the HPEF is better equipped to seek donations, write grants, and continuously operate the program. HPEF is the state's only non-profit foundation statutorily created to encourage persons from underrepresented communities to become health professionals and increase access to health providers in medically underserved areas. Supported by grants, donations, licensing fees, and special funds, HPEF provides scholarship, loan repayment and programs to students and graduates who agree to practice in California's medically underserved communities. Housed in OSHPD, HPEF's track record of delivering health providers to areas of need has resulted in approximately 8,776 awards totaling more than $92 million to allied health, nursing, mental health and medical students and recent graduates practicing in 57 of California's 58 counties.

Staff Recommendation: ***The Board should inform the Committees of whether it has sought matching funds from foundations and private sources as authorized under AB 982. The Board should continue to explore ways to increase participation in the program, including whether it should transfer administration of the program to the HPEF, which may be better equipped to generate and distribute funds under the program. The Board should advise the Committees on whether any statutory changes are necessary to fully utilize this program. The Committees should ensure this money, which has been available for use for over the last 10 years, is distributed and used to increase access to care in underserved areas.***

DBC Response: In 2002, legislation established the Board's authority to spend $3 million to fund a loan repayment program to assist dentists who practice in dentally underserved areas with repayment

of their dental school loans. Early on, there were as many as 24 applicants per cycle seeking these funds. For unexplained reasons, applications dropped off for three years between 2007 and 2010. Since 2010, the number of candidates seeking application to these funds has dwindled to one to three applicants per cycle. The Board has not sought matching funds from foundations and private sources as authorized under AB 982 to increase this fund.

Assembly Bill 2485 (Santiago, Chapter 575, Statutes of 2016) revises the program provisions governing eligibility, application, selection, and placement. Additionally, the bill requires the Board to develop a process for repayment of loans or grants disbursed, should the applicant be prematurely terminated or unable to complete qualifying employment. The bill was signed by the Governor and filed with Secretary of State on September 24, 2016.

As a result of the enactment of AB 2485, Board staff created an action plan outlining the proposed changes to the Loan Repayment Program. Notable changes include an updated application and agreement, as well as a new annual progress report that will be submitted by the program participant. In addition, the California Code of Regulations, Title 16, Sections 1042 – 1042.6 will be updated to match the amended Business and Professions Codes.

Board staff drafted revisions to the California Dental Corps Loan Repayment Application to reflect updated criteria regarding eligibility, selection, and placement. Eligibility criteria has been expanded to include applicants that are currently eligible for graduation from a pre-doctoral or post-doctoral education program approved by the Board or the Commission on Dental Accreditation. Selection and placement criteria were refined to allow more applicants to qualify for priority consideration with the Board.

Business and Professions Code Section 1972(a)(5) requires that the participant provide an annual progress report to the Board. The progress report allows the Board to verify the applicant's full-time status with the qualified practice setting specified in the contract. Board staff drafted a progress report form to be completed by the employer and submitted to the Board on behalf of the applicant.

The Board has already developed a process for repayment of loans or grants disbursed. Pursuant to California Code of Regulations, Section 1042.5, a dentist who is unable to complete the required three (3) years of service must repay the Dental Board the total amount of loan repayment paid by the program. The Board shall notify the participant in writing of any amounts to be repaid to the Board, and when the dentist shall make such a payment. The repayment is due within one (1) calendar year after written notification from the Board. California Code of Regulations, Section 1042.5, is included with the California Dental Corps Loan Repayment Program agreement.

Business and Professions Code Section 1972(f) was amended to allow the Board to contact dental organizations and educational institutions for outreach to potentially eligible applicants. The Board may also create flyers advertising the program benefits and related qualifications. Board staff may visit such organizations and institutions to promote the Loan Repayment Program in 2018.

The Dental Board's website was updated to reflect the changes made to the program. An overview of the program and minimum qualifications is clearly posted on the Loan Repayment webpage. The Board included a link to the Health Professional Shortage Area (HPSA) search engine so applicants may locate qualified underserved clinics in California. In addition, links to the revised application and related code sections are provided on the webpage.

Board staff is currently developing regulations to coincide with the modifications made to the program pursuant to AB 2485. The regulations must reflect the revised eligibility criteria and priority consideration factors. The rulemaking process will last 12-18 months. As such, the Board anticipates the amended regulations will be effective in Spring 2019.

ISSUE #13: DIFFICULTY COLLECTING CITATIONS AND FINES AND COST RECOVERY. ***How can the Board enhance its efforts to collect fines and cost recovery?***

Background: BPC § 125.9 authorizes the Board to issue citations and fines for certain types of violations of the Act. Among other things, the Board is authorized to issue administrative citations to dentists who fail to produce requested patient records within the mandated 15-day time period (BPC §1684.1(a)(1)) or who fail to meet standards as evidenced through site inspections (BPC §1611.5)). The Board continues to hold licensees accountable to this timeframe and issues citations with a $250/day fine, up to $5,000 maximum. The Board also addresses a wider range of violations that can be more efficiently and effectively addressed through a cite-and-fine process with abatement or remedial education outcomes, for example, when patient harm is not found. The length of time before administrative discipline could result is also taken into consideration when determining whether a case is referred for an accusation or an administrative citation is more appropriate to send a swift message regarding unprofessional conduct or to achieve prompt abatement, and citations can address skills and training concerns promptly. The Board typically issues administrative fines up to a maximum of $2,500 per violation, with totals averaging $3,506 per citation.

When issuing citations, the Board's goal is not to be punitive; rather, the Board seeks to protect consumers by getting the dentist's attention, re-educating him or her as to the DPA, and emphasizing the importance of following dental practices that fall within the community's standard of care. When deciding whether to issue a citation and an appropriate corresponding fine, factors such as the nature and severity of the violation and the consequences of the violation (e.g., potential or actual patient harm) are taken into account. Examples of "lesser" violations of the DPA that may not warrant referral to the OAG, but where a citation and fine may be more appropriate, include documentation issues (e.g., deficient records/recordkeeping), advertising violations, failure to keep up with continuing education requirements, unprofessional conduct for the failure to disclose or report convictions (e.g., DUI), and disciplinary actions taken by another professional licensing entity. In addition to using citations as a tool to address less egregious violations that would not otherwise result in meaningful discipline, the Board views citation as a means of establishing a public record of an event that might otherwise have been closed without action, and thereby remain undisclosed.

CITATION AND FINE	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Citations Issued	42	15	28	82
Average Days to Complete	127	339	410	272
Amount of Fines Assessed	$135,900	$28,000	$55,200	$301,150
Reduced, Withdrawn, Dismissed	0	7	4	8
Amount Collected	$15,850	$10,469	$88,026	$28,782

*The increase in citations in FY 13/14 was due to one individual to whom the Board issued 48 citations to one individual who did not provide records based on 48 complaints received by the Board. The subject's license was

revoked. Another reason for the increase in citations was based on the Board escalating the number of inspections for infection control standards.

BPC § 125.9 authorizes the Board to add the amount of the assessed fine to the fee for license renewal. In the event that a licensee fails to pay their fine, a hold is placed on the license and it cannot be renewed without payment of the renewal fee and the fine amount. This statute also authorizes the Board to take disciplinary action for failure to pay a fine within 30 days from the date issued, unless the citation is appealed. When a license is revoked, the individual's ability to secure gainful employment and reimburse the Board is diminished significantly. Presently, the Board does not use the Franchise Tax Board (FTB) Intercept program to collect citation fines. While the amount in assessed fines has increased dramatically, the amount collected has fallen and reflects only a small portion of fines assessed.

The Board, however, emphasizes that when it issues citations, its goal is not to be punitive. Rather, the Board uses citations as a tool to protect the health and safety of California's consumers by gaining dentists' compliance and/or helping them become better dental care providers by re-educating them as to the Act. In addition, the Board believes that the ability to assess a larger fine will get individuals to take the Board's citations more seriously. The Board has identified increasing the maximum fine per violation from $2,500 to $5,000 per violation as one of the Board's regulatory priorities for FY 15/16.

BPC § 125.3 specifies that in any order issued in resolution of a disciplinary proceeding before any board, the Administrative Law Judge (ALJ) may direct the licensee at fault to pay for the reasonable costs of the investigation and enforcement of the case. The Board's request for recovery is made to the presiding ALJ who decides how much of the Board's expenditures will be remunerated. The ALJ may award the Board full or partial cost recovery, or may reject the Board's request. In addition to cost recovery in cases that go to hearing, the Board also seeks cost recovery for its settlement cases.

It continues to be the Board's policy and practice to request full cost recovery for all of its criminal cases as well as those that result in administrative discipline (BPC § 125.3). The Board also has authority to seek cost recovery as a term and condition of probation. In revocation cases, where cost recovery is ordered, but not collected, the Board will transmit the case to the FTB for collection. The Board may also pend ordered costs in the event the former licensee later returns and petitions for reinstatement. The Board also experiences difficulties in collecting cost recovery, as seen below.

Cost Recovery (dollars in thousands)				
	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Total Enforcement Expenditures	6,975	6,792	6,588	7,037
Potential Cases for Recovery *	106	111	97	91
Cases Recovery Ordered	50	67	46	64
Amount of Cost Recovery Ordered	3,907	4,579	3,222	6,819
Amount Collected	1,816	2,201	2,711	3,427
* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.				

The Board has had success utilizing the FTB Intercept Program to collect cost recovery. However, due to limited staff resources, only a few licensees have ever been referred. The Board is currently working

towards increasing our participation in this program and is identifying appropriate cases that can be enrolled. Challenges will remain in instances when the license has been surrendered or revoked, and the former licensee has employment challenges resulting in their inability to generate a taxable income.

Staff Recommendation: ***The Board should inform the Committees of why it does not utilize the FTB Intercept program to collect citations. The Board should consider working with the FTB Intercept program and contracting with a collection agency for the purpose of collecting outstanding fines and to seek cost recovery. In light of the low collection rate under current fines, the Board should explain to the Committees why it believes the ability to assess larger fines will assist its enforcement efforts.***

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

ISSUE #14: CONTINUING EDUCATION. *Should the Board conduct CE audits for RDAs?*

Background: Dentists are required to complete not less than 50 hours of approved CE during the two- year period immediately preceding the expiration of their license. RDAs are required to take 25 hours of approved CE during the two-year period immediately preceding the expiration of their license. As part of the required CE, courses in basic life support, infection control, and California law and ethics
are mandatory for each renewal period for all licensees. All unlicensed dental assistants in California must complete an approved 8-hour infection control course, an approved 2-hour course in CA law and ethics, and a course in basic life support. In addition, there are initial and ongoing competency requirements for specialty permit holders.

Licensees are required to maintain documentation of successful completion of their courses, for no fewer than four years and, if audited, are required to provide that documentation to the Board upon request. As part of the renewal process, licensees are also required to certify under penalty of perjury that they have completed the requisite number of continuing education hours, including any mandatory courses, since their last renewal. Starting with the February 2011 renewal cycle, random CE audits for dentists were resumed. Staff has been auditing 5% of the dental renewals received each month. In keeping with the Board's strategic plan and succession planning efforts, staff has developed a desk manual with written procedures for the auditing process. As of September 30, 2014, staff has conducted 521 CE audits. Seven licensees, or approximately 1% of those audited, failed the audit. Dentists who are not able to provide proof of CE units may be issued a citation and fine. Without additional resources, audits for registered dental assistants are only conducted in response to a complaint or other evidence of noncompliance. The Board also anticipates submitting a BCP for FY
2016/17 for one staff to initiate regular and ongoing audits for RDAs and RDAEFs.

Staff Recommendation: ***The Board should pursue a BCP for staff to conduct regular and***

ongoing audits for RDAs and RDAEFs to hold licensees accountable and promote proper standard of care.

DBC Response: The Board anticipates submitting a BCP for staff positions to initiate regular and ongoing continuing education audits for RDAs and RDAEFs in order to hold licensees accountable and promote proper standard of care.

~~ISSUE #15~~: DISCIPLINARY CASE MANAGEMENT TIMEFRAMES ARE STILL EXCEEDING CPEI's PERFORMANCE MEASURE OF 540 DAYS. *Will the Board be able to meet its goal of reducing the average disciplinary case timeframe from 36 months to 18 months?*

Background: The Board receives between 3,500 and 4,000 complaints per year, and refers almost all of those complaints to investigations. Over the last four fiscal years, the average time to close a desk investigation was 96 days. This timeframe represents a marked improvement from the Board's last sunset review, when the average number of days to close a complaint was 435 days. In addition, the average time to close a non-sworn investigation was 375 days, and to close a sworn investigation was 444 days. In recent years, the amount of time to close a sworn investigation has decreased and fell to 391 days in the last fiscal year. Based on these statistics, the Board completed 3,759 investigations in the last fiscal year, and average 190 days per investigation.

Enforcement Statistics				
	FY 10/11	**FY 11/12**	**FY 12/13**	**FY 13/14**
INVESTIGATION				
All Investigations				
First Assigned	3640	3570	3973	3699
Closed	3981	3496	3691	3758
Average days to close	181	173	156	187
Desk Investigations				
Closed	2987	2404	2889	2855
Average days to close	106	72	87	118
Non-Sworn Investigation				
Closed	377	593	257	320
Average days to close	278	364	384	473
Sworn Investigation				
Closed	572	492	543	584
Average days to close	505	453	421	391

The CPEI sets a target of completing formal disciplinary actions within 540. The Board is currently exceeding that target, averaging 1,084 days to complete a formal accusation over the last four fiscal years, and has increased this past fiscal year.

ACCUSATIONS				
	FY 10/11	FY 11/12	FY 12/13	FY 13/14
Accusations Filed	89	103	75	73
Accusations Withdrawn	9	8	10	2

Accusations Dismissed	0	0	2	1
Accusations Declined	7	1	3	0
Average Days Accusations (from complaint receipt to case outcome)	1043	1087	934	1271
Pending (close of FY)	200	234	188	168

The Board notes, however, that while the total time to complete a formal disciplinary case exceeds the target and has been increasing, the longest part of the delay occurs once the case is has been referred to the AG's office, as demonstrated in the chart below, which shows the number of days for the Board to complete investigations is well within the CPEI's goal of completing investigations within 270 days.

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

The Board notes that the increase in FY 13/14 for completing an accusation is outside of the Board's control. According to the Board, the number of accusations filed on behalf of the Board has remained relatively constant over the last eight years and has actually dropped in recent years due to the Board's utilization of the citation process as an alternative to formal discipline in the less egregious cases. However, the average number of days to complete a case that has been referred to the AG for disciplinary action has continued to increase from 929 days in FY 09/10 to over 1185 days in 2014, an increase of over 27%. In addition, while the Board, along with many other boards, received additional positions under CPEI, which has increased its enforcement capacity and ability to investigate and bring cases forward, the AG's office and the Office of Administrative Hearings, which hears the cases, did
not receive additional staff. Additional reasons for the delays that are beyond the control of staff include delays caused by opposing counsel, suspensions while criminal matters are pending, and difficulty in scheduling amongst witnesses, patients, and other parties, as well as in scheduling hearing dates with the Office of Administrative Hearings (three months out for a one to two day hearing, eight months out for a hearing of four or more days).

Staff Recommendation: ***The Board should continue to focus on closing its oldest cases and reducing the amount of time it takes to close an investigation and to complete an accusation. The Board should continue to explore alternatives to formal discipline when appropriate, such as the use of citations, cease and desist letters, and working with licensees to agree to disciplinary terms. The Board should note whether any of these disciplinary timeframes include cases that have been adjudicated but are on appeal, which may skew the numbers. The Committees should work with the Board and other stakeholders to determine if it is feasible to increase the number of AGs and ALJ in response to the increase in enforcement staff under CPEI to truly address the ability to reduce enforcement times.***

DBC Response: CPEI sets a target of completing formal disciplinary action within 540 days; the Board is currently exceeding that target. A contributing factor to case aging occurs when a case has been

concluded and a writ petition is filed in superior court. The case is re-opened, and the aging clock on that case starts with the date the case was *first* referred to the AG. The case is finally closed when the petition decision by the court is received, or when five years have passed with no action on the petition.

The Board notes that some of the timeframes in completing an accusation are outside the Board's control. The number of accusations filed has remained relatively constant over the last eight years however the timeframes have actually dropped in recent years due to utilizing citations as an alternative to formal discipline in the less egregious cases.

The Board acknowledges that while the total time to complete a formal disciplinary case exceeds the target of 540 days, the number of days for the Board to complete its investigation is 270 days - well within CPEI's goal relative to investigation completion.

In addition, while the Board, along with many other boards, received additional positions under CPEI, which has increased its enforcement capacity and ability to investigate and bring cases forward, the AG's office and the Office of Administrative Hearings (OAH) are only now able to hire additional staff. Additional reasons for the delays that are beyond the control of staff include delays caused by opposing counsel, suspension of case activity while criminal matters are pending, and difficulty in scheduling interviews with witnesses, patients, and other parties, as well as in scheduling hearing dates with the OAH.

The Board has committed to focusing investigators' time on older cases, on exploring additional opportunities for the issuance of cease and desist orders, and has increased utilizing citations where appropriate. In addition, we are looking for alternatives to shorten time frames for completing the discipline process by including settlement terms and conditions when a signed accusation or statement of issues is returned to the Office of the Attorney General for service on the Respondent.

ISSUE #16: ENFORCEMENT STAFFING ISSUES. *Does the Board employ an adequate number of staff to perform enforcement functions in a timely manner?*

Background: In 2011, the Board began filling the 12.5 positions allocated under the DCA's CPEI budget change proposal, and sworn investigator positions were distributed between the two Northern and Southern California field offices, and the IAU was established in the Sacramento headquarters office. The Board's enforcement managers developed case assignment guidelines, conducted an extensive case review of all open, previously unassigned cases, and distributed them among new and existing staff, resulting in the elimination of a backlog of over 200 cases. However, the success of DBC's increased enforcement efforts has resulted in a strain on the existing administrative support staff. Because CPEI did not include technical staff to perform support administrative functions generated by the increase in completed investigations, investigative staff performs these functions to avoid delays, which reduces their efficiency in working investigations. The Board has recently submitted a BCP to add two Office Technician positions to address this gap. This request was approved.

Since the 2011 sunset review of the Board, the Board has been fortunate to be able to fill the majority of its sworn and non-sworn enforcement positions. Case closure rates climbed following the addition of CPEI positions and remain steady, averaging 968 cases per year, up from 651 cases per year four years ago. Currently, the Board has 2.5 vacancies for sworn investigators and 2

vacancies for non- sworn investigators. The Board expects the candidates to be hired within the next three to four months. These hires will assist in lowering the investigative caseload and help lower case aging.

FISCAL YEAR	10/11		11/12		12/13		13/14	
Classification	Positions	Vacant	Positions	Vacant	Positions	Vacant	Positions	Vacant
Total Sworn Staff	20	4	20	3.5	20	3.5	20	2.5
Total Non-Sworn Staff	24	2	24	2	23	1.5	23	2
Total Enforcement APs	44	6	44	5.5	43	5	43	4.5

Despite an augmentation in enforcement staffing levels from CPEI, the Board notes that the caseload per investigator continues to remain significantly higher than other programs within the DCA, including the MBC and the DCA's Department of Investigation (DOI). In addition to an investigation caseload, Dental Board investigators also carry a probation-monitoring caseload averaging 10 per sworn investigator and up to 25 for Special Investigators. The Board reports that the number of licensees placed on probation has nearly doubled from 148 in FY 10/11 to 311 at the end of FY 13/14. The Board also reports that in general, the enforcement time commitment to manage a probationary licensee is four times greater than an investigation due to the number of meetings and quarterly reports that may be required.

High caseloads can adversely affect performance when staff is diverted from their work by competing demands. The Board will be studying options to determine if additional sworn or non-sworn staff will be sufficient to reduce investigative caseloads, or if the development of a probation unit will better support this challenge and adding staff dedicated strictly to probation monitoring will be necessary. Ideally, the Board would like to reduce its investigative caseloads similar to the MBC or DOI as the Board's cases are also very complex and technical in nature.

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

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

Additionally, the Board notes that it is currently experiencing a shortage of available SMEs to provide case review of our completed investigations. SMEs conduct an in-depth review of the treatment provided to patients in cases alleging substandard care. Experts must be currently practicing, possess a minimum of five years' experience in their field, and cannot have had any discipline taken against their license in California or any other state where they have been licensed. The shortage of SMEs can be

attributed to several factors, including the increase in the number of investigations being conducted and stagnant compensation rates. While the majority of SMEs recognize they are providing a service to consumers and their profession, the possibility of having to testify at hearing and close their practice for several days at a time can become a financial hardship to an individual licensee. The current compensation rate, which pays $100 for written review and $150 per hour for testimony, has not been increased since 2009. By comparison, physicians at the Medical Board are compensated at $150 per hour for written review and $200 per hour for testimony. The Board has been trying to recruit experts through its Web site and outreach to dental societies. An increase in the number of experts in the resource pool will allow staff to more quickly refer their cases for review.

Staff Recommendation: ***The Board should consider conducting a staff and workload analysis after it receives the results of its fee audit to determine the appropriate level of staffing to ensure that the Board is able to perform all of its functions in a timely manner. The Board should inform the Committees of how large its current SME pool is, and the ideal ratio of cases to SMEs. The Board should continue recruitment efforts to attract more SMEs, and consider raising the compensation rate to increase participation in the program.***

DBC Response: In 2011, the Board was allotted 12.5 positions under the DCA's CPEI budget change proposal, and investigator positions were distributed between our Northern and Southern field offices. An Investigative Analytical Unit was established in the Sacramento headquarters office. The Board's enforcement managers developed case assignment guidelines, conducted an extensive case review of all open, previously unassigned cases, and distributed them among new and existing staff, resulting in the elimination of a backlog of over 200 cases. The process remains in effect.

The success of the Board's increased enforcement efforts resulted in a strain on the existing administrative support staff. CPEI did not include technical staff to perform support functions generated by the increase in completed investigations; consequently, investigative staff performs these functions to avoid delays, which reduces time spent on investigations. The Board recently was able to hire additional support staff to address this gap.

Despite an augmentation in enforcement staff levels from CPEI, the Board notes that the caseload per investigator continues to remain significantly higher than other programs within the DCA. In addition to an investigation caseload, Board investigators also carry a probation-monitoring caseload. We are looking into the possibility of adding staff dedicated strictly to probation monitoring and creating a probation unit to better support this challenge.

The Board is considering hiring an outside consultant to review the enforcement program in order to conduct a work load analysis to determine the appropriate level of staff that will be sufficient to reduce investigative caseloads and to identify where process improvements can be made.

The Board currently has over 130 available SMEs to provide case reviews of our completed investigations. The experts conduct an in-depth review of the treatment provided to patients in cases alleging substandard care and when necessary, provide testimony at hearings. The current compensation rate pays $100 per hour for written review and $150 per hour for testimony, and has not been increased since 2009. We will be looking at compensation rates for SME's used by other Boards to see if increasing the compensation to our experts might result in some continuity and a larger expert pool. The Board has been recruiting experts through its web site and outreach to dental societies.

Through our recent recruitment efforts we believe we have resolved this issue for now.

OTHER ISSUES

ISSUE #17: LOW RATE OF RESPONSE TO CONSUMER SATISFACTION SURVEYS AND LOW RATE OF CONSUMER SATISFACTION WITH DBC. ***During the past four years, the Board has received an average survey return rate of approximately 2.55%, below the minimum level of 5% needed to be considered statistically relevant. In addition, the 2013/2014 Consumer Satisfaction Survey of DBC shows over 60% of complainants were dissatisfied with the way the Board handled their complaints.***

Background: In 2010, DCA launched an online Consumer Satisfaction Survey. The Board continues to survey consumers to learn about their experience with the complaint and enforcement process. The Survey is included as a web address within each closure letter, which directs consumers to an online "survey monkey" with 19 questions. Overall participation has been low. Acting on the belief that consumers may be increasingly reluctant to participate in online surveys, staff have also provided self-addressed, postage paid survey cards in closure envelopes. This has not had any discernible effect to the participation rate. During the past four years, the Board has received an average survey return rate of approximately 2.55%, below the minimum level of 5% needed to be considered statistically relevant. By comparison, DCA has reported a 2.6% average participation rate from all boards and bureaus. It should be noted that in reviewing the individual responses, consumers chose to skip or not answer a number of the questions.

With regard to specific survey results, the Board has identified that the participating consumers expressed dissatisfaction surrounding the complaint intake process; initial response time; complaint resolution time; and explanation regarding the outcome of the complaint. The Board notes that the average initial response time is nine days, which is below the maximum time allowed by law. In addition, with the exception of complaints resulting in discipline, the Board's average resolution time is 164 days, which is below the 270 day performance target. Regarding explanations regarding the outcomes of complaints, the Board notes that in 27% of complaints that were closed, dental consultants who reviewed dental issues determined that there was no violation of the Act, due to simple negligence, and 9% of those closed complaints were due to non-jurisdictional requests for refunds, and that both of those outcomes may have impacted a consumers satisfaction.

In October of 2014, Board staff has begun participating in a DCA focus group to draft new questions and consider alternative formats to increase consumer participation. In addition, Board staff is also reviewing the link on the current closure letter to determine if revisions may be necessary.

Staff Recommendation: ***The Board should continue to explore ways to increase responses to its consumer satisfaction surveys.***

DBC Response: The Board has been working with the DCA on increasing the response returns on our consumer satisfaction surveys. In an effort to solicit more responses from consumers, Board staff have placed a link on the final letters sent to the consumers/complainants, enclosed postage paid, post

card survey forms and attached a link to their e-mail signature line to an on line survey.

CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT PROFESSION BY THE NAME OF BOARD

ISSUE #18: CONTINUED REGULATION BY THE BOARD. ***Should the licensing and regulation of the dental profession be continued and be regulated by the current Board membership?***

Background: The health, safety and welfare of consumers are protected by the presence of a strong licensing and regulatory Board with oversight over the dental profession. The Board should be continued with a four-year extension of its sunset date so that the Legislature may once again review whether the issues and recommendations in this Background Paper have been addressed.

Staff Recommendation: ***Recommend that the licensing and regulation of the dental profession continue to be regulated by the current Board members in order to protect the interests of the public and be reviewed again in four years.***

DBC Response: The Board supports this recommendation.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
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MEMORANDUM

DATE	May 1, 2018
TO	Members of the Dental Board of California
FROM	Tina Vallery, Associate Governmental Program Analyst Dental Board of California
SUBJECT	**Agenda Item 22B:** New Issues for 2019 Legislative Oversight Hearing

Background:

In preparation for the Sunset Review Hearings that will take place in early 2019, staff has identified several issues for the Board's discussion and possible action regarding the pathways to licensure for dental applicants. There are five areas that have been identified for discussion at this meeting:

I. Licensure by Credential
II. Licensure by Residency
III. Licensure by WREB
IV. New License to Replace a Cancelled License
V. Certification of Proof of Graduation for Dental Education – Dean or Dean Delegate Signature Authority

The Dental Practice Act (Act) provides for the licensure and regulation of dentists by the Dental Board of California (Board). Currently, the Board offers qualified applicants four pathways to obtain licensure as a dentist in California: Licensure by Credential (Credential); Licensure by Residency (Residency); Licensure by Western Regional Examination Board (WREB); and, Licensure by Portfolio Examination (Portfolio).

To date, Board staff have received many inquiries and concerns regarding some of the criteria for obtaining licensure in California within these pathways. Board staff have been researching the corresponding requirements for each pathway and have found that additional clarification may be warranted that would require statutory amendments.

I. Licensure by Credential

Current Requirements

In 1996, Business and Professions Code (Code) Section 1635.5 was implemented and became operative on July 01, 2002. This pathway allowed an applicant to apply for licensure without taking an examination if they show evidence of a current license issued by another sate to practice dentistry that is not revoked or suspended or

otherwise restricted and proof that they have been in active clinical practice or have been a full-time faculty member in an accredited dental education program and in active clinical practice for a total of at least 5,000 hours in five of the seven consecutive years immediately preceding the date of his or her application. It also allowed an applicant to receive credit for two of the five years of clinical practice by demonstrating completion of a residency program accredited by the Commission on Dental Accreditation (CODA) including, but not limited to, a general practice residency, an advanced education in general dentistry program, or a training program in a specialty recognized by the American Dental Association. An applicant could also qualify with no previous clinical practice if they agreed to practice dentistry full time for two years in at least one primary care clinic or agreed to teach or practice dentistry full time for two years in at least one accredited dental education program as approved by the Dental Board of California.

Identification of Issues

Currently Code Section 1635.5 outlines the requirements for Licensure by Credential, however, the Board continues to receive questions and complaints from applicants regarding the eligibility criteria for this pathway because the statute does not clearly convey the eligibility requirements.

1. BPC 1635.5(a)(2) states that the applicant must show:
   Proof of a current license issued by another state to practice dentistry that is not revoked or suspended or otherwise restricted.

   Staff receives numerous questions regarding this section. Some of them are;
   - Does the dental license have to be issued in the United States (i.e. is a dental license issued by a state within the country of Canada permitted)?
   - What does the term “otherwise restricted” mean? Is it referring to disciplinary action? Is it referring to specialty, faculty, or residency licenses? Do we want to exclude applicants that only have a specialty license in another state?
   - Do we want to consider making an accommodation for applicants that only possess a medical license issued by another state (i.e. Oral and Maxillofacial Surgeons) the ability to apply through this pathway and apply their clinical practice time to the clinical practice requirement?
   - What status does their license have to have been in during the time in which the clinical practice is being used for qualification within this section. (i.e. Can they use clinical practice time while only possessing a residency license or another type of restricted license in another state if they have an unrestricted license at the time of application)?

2. BPC 1635.5(a)(3) states that the applicant must show:
   Proof that the applicant has either been in active clinical practice or has been a full-time faculty member in an accredited dental education program and in active clinical practice for a total of at least 5,000 hours in five of the seven consecutive years immediately preceding the date of his or her application under this section.

This section causes applicants and staff the most confusion. It is unclear how an applicant can complete the 5,000-hour requirement. For example;

- Can an applicant complete the 5,000 hours within a two to three-year period? Or,
- Do we want the applicant to have five years of clinical practice with a minimum number of hours per year (i.e. 1,000 hours per year for five years out of the last seven years) taking into consideration, on a case-by-case basis, any "qualifying events" (i.e. military leave, disability, etc.)?
- Also, do we want the clinical practice to have been completed immediately preceding the date of the application, with consideration, on a case-by-case basis, for any "qualifying events" (i.e. military leave, disability, etc.). Or can they have a gap in clinical practice in the two years immediately preceding the date of application?
  - If the clinical practice can be completed over the seven-year period, what types and what duration of gaps in clinical practice are permissible for licensure?
  - Does the clinical practice have to be consecutive?
- If an applicant certifies that they are or were self-employed, we require them to submit a copy of their tax forms for each year that they are claiming self-employment. The tax forms that we currently accept are; page one, of Schedule C Form 1040 or, if incorporated, page one of Form 1120S.
  - The issue is that the statute does not mention that these forms are required for anyone that is self-employed.
  - It is unclear how these forms are to be used to determine if the applicant has met the clinical practice requirements.
  - Applicants also ask if they can submit other types of tax documents instead of the ones mentioned previously.
    - Do we want to require some form of verification for self-employed doctors and if so, what do we want to deem as acceptable verification and what would staff need to verify?

3. BPC 1635.5(a)(3)(A) states that:
The applicant may receive credit for two of the five years of clinical practice by demonstrating completion of a residency training program accredited by the American Dental Association Commission on Dental Accreditation, including, but not limited to, a general practice residency, an advanced education in general dentistry program, or a training program in a specialty recognized by the American Dental Association.

The way that this section is worded seems to imply that an applicant can receive two years of credit, toward the five-year requirement, for completing a residency program. It does not specify that the credit for residency will be applied on a year-for-year basis. Do we want an applicant that only completes a one-year residency program to receive credit for two years?

4. BPC 1635.5(a)(3)(B) states that:

The applicant agrees to practice dentistry full time for two years in at least one primary care clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code or primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code, or a clinic owned or operated by a public hospital or health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code. The board may periodically request verification of compliance with these requirements, and may revoke the license upon a finding that the employment requirement, or any other requirement of this subparagraph, has not been met. Full-time status shall be defined by the board for the purposes of this subparagraph, and the board may establish exemptions to this requirement on a case-by-case basis.

Recently this section has been challenged because it implies that they must agree to practice dentistry full time for two years in at least one primary care clinic, but it does not specify if the applicant must complete the full two years at the same clinic. Licensees that utilize this option are issued a location restricted license and the restriction stays on their license until they complete their contract.

The question then becomes, do we want to allow applicants the ability to switch clinics at any point during their two-year contract if the new clinic still meets the requirements outlined within and if so, would their two-years start over each time?

5. BPC 1635.5(a)(3)(C) states that:
   The applicant agrees to teach or practice dentistry full time for two years in at least one accredited dental education program as approved by the Dental Board of California. The board may periodically request verification of compliance with these requirements, and may revoke the license upon a finding that the employment requirement, or any other requirement of this subparagraph, has not been met. Full-time status shall be defined by the board for the purposes of this subparagraph, and the board may establish exemptions to this requirement on a case-by-case basis.

   There have been questions about whether or not an applicant can apply having agreed to work in an accredited dental education program as a resident, instead of a faculty member. Do we want this section to only allow applicants to be considered if they are agreeing to teach or practice dentistry full time for two years as a full time faculty member or will we allow them to work in other capacities? If so, what would be acceptable?

6. BPC 1635.5(a)(6) states that:
   Proof that the applicant has not failed the examination for licensure to practice dentistry under this chapter within five years prior to the date of his or her application for a license under this section.

The questions that staff have received regarding this section are:

- If an applicant has failed the WREB exam in the last five years, but retook the exam and passed, can the passing score supersede the original failure score?
- Also, do we want to require applicants that previously took the ADEX examination to provide proof of not failing the ADEX exam within the last 5 years?

7. BPC 1635.5(a)(8) states that:
   Documentation of 50 units of continuing education completed within two years of the date of his or her application under this section. The continuing education shall include the mandatory coursework prescribed by the board pursuant to subdivision (b) of Section 1645.

The issue that arises from this section is that it does not specify that the fifty (50) units of continuing education (CE) must meet the requirements specified for current licensees as outlined in CCR, Section 1016 and 1017. This means that we cannot impose any of the requirements we have outlined for acceptable CE units for license renewal on applicants.

Action Requested:
The Board may discuss and consider possible amendments to statute and/or regulations to address concerns with current requirements and direct staff to include those recommendations as part of the Board's Sunset Review Report.

II. Licensure by Residency

Current Requirements
In 2006, Code Section 1634.1 was enacted and became operative on January 1, 2007. This pathway required that an applicant show evidence of having completed a clinically based advanced education program in general dentistry (GPR) or an advanced education program in general practice residency (AEGD) that is, at minimum, one year in duration and is accredited by either the Commission on Dental Accreditation (CODA) of the American Dental Association or a national accrediting body approved by the Board. The advanced education program shall include a certification of clinical residency program completion approved by the Board, to be completed upon the resident's successful completion of the program in order to evaluate his or her competence to practice dentistry in the state.

In 2007, Code Section 1634.2 was implemented through SB 683 (Chapter 805, Statutes of 2006) and became operative on January 1, 2007. Code Section 1634.2(c) required that the clinical residency program completion certification form, that was required by Code 1634.1(c), include a list of core competencies that were equal to those found in the board's examinations. The board was required to implement the use of the clinical residency program completion certification form, to include the core competency list, through the adoption of emergency regulations by January 1, 2008.

In 2008, California Code of Regulations, Title 16, Section 1028.3 was added to require that the applicant show evidence of completion pursuant to Code 1634.1 by submitting a "Certification of Clinical Residency Completion" form and that it be signed by the current director of the residency program.

Identification of Issues

Currently Code 1634.1(c) and CCR 1028.3 do not specify a timeframe in which an applicant applying through the residency pathway must have their residency completion form signed by the current program director or a deadline by which an applicant may apply for a licensure after completing a residency program.

1. As provided in subdivision (c) of section 1634.1, the certification of clinical residency program completion must be completed **upon** the resident's successful completion of the program. The word "upon" suggests that the form should be completed at or near the time of completion of the residency program, but the length of time in which they must do this is vague.

   Without specifying a cutoff date, the Board could potentially have applicants applying for licensure that completed their residencies over twenty years ago, which makes it difficult to determine if the applicant is up to date on the best practices of the profession and/or dental technologies. This can also potentially pose a risk to the health and safety of the consumers in California.

   Should the statute be amended to include a specified timeline for candidates to have their residency completion forms completed and apply for licensure through the residency pathway.

   BPC 1634.1 states that:
   Notwithstanding Section 1634, the board may grant a license to practice dentistry to an applicant who submits all of the following to the board:
   (a) A completed application form and all fees required by the board.
   (b) Satisfactory evidence of having graduated from a dental school approved by the board or by the Commission on Dental Accreditation of the American Dental Association.
   (c) Satisfactory evidence of having completed a clinically based advanced education program in general dentistry or an advanced education program in general practice residency that is, at minimum, one year in duration and is accredited by either the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the board. The advanced education program shall include a certification of clinical residency program completion approved by the board, to be completed upon the resident's successful completion of the program in order to evaluate his or her competence to practice dentistry in the state.
   (d) Satisfactory evidence of having successfully completed the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.
   (e) Satisfactory evidence of having successfully completed an examination in California law and ethics.

(f) Proof that the applicant has not failed the examination for licensure to practice dentistry under this chapter within five years prior to the date of his or her application for a license under this chapter.

Do we want to add the requirements to mirror the WREB and Portfolio pathways in California Code of Regulations, Title 16, Section 1028? The additional requirements would be:

- 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;
- Where applicable, a record of any previous dental practice and certification of license status in each state or jurisdiction in which licensure as a dentist has been attained;
- Applicant's name, social security number, address of residency, mailing address if different from address of residency, date of birth, telephone number, and gender of applicant;
- Any request for accommodation pursuant to the Americans with Disabilities Act;
- 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 11/2014);
- Information regarding applicant's education including dental education and postgraduate study, if applicable;
- 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;
- 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;
- 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;
- 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;
- 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;
- Information as to whether the applicant has ever been convicted of any 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;
- 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
- A certification, under the penalty of perjury, by the applicant that the information on the application is true and correct.

Action Requested:
The Board may discuss and consider possible amendments to statute and/or regulations to address concerns with current requirements and direct staff to include those recommendations as part of the Board's Sunset Review Report.

III. Licensure by WREB

Current Requirements
In 2004, Code 1632 and 1632.5 were implemented and became operative on September 21, 2004. These sections required an applicant to have taken and received a passing score on a clinical and written examination administered by the Western Regional Examining Board (WREB) on or after January 1, 2005.

Identification of Issues
Currently Code Sections 1632 and 1632.5 do not specify an expiration date for the validity of the WREB examination results. Without imposing an expiration date, the Board could potentially have applicants applying for licensure that took the WREB examination at any point since 2005. This makes it difficult to determine if the applicant is up to date on the best practices of the profession and/or dental technologies. This can also potentially pose a risk to the health and safety of the consumers in California.

The following are the suggested modifications to the current statute:

Code 1632.5(a)
(a) Prior to implementation of paragraph (2) of subdivision (c) of Section 1632, the department's Office of Professional Examination Services shall review the

Western Regional Examining Board examination to ensure compliance with the requirements of Section 139 and to certify that the examination process meets those standards. If the department determines that the examination process fails to meet those standards, paragraph (2) of subdivision (c) of Section 1632 shall not be implemented. The review of the Western Regional Examining Board examination shall be conducted during or after the Dental Board of California's occupational analysis scheduled for the 2004–05 fiscal year, but not later than September 30, 2005. ~~However, an applicant who successfully completes the Western Regional Examining Board examination on or after January 1, 2005, shall be deemed to have met the requirements of subdivision (c) of Section 1632 if the department certifies that the Western Regional Examining Board examination meets the standards set forth in this subdivision.~~ However, an applicant who successfully completes the Western Regional Examining Board examination within the five (5) years immediately preceding the date their application was received by the Board, shall be deemed to have met the requirements of subdivision (c) or Section 1632 if the department certifies that the Western Regional Examining Board examination meets the standards set forth in this subdivision.

CCR 1028(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, within the five (5) years immediately preceding the date their application was received by the Board.

Action Requested:
The Board may discuss and consider possible amendments to statute and/or regulations to address concerns with current requirements and direct staff to include those recommendations as part of the Board's Sunset Review Report.

IV. New License to Replace a Cancelled License

Current Requirements
In 1961, Code Section 1718.3 was implemented. This section afforded licensees that had not renewed their licenses within five years after its expiration the ability to apply for and obtain a new license.

Identification of Issues
Currently Code Section 1718.3 does not give licensees that have let their licenses cancel the option to reapply through another existing pathway to licensure, thereby requiring payment of all back licensing fees.

The following are the suggested modifications to the current statute:

Code Section 1718.3

(a) A license which is not renewed within five years after its expiration may not be renewed, restored, reinstated, or reissued thereafter, but the holder of the license may apply for and obtain a new license if the following requirements are satisfied:
(1) No fact, circumstance, or condition exists which would justify denial of licensure under Section 480.
(2) He or she pays all of the fees which would be required of him or her if he or she were then applying for the license for the first time and all renewal and delinquency fees which have accrued since the date on which he or she last renewed his or her license.
(3) He or she takes and passes the examination, if any, which would be required of him or her if he or she were then applying for the license for the first time, or otherwise establishes to the satisfaction of the board that with due regard for the public interest, he or she is qualified to practice the profession or activity in which he or she again seeks to be licensed.
(4) He or she applies for licensure, as a new applicant, through one of the available licensing pathways and meets all the requirements for licensure outlined therein.
(b) The board may impose conditions on any license issued pursuant to this section, as it deems necessary.
(c) The board may by regulation provide for the waiver or refund of all or any part of the examination fee in those cases in which a license is issued without an examination under this section.

Action Requested:
The Board may discuss and consider possible amendments to statute and/or regulations to address concerns with current requirements and direct staff to include those recommendations as part of the Board's Sunset Review Report.

V. Certification of Proof of Graduation for Dental Education – Dean or Dean Delegate Signature Authority

Current Requirements
On March 23, 1988, California Code of Regulations, Title 16, Section 1028 was implemented. This section detailed the requirements for applicants applying through the WREB and Portfolio pathways. Specifically, paragraph (10) of subdivision (b) specifies that the applicant must submit certification from the dean of the qualifying dental school attended by the applicant to certify the date the applicant graduated.

Code Section 1634.1 detailed the requirements for applicants applying through the Residency pathway. Specifically, subdivision (b) specifies that the applicant must submit satisfactory evidence of having graduated from a dental school approved by the board or by the Commission on Dental Accreditation of the American Dental Association.

Identification of Issues
Currently, Code 1634.1(b) and CCR 1028(b)(10) do not allow for a delegate of the dean of the qualifying dental school attended by the applicant to certify the date the

applicant graduated. Board staff has received feedback from the dental schools that this requirement does not work with their current business practices.

The following are the suggested modifications to the current statute and regulation:

1634.1(b)
(b) Satisfactory evidence of having graduated from a dental school approved by the board or by the Commission on Dental Accreditation of the American Dental Association~~.~~, signed by the dean of the qualifying dental school or his or her delegate.

1028(b)(10)
(10) Certification from the dean or his or her delegate of the qualifying dental school attended by the applicant to certify the date the applicant graduated;

Action Requested:
The Board may discuss and consider possible amendments to statute and/or regulations to address concerns with current requirements and direct staff to include those recommendations as part of the Board's Sunset Review Report.

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MEMORANDUM

DATE	April 17, 2018
TO	Members of the Dental Board of California
FROM	Carlos Alvarez, Enforcement Chief Dental Board of California
SUBJECT	**Agenda Item 23A:** Enforcement Statistics and Trends

The following are the Enforcement Division statistics for the third quarter (January 1, 2018 to March 31, 2018) of Fiscal Year 2017-2018. Trends over the last three fiscal years and the last two quarters are included, along with Charts 1-3 for reference.

Complaints & Compliance

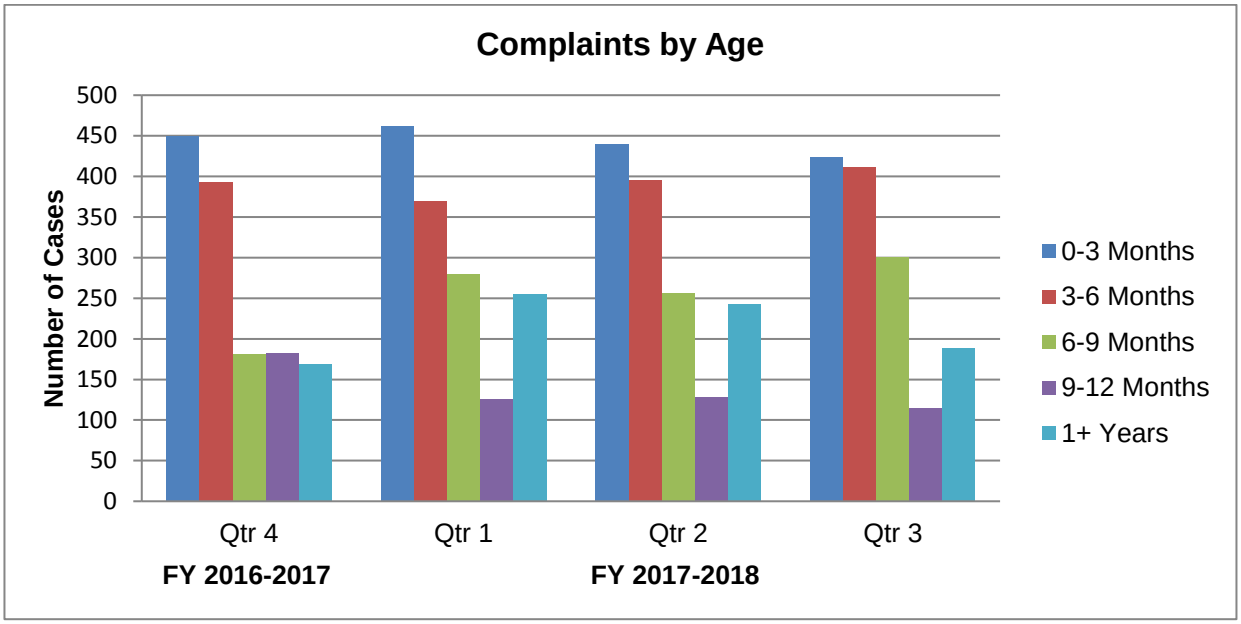
Complaints Received: 851

During quarter three, a total of 851 complaints were received. Complaints received have increased by approximately **8** cases from the last quarter. The monthly average of complaints received for quarter three was **284**.

Complaint Cases Open: 1438

A total of 1438 complaint cases are pending. The Complaint cases open have decreased by **22** from the last quarter. The average caseload per Consumer Services Analyst (CSA) during the third quarter was **260**.

Complaint Age	FY 2016-2017	FY 2017-2018			
	Q4 Cases	Q1 Cases	Q2 Cases	Q3 Cases	Q3%
0 – 3 Months	450	**462**	**439**	**424**	**29%**
3 – 6 Months	393	**369**	**395**	**411**	**29%**
6 – 9 Months	181	**280**	**256**	**300**	**21%**
9 – 12 Months	182	**126**	**128**	**115**	**8%**
1+ Years	169	**255**	**242**	**188**	**13%**
Total	1375	**1492**	**1460**	**1438**	**100%**



Complaint Cases Closed: 722

During quarter three, there were 722 total complaint cases closed. The average cases closed per month was **241**. A complaint took an average of **218** days to close which is approximately seventeen days slower than during the previous quarter.

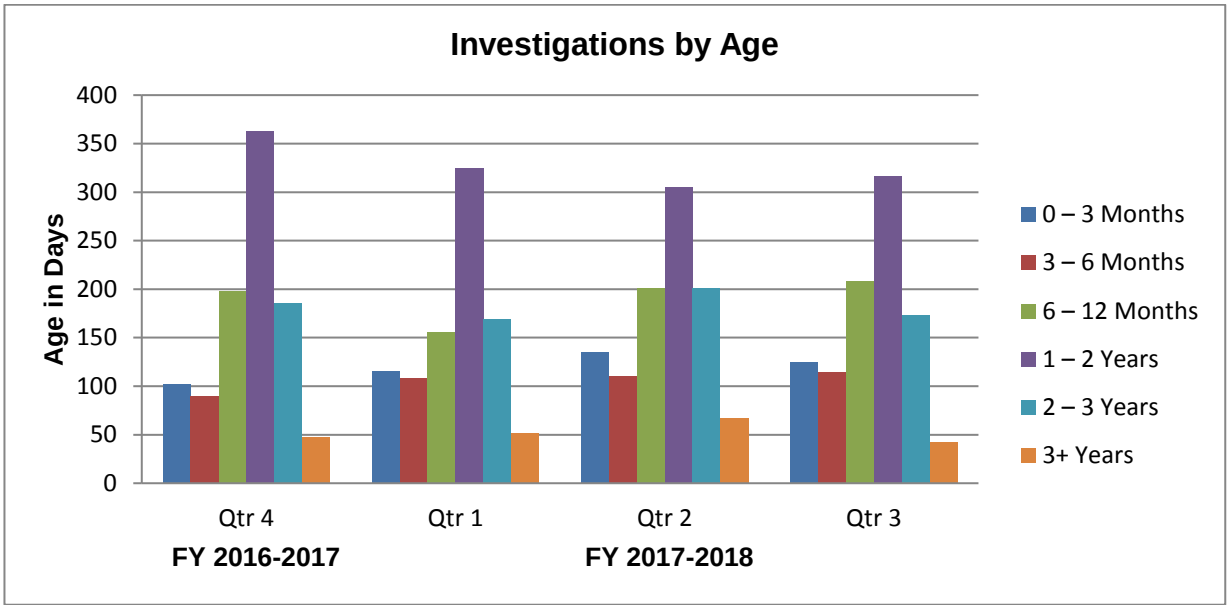
Chart 1 displays the average complaint closure age over the previous three fiscal years through the current quarter.

Investigations

Investigation Cases Open: 978

At the end of quarter three, there were approximately 978 open investigative cases and **74** open inspection cases.

Investigation Age	FY 2016-2017	FY 2017-2018			
	Q4 Cases	Q1 Cases	Q2 Cases	Q3 Cases	Q3 %
0 – 3 Months	102	**116**	**135**	**125**	**13%**
3 – 6 Months	90	**108**	**110**	**114**	**12%**
6 – 12 Months	198	**156**	**201**	**208**	**21%**
1 – 2 Years	363	**325**	**305**	**316**	**32%**
2 – 3 Years	185	**169**	**201**	**173**	**18%**
3+ Years	47	**52**	**67**	**42**	**4%**
Total	**985**	**926**	**1019**	**978**	**100%**



Comparing this third quarter to the last, there has been a 4% decrease in open investigation cases.

Investigation Cases Closed: 321

During quarter three, there were 321 total investigation cases closed. The average cases closed per month was **107**.The total number of investigation cases closed, filed with the Office of the Attorney General (OAG), or filed with the District/City Attorney during the third quarter was 52 (an average of **17** per month).

The average number of days to complete an investigation during the third quarter was **563** days (see Chart 1). This is nine days slower than during the previous quarter.

Administrative and Disciplinary Action:

A total of **24 citations** were issued during the third quarter, an increase from the total of 16 that were issued in the last quarter.

A total of **18 accusations** were filed during the third quarter, a decrease from the total of 27 that were filed during the last quarter.

A total of **52 cases were referred to the OAG** with a total of **156** cases pending as of March 31, 2018.

There were approximately **198 open probation cases** at the end of the third quarter. The three-month average for a disciplinary case to be completed was **1086** days. This is one-hundred and thirty-six days faster than during the previous quarter.

Chart 1 below displays the average closure age over the last three fiscal years through the second and third quarter for complaint, investigation, and disciplinary cases.

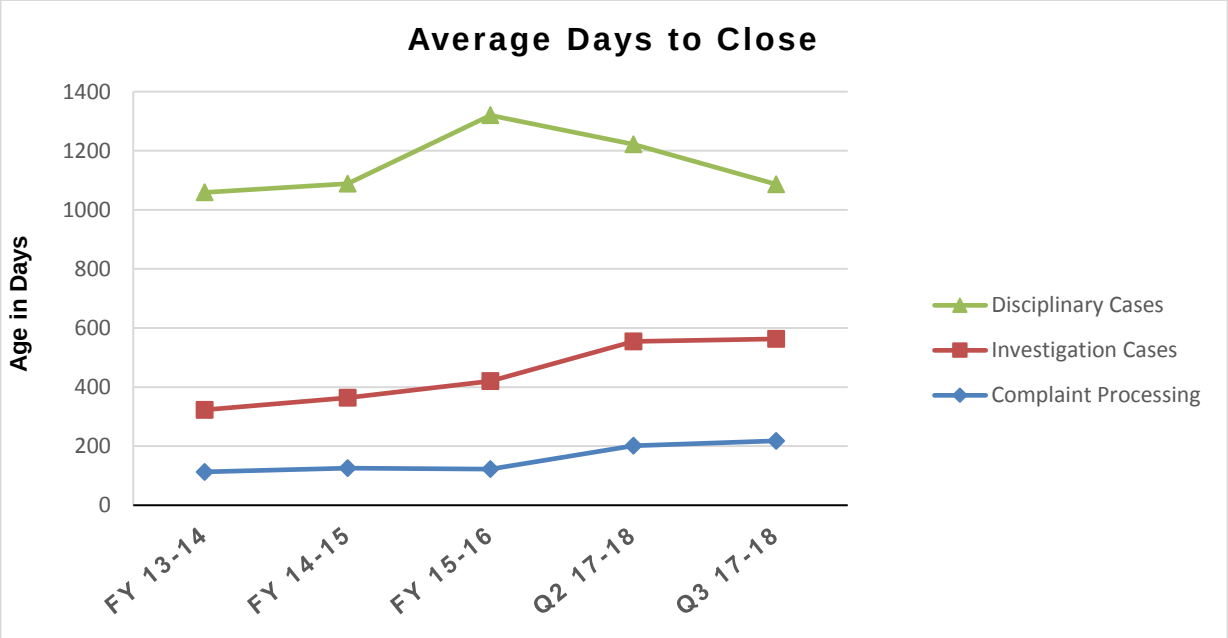


Chart 1:

Average Days to Close	FY 14-15	FY 15-16	FY 16-17	Q2 FY 17-18	Q3 FY 17-18
Complaint Processing	113	126	122	**201**	**218**
Investigation Cases	323	364	420	**554**	**563**
Disciplinary Cases	1059	1089	1320	**1222**	**1086**

Chart 2:

ENFORCEMENT STATISTICS	FY 14-15	FY 15-16	FY 16-17	FY 2017-2018	
				Q2	Q3
COMPLAINTS					
Total Intake Received	4180	3528*	3389	**843**	**851**
Complaints Received	3557	3078*	3101	**731**	**764**
Convictions/Arrests Received	623	450*	288	**91**	**87**
Total Complaints Closed	2762	1981*	2320	**655**	**722**
Pending at end of period	989	804	1375	**1460**	**1438**
INVESTIGATIONS					
Cases Opened	1426	908*	828	**194**	**199**
Cases Closed	1195	1434*	953	**163**	**321**
Referred to AG	188	50*	185	**45**	**52**
Referred for Criminal	20	89*	15	**6**	**13**
Pending at end of period	1082	884	985	**1019**	**978**
Citations Issued	48	46*	45	**16**	**24**
Office of the Attorney General					
Cases Pending at AG	189	210	152	**143**	**156**
Administrative Actions:					
Accusation	70	17	114	**27**	**18**
Statement of Issues	4	3	10	**2**	**6**
Petition to Revoke Probation	3	1	4	**1**	**1**
Licensee Disciplinary Actions:					
Revocation	21	3	20	**6**	**6**
Probation	38	11	62	**12**	**15**
Suspension/Probation	0	0	0	**0**	**0**
License Surrendered	9	2	23	**3**	**6**
Public Reprimand	11	3	28	**2**	**5**
Other Action (e.g. exam required, education course, etc.)	11	1	28	**11**	**0**
Accusation Withdrawn	3	2	10	**6**	**9**
Accusation Declined	2	1	4	**0**	**0**
Accusation Dismissed	0	1	2	**0**	**1**
Total, Licensee Discipline	95	24	160	**40**	**42**
Other Legal Actions:					
Interim Suspension Order Issued	0	0	3	**0**	**0**
PC 23 Order Issued	3	0	3	**0**	**0**

*FY15-16 Numbers updated due to system transition to Breeze.

Complaint Allegations

Charts 3a and 3b below list the types of allegations made for all complaints received for the current quarter, along with their corresponding percentages.

Chart 3a:

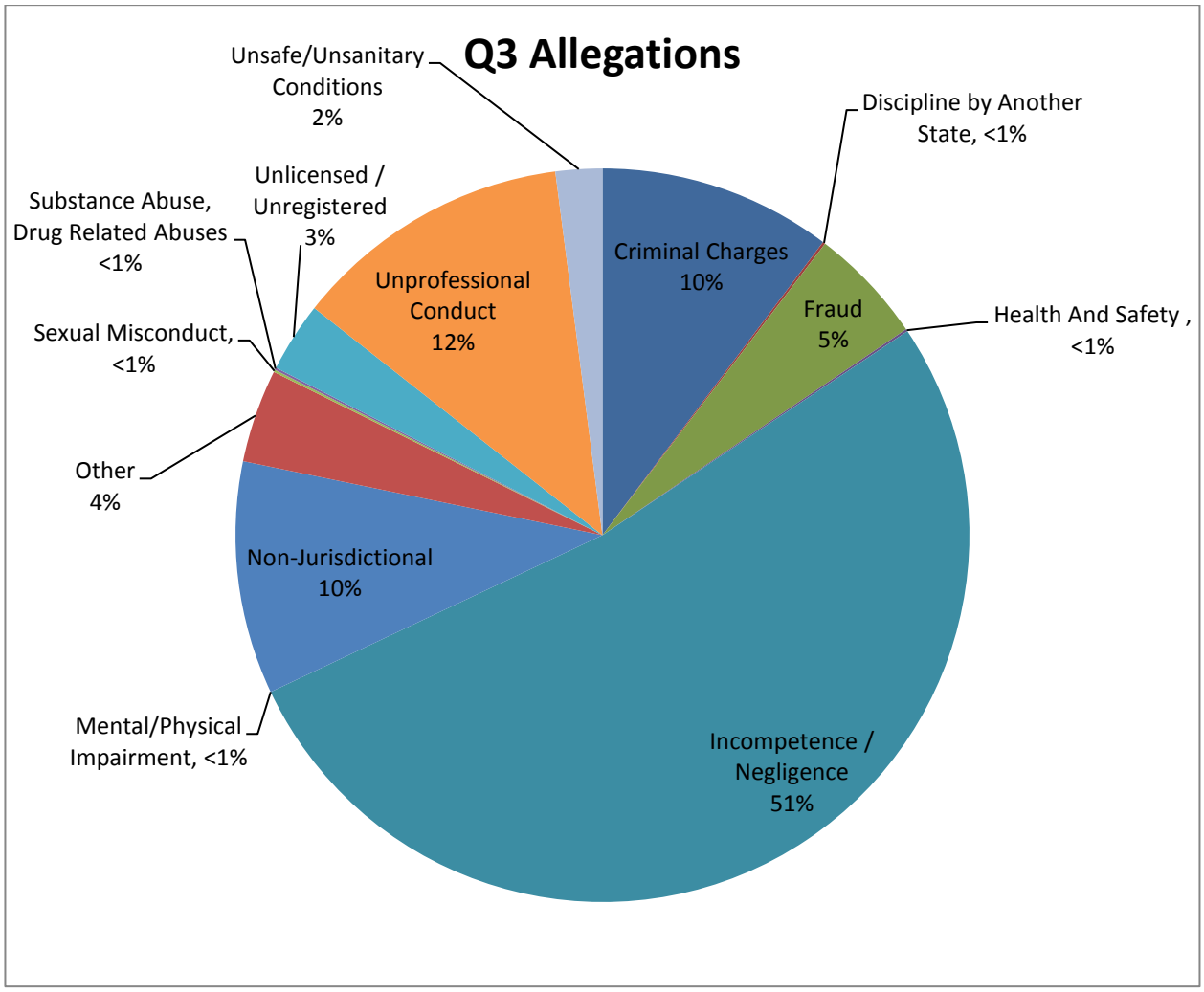


Chart 3b:

	FISCAL YEAR COUNTS			2017-2018		
ALLEGATIONS	**2014-15**	**2015-16***	**2016-17**	**Q2**	**Q3**	**Q3 %**
Criminal Charges	669	353	293	**92**	**87**	**10%**
Discipline by Another State	11	10	3	**0**	**1**	**<1%**
Fraud	389	214	149	**14**	**41**	**5%**
Health and Safety	0	0	9	**0**	**1**	**<1%**
Incompetence / Negligence	2218	1454	2059	**464**	**434**	**51%**
Mental/Physical Impairment	0	0	6	**0**	**1**	**<1%**
Non-Jurisdictional	266	198	404	**72**	**82**	**10%**
Other	332	114	116	**32**	**41**	**4%**
Sexual Misconduct	20	6	11	**0**	**1**	**<1%**
Substance Abuse, Drug Related Abuses	0	0	40	**0**	**2**	**<1%**
Unlicensed / Unregistered	227	125	157	**22**	**26**	**3%**
Unprofessional Conduct	250	143	181	**95**	**99**	**12%**
Unsafe/Unsanitary Conditions	110	32	38	**13**	**15**	**2%**
Total	4492	2649	3466	**804**	**853**	**100%**

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MEMORANDUM

DATE	April 27, 2018
TO	Member of the Dental Board of California
FROM	Carlos Alvarez, Enforcement Chief Dental Board of California
SUBJECT	**Agenda Item 23B:** Review of Fiscal Year 2017-2018 First/ Second/ Third Quarters Performance Measures

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

Department of Consumer Affairs

Dental Board of California

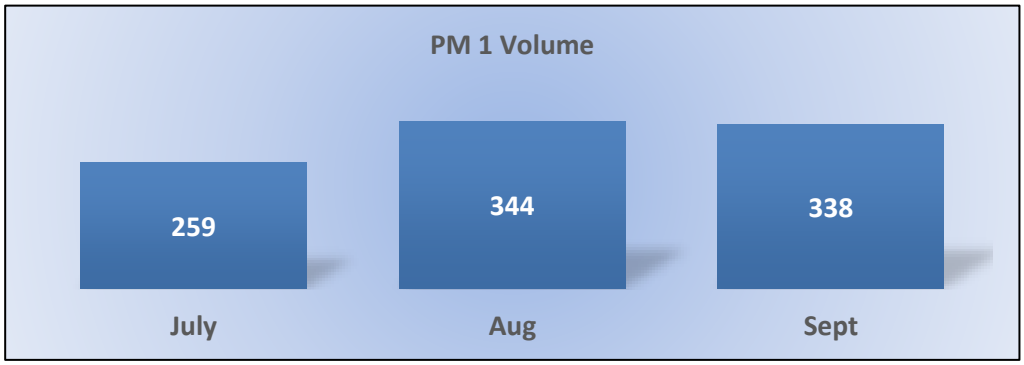
Enforcement Performance Measures

Q1 Report *(July - September 2017)*

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.

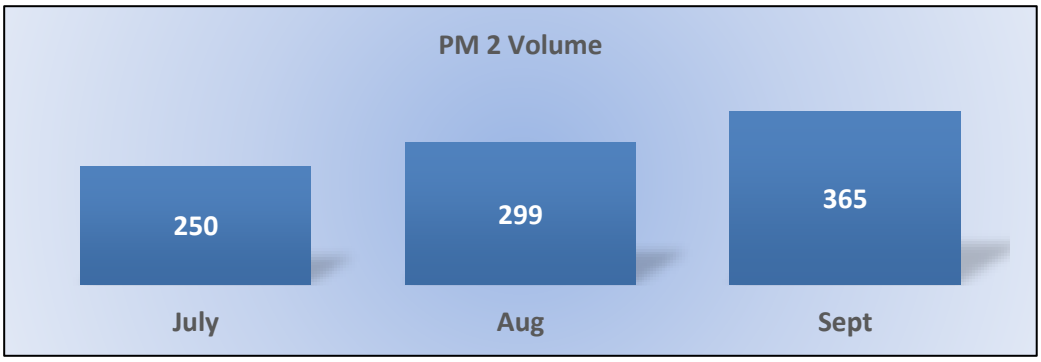


Total Received: 941 | **Monthly Average**: 314

Complaints: 784 | **Convictions**: 157

PM2 | Intake – Volume

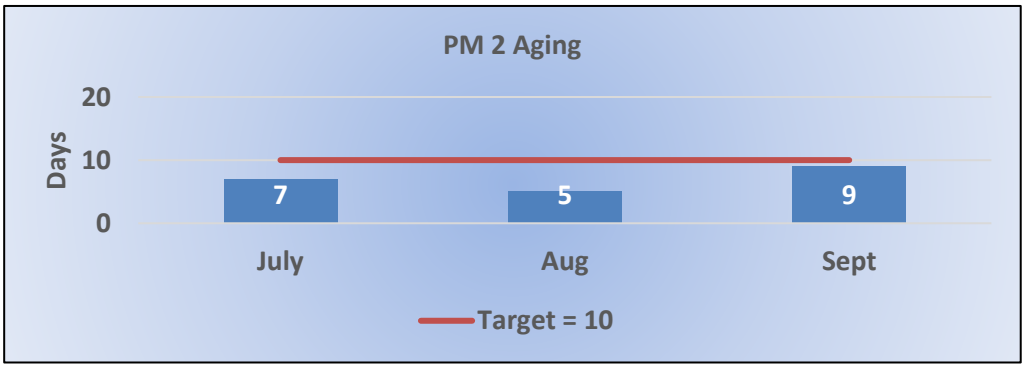
Number of complaints closed or assigned to an investigator.



Total: 915| **Monthly Average:** 305

PM2 | Intake – Cycle Time

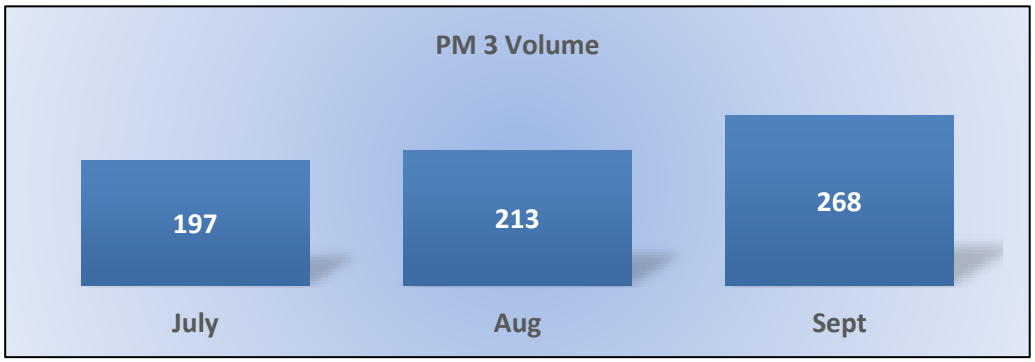
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



Target Average: 10 Days | **Actual Average:** 7 Days

PM3 | Investigations – Volume

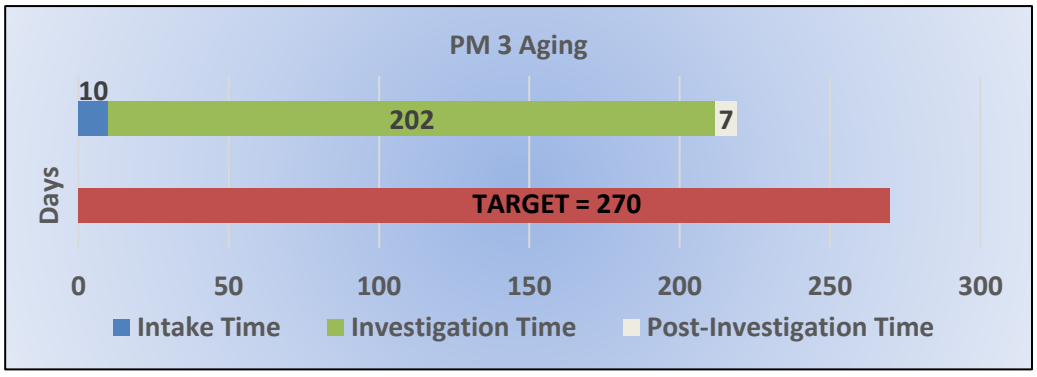
Number of investigations closed (not including cases transmitted to the Attorney General).



Total: 678**| Monthly Average:** 226

PM3 | Investigations – Cycle Time[1]

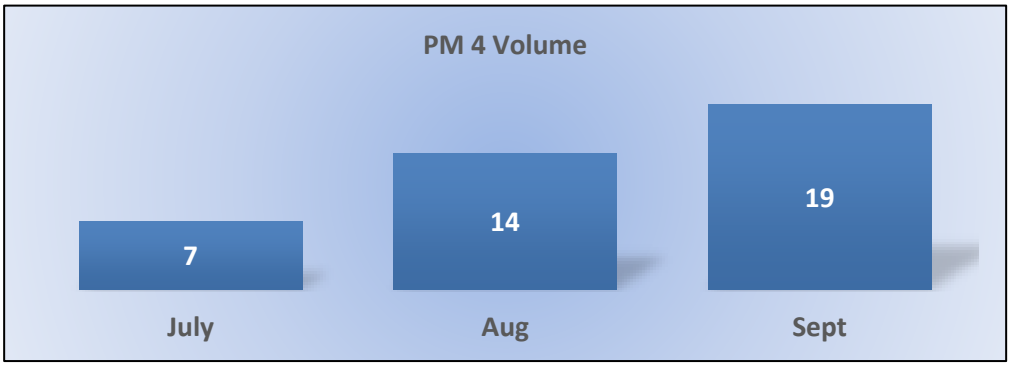
Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General.
(Includes intake and investigation)



Target Average: 270 Days | **Actual Average:** 216 Days

PM4 | Formal Discipline – Volume

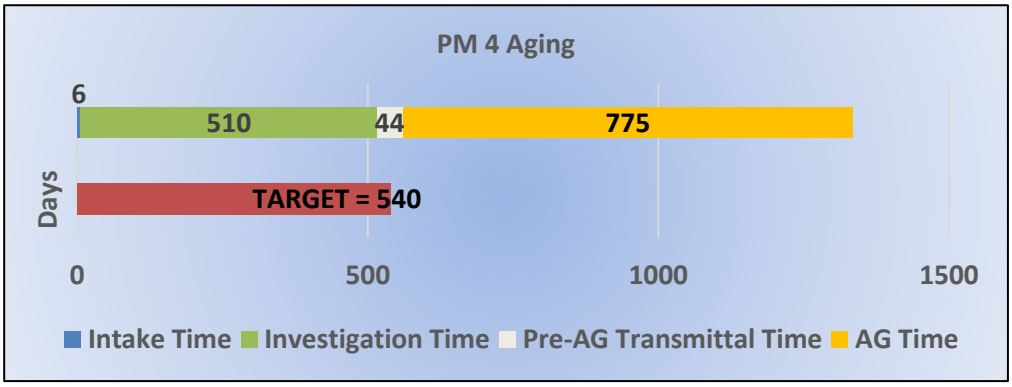
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Total: 40**| Monthly Average:** 13

PM4 | Formal Discipline – Cycle Time[2]

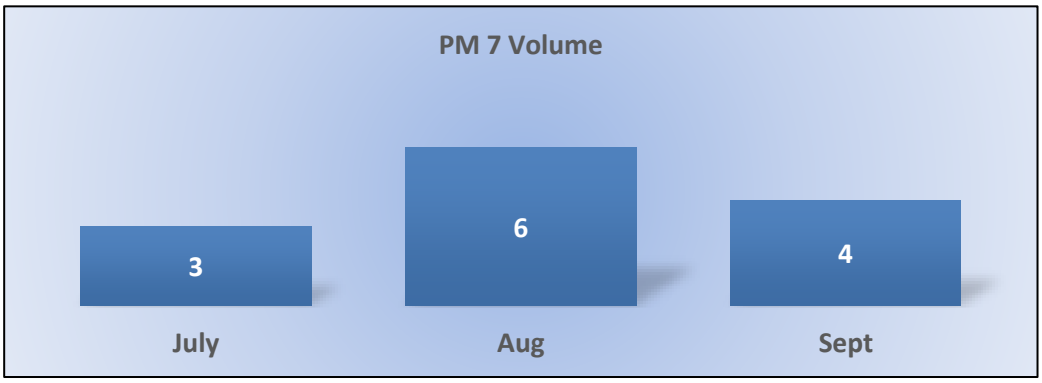
Average number of days to close cases transmitted to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Target Average: 540 Days | **Actual Average:** 1,335 Days

PM7 |Probation Intake – Volume

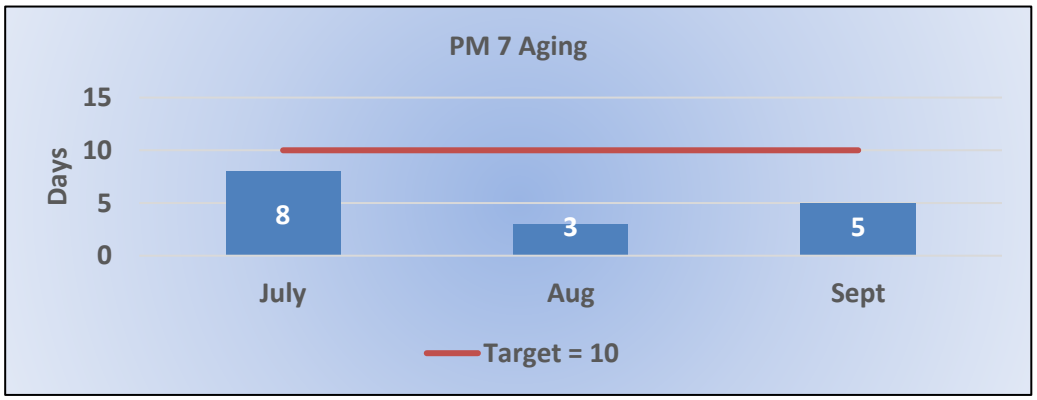
Number of new probation cases.



Total: 13

PM7 |Probation Intake – Cycle Time

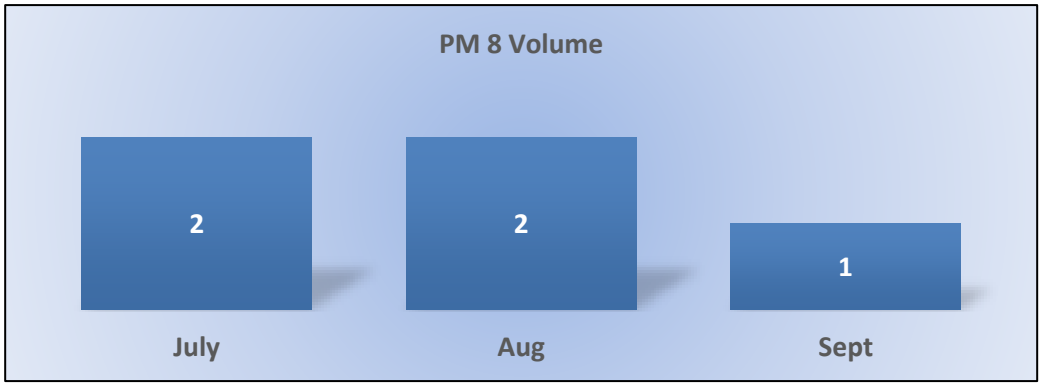
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 10 Days | **Actual Average:** 4 Days

PM8 |Probation Violation Response – Volume

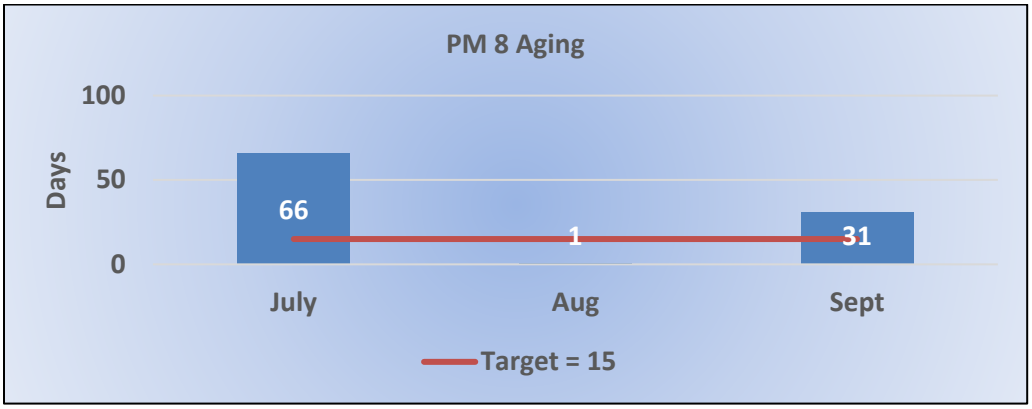
Number of probation violation cases.



Total: 5

PM8 |Probation Violation Response – Cycle Time

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



Target Average: 15 Days | **Actual Average:** 33 Days

Department of Consumer Affairs

Dental Board of California

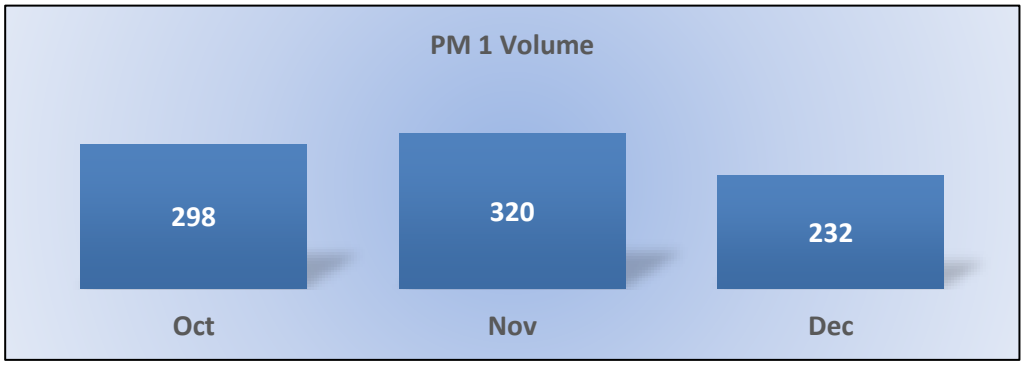
Enforcement Performance Measures

Q2 Report *(October - December 2017)*

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.

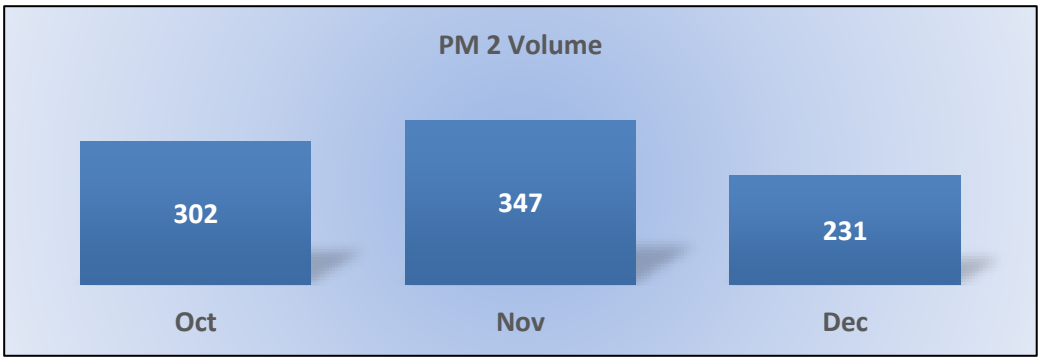


Total Received: 850 | **Monthly Average**: 283

Complaints: 752 | **Convictions**: 98

PM2 | Intake – Volume

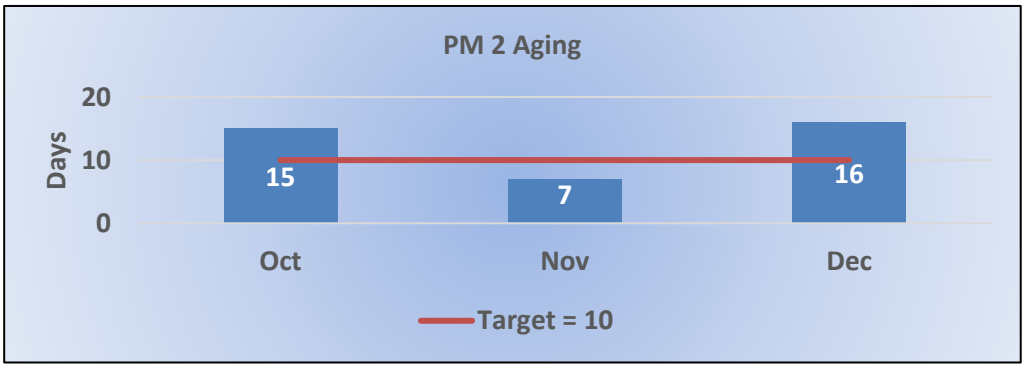
Number of complaints closed or assigned to an investigator.



Total: 880**| Monthly Average:** 293

PM2 | Intake – Cycle Time

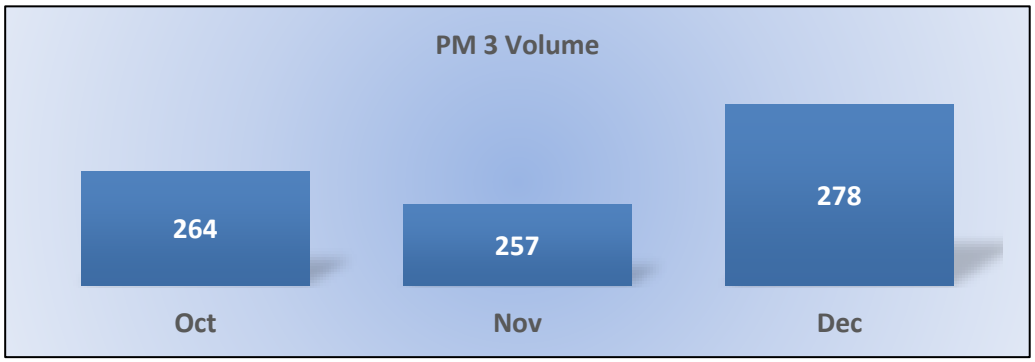
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



Target Average: 10 Days | **Actual Average:** 12 Days

PM3 | Investigations – Volume

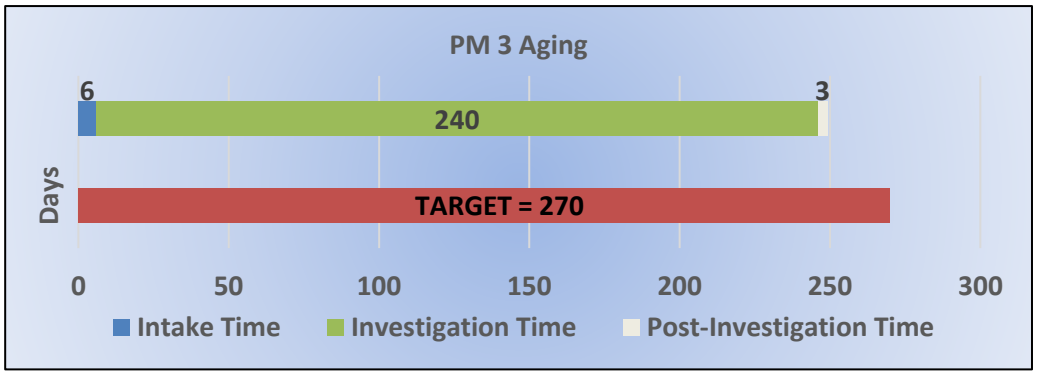
Number of investigations closed (not including cases transmitted to the Attorney General).



Total: 799**| Monthly Average:** 266

PM3 | Investigations – Cycle Time[1]

Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General.
(Includes intake and investigation)



Target Average: 270 Days | **Actual Average:** 249 Days

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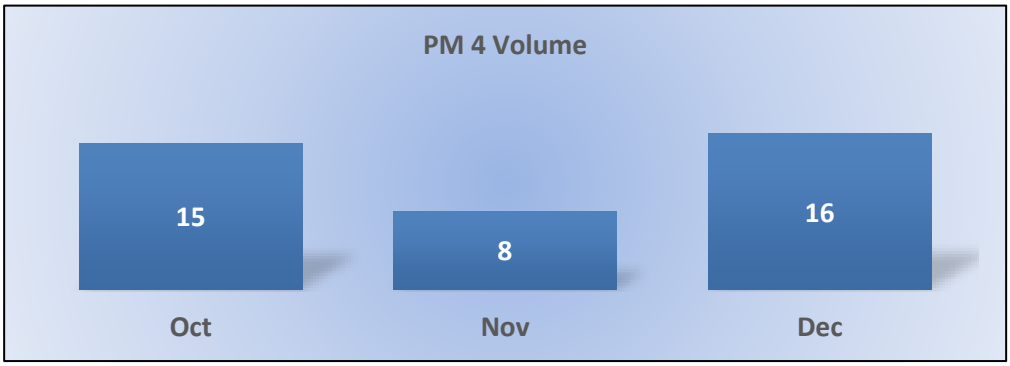
PM4 | Formal Discipline – Volume

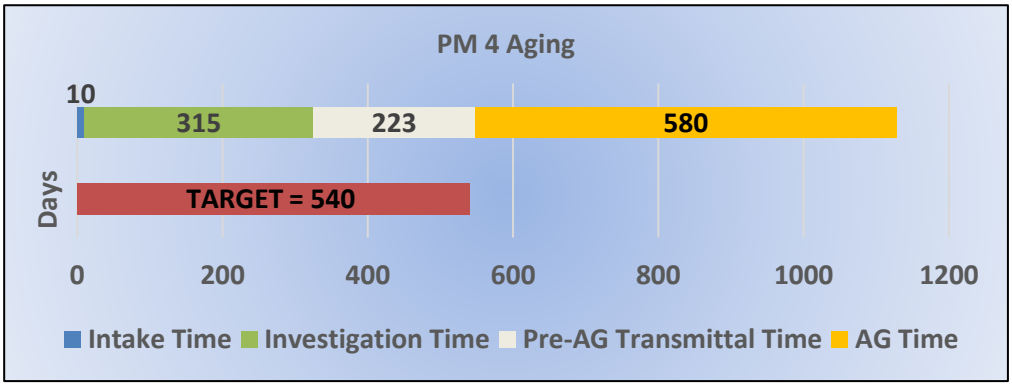
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Total: 39**| Monthly Average:** 13

PM4 | Formal Discipline – Cycle Time[2]

Average number of days to close cases transmitted to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Target Average: 540 Days | **Actual Average:** 1,128 Days

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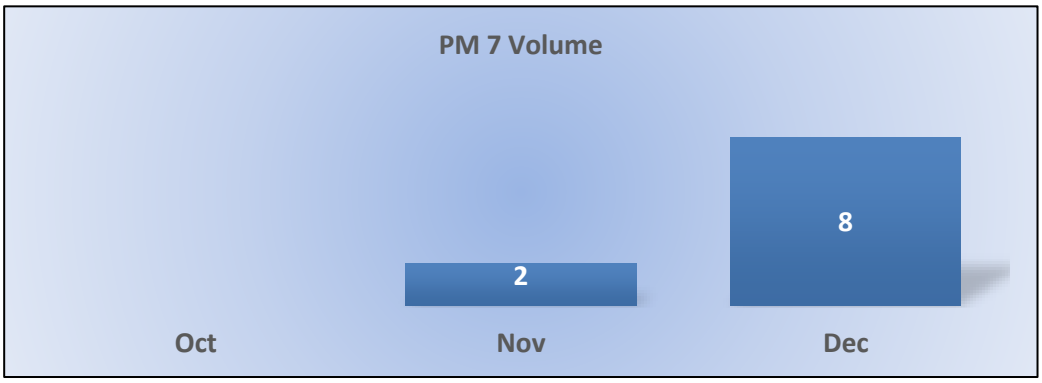
PM7 |Probation Intake – Volume

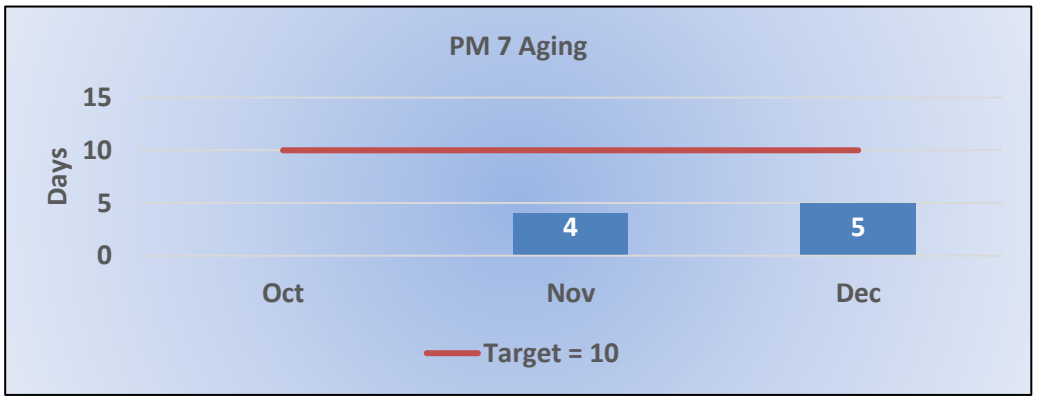
Number of new probation cases.



Total: 10

PM7 |Probation Intake – Cycle Time

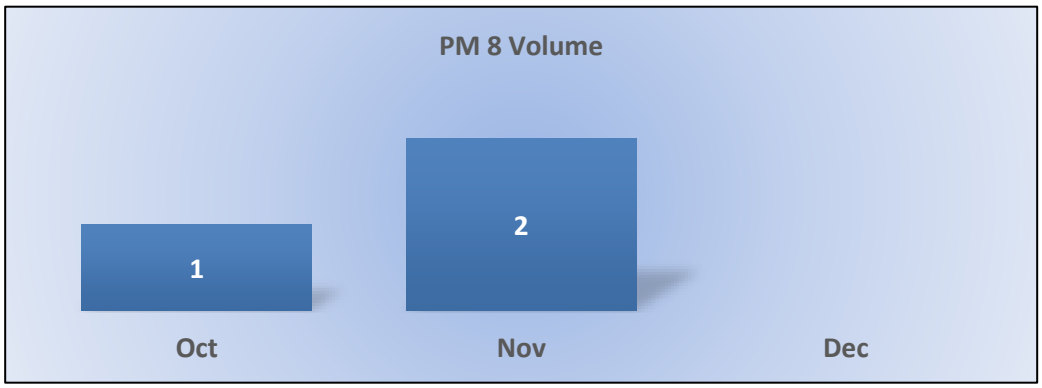
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 10 Days | **Actual Average:** 5 Days

PM8 |Probation Violation Response – Volume

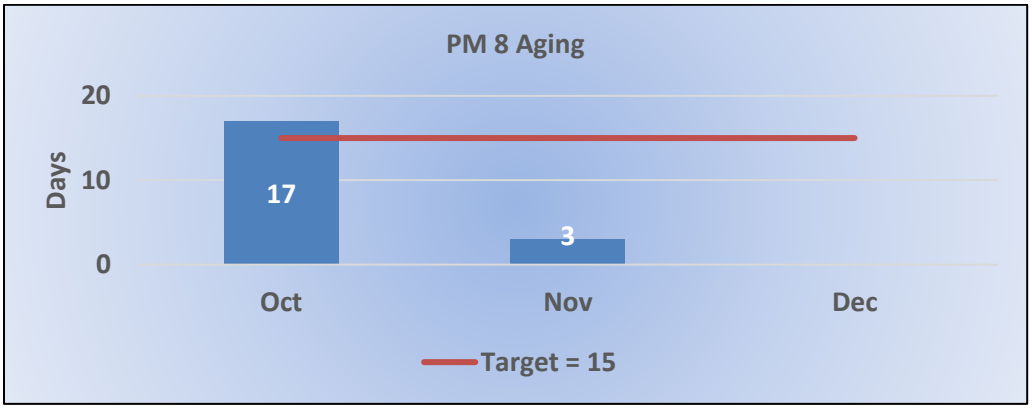
Number of probation violation cases.



Total: 3

PM8 |Probation Violation Response – Cycle Time

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



Target Average: 15 Days | **Actual Average:** 8 Days

Department of Consumer Affairs

Dental Board of California

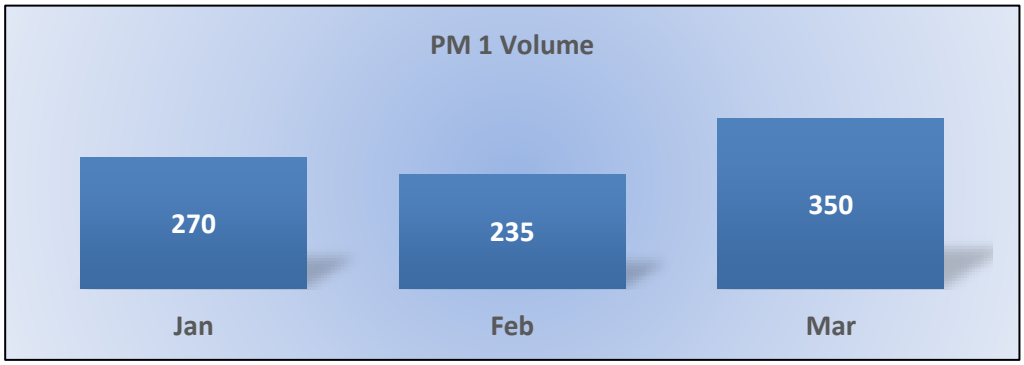
Enforcement Performance Measures

Q3 Report *(January - March 2018)*

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.

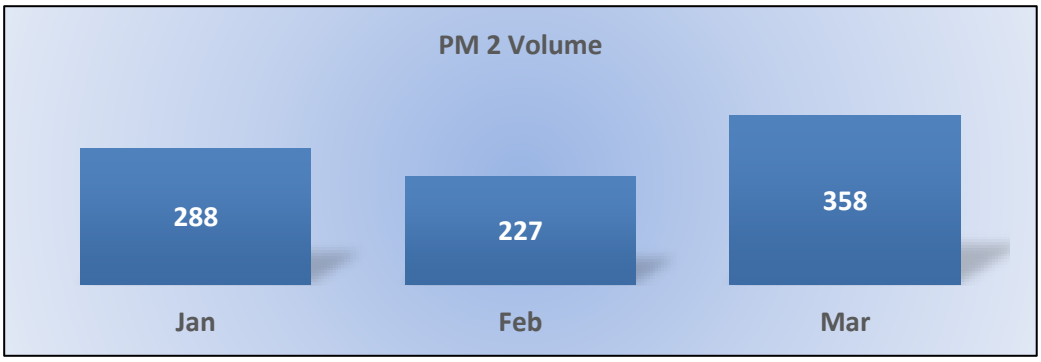


Total Received: 855 | **Monthly Average**: 285

Complaints: 766 | **Convictions**: 89

PM2 | Intake – Volume

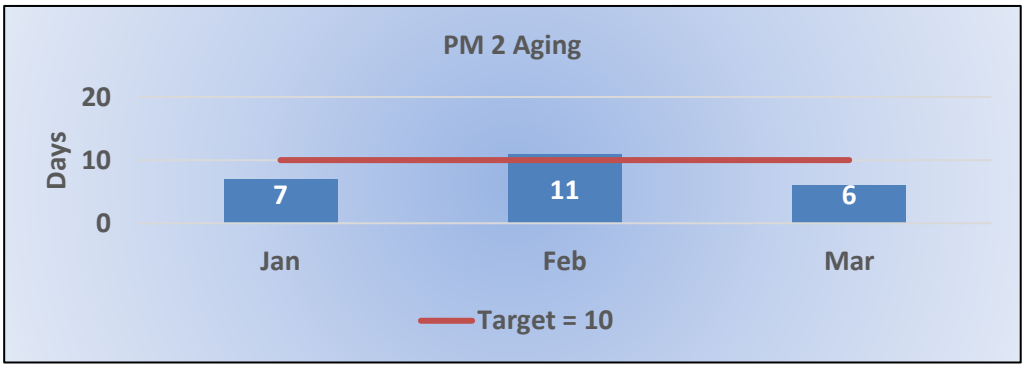
Number of complaints closed or assigned to an investigator.



Total: 873 **| Monthly Average:** 291

PM2 | Intake – Cycle Time

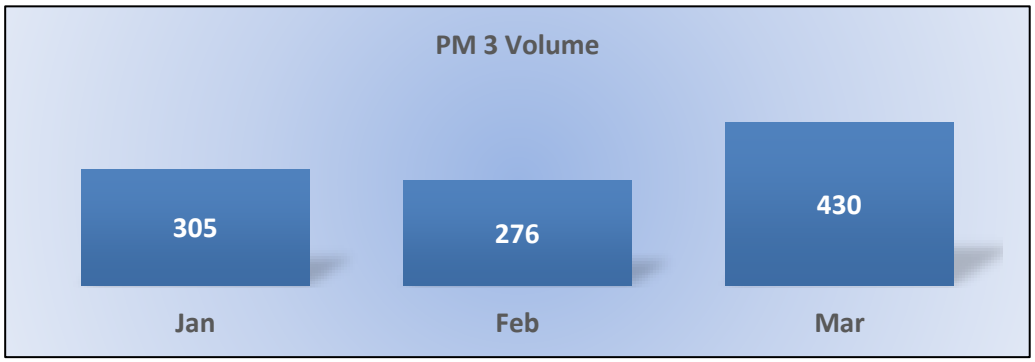
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



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

PM3 | Investigations – Volume

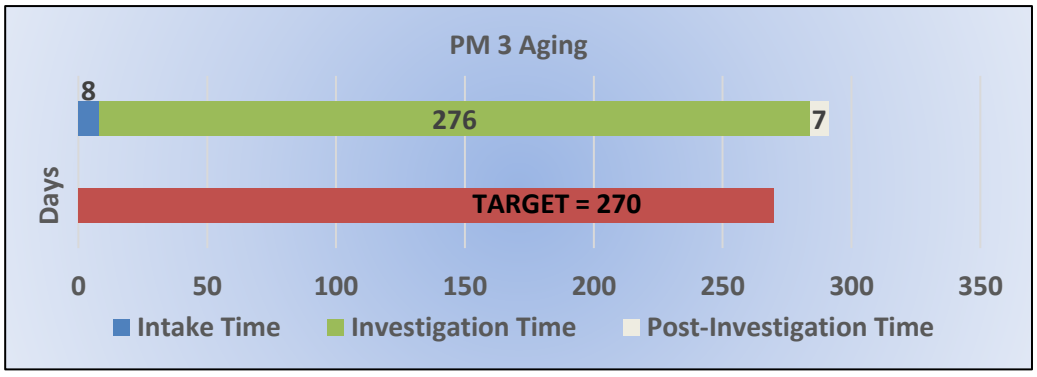
Number of investigations closed (not including cases transmitted to the Attorney General).



Total: 1011**| Monthly Average:** 337

PM3 | Investigations – Cycle Time[1]

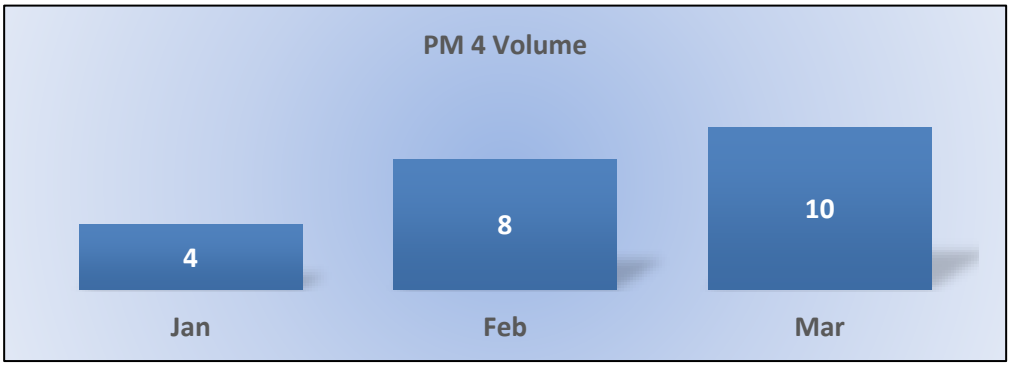
Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General.
(Includes intake and investigation)



Target Average: 270 Days | **Actual Average:** 291 Days

PM4 | Formal Discipline – Volume

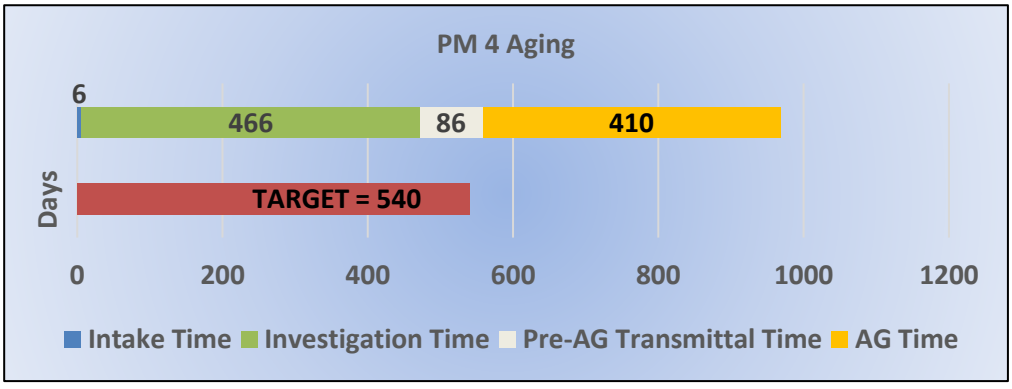
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Total: 22| **Monthly Average:** 7

PM4 | Formal Discipline – Cycle Time[2]

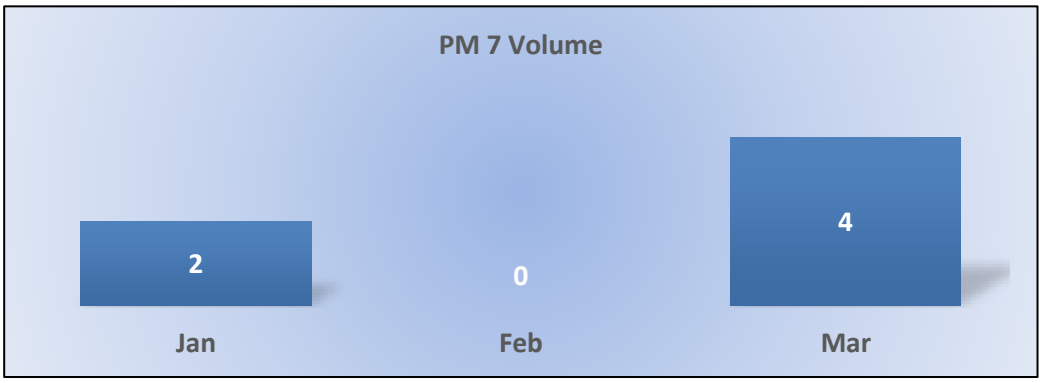
Average number of days to close cases transmitted to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Target Average: 540 Days | **Actual Average:** 962 Days

PM7 |Probation Intake – Volume

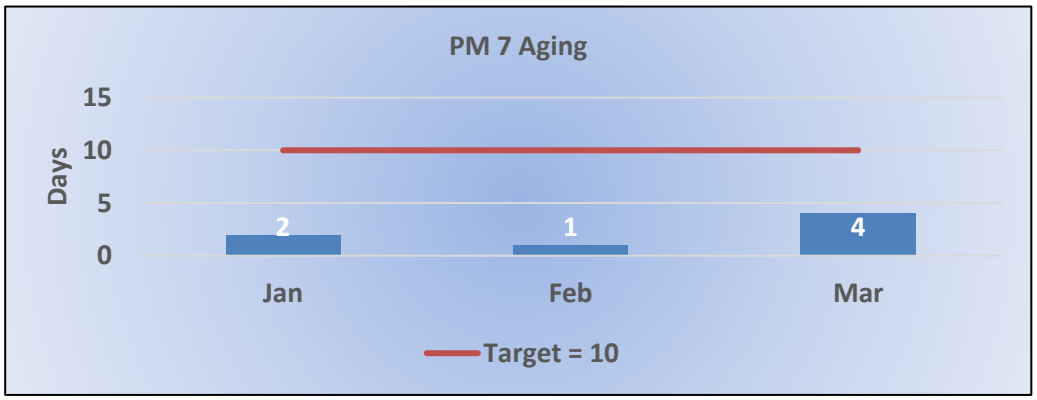
Number of new probation cases.



Total: 6

PM7 |Probation Intake – Cycle Time

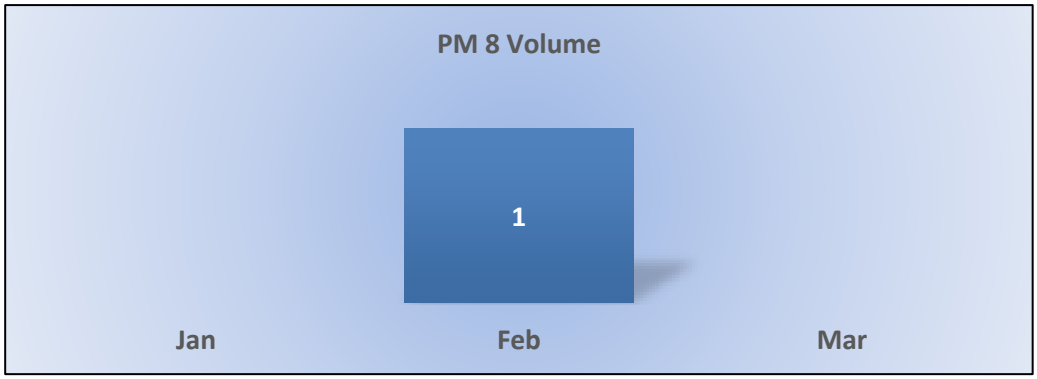
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 10 Days | **Actual Average:** 2 Days

PM8 |Probation Violation Response – Volume

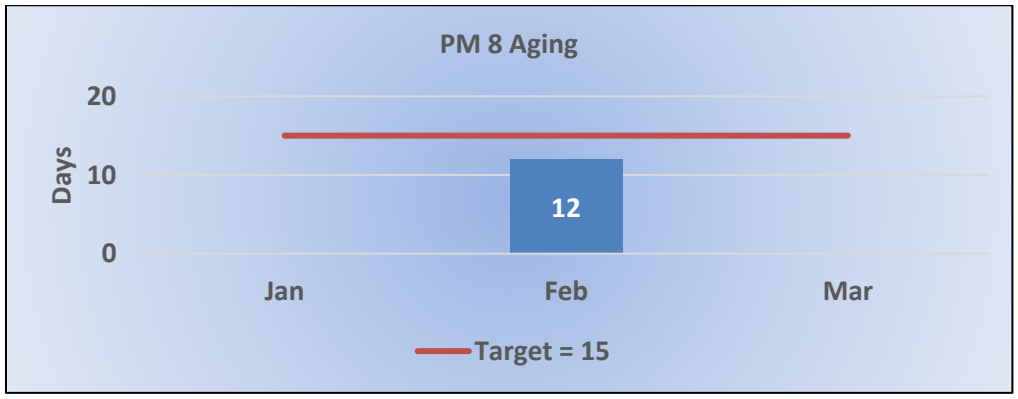
Number of probation violation cases.



Total: 6

PM8 |Probation Violation Response – Cycle Time

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



Target Average: 15 Days | **Actual Average:** 12 Days