

**FULL BOARD MEETING  
May 16-17, 2013**



**WATERFRONT HOTEL  
10 WASHINGTON STREET  
OAKLAND, CA 94607**



**Thursday, May 16, 2013**

**Agenda**

**Dental Board of California**



**NOTICE OF PUBLIC MEETING** – Notice is hereby given that a public meeting of the Dental Board of California will be held as follows:

**Thursday, May 16, 2013**

Waterfront Hotel  
10 Washington Street, Oakland, CA 94607  
(510)379-5293 or (916)263-2300

**Notice Regarding This Two-Day Meeting:** During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should items not be completed, it is possible that it could be carried over and be heard beginning at 8:30 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.

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

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

**Thursday, May 16, 2013**

**1:30 P.M. - FULL BOARD - OPEN SESSION**

Oath of Office and Introduction of New Board Members

ROLL CALL ..... Establishment of a Quorum

AGENDA ITEM 1 ..... Approval of the February 28 – March 1, 2013 Full Board Meeting Minutes and the April 4, 2013 Full Board Meeting Minutes

AGENDA ITEM 2 ..... President's Report

AGENDA ITEM 3 ..... Update by Dr. Paul Glassman on the Virtual Dental Home Project

AGENDA ITEM 4 ..... Presentation of Final Portfolio Pathway to Licensure Report by Norman Hertz, Ph.D., Applied Psychologist at Progeny Systems Corporation

(a) Discussion Regarding the Portfolio Pathway to Licensure Report

(b) Update on Portfolio Regulations and Handbook Review

AGENDA ITEM 5 ..... Legislative Process Overview and Discussion and Possible Action on the  
Following Legislation:

AB X1 1 (Perez) Medi-Cal Eligibility: Expansion  
AB X1 2 (Pan) Health Care Coverage  
AB 18 (Pan) Individual Health Care Coverage  
AB 50 (Pan) Health Care Coverage: Medi-Cal Eligibility  
AB 186 (Maienschein) Professions and Vocations: Military Spouses: Licenses  
AB 209 (Pan) Medi-Cal: Managed Care: Quality and Accessibility  
AB 213 (Logue) Healing Arts: Certification: Military Experience  
AB 258 (Chavez) State Agencies: Veterans  
AB 291 (Nestande) California Sunset Review Commission  
AB 318 (Logue) Dental Care: Telehealth  
AB 376 (Donnelly) Regulations: Notice  
AB 393 (Cooley) Office of Business and Economic Development: Web Site  
AB 496 (Gordon) Medicine: Sexual Orientation: Gender Identity  
AB 512 (Rendon) Healing Arts: Licensure Exemption  
AB 772 (Jones) Consumer Affairs: Intervention in State Agency  
AB 809 (Logue) Healing Arts: Telehealth  
AB 827 (Hagman) Department of Consumer Affairs  
AB 836 (Skinner) Dentists: Continuing Education  
AB 851 (Logue) Dentistry: Licensure and Certification Requirements  
AB 894 (Mansoor) Consumer Affairs  
AB 1003 (Maienschein) Professional Corporations: Healing Arts  
AB 1013 (Gomez) Consumer Affairs  
AB 1017 (Gomez) Incoming Telephone Calls: Messages  
AB 1174 (Bocanegra) Oral Health: Virtual Dental Homes  
AB 1231 (Perez) Regional Centers: Telehealth and Teledentistry  
SB X1 1 (Hernandez) Medi-Cal Eligibility  
SB X1 2 (Hernandez) Health Care Coverage  
SB 12 (Corbett) Consumer Affairs  
SB 13 (Beall) Public Employees' Retirement Benefits  
SB 28 (Hernandez) Medi-Cal: Eligibility  
SB 456 (Padilla) Health Care Coverage  
SB 532 (De Leon) Professions and Vocations: Military Spouses  
SB 562 (Galgiani) Dentists: Mobile or Portable Dental Units  
SB 690 (Price) Licenses  
SB 809 (DeSaulnier) Controlled Substances: Reporting  
SB 821 (B,P &E D) Healing Arts

**RECESS**





## **Agenda Item 1**

### **Approval of Meeting Minutes**

**Thursday, February 28, 2013**



## **DENTAL BOARD OF CALIFORNIA MEETING MINUTES**

**Thursday, February 28, 2013**

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

**DRAFT**

### **Members Present:**

Huong Le, DDS, President  
Fran Burton, Vice President  
Steve Afriat, Public Member  
Luis Dominicus, DDS  
Judith Forsythe, RDA  
Kathleen King, Public Member  
Suzanne McCormick, DDS  
Steven Morrow, DDS  
Thomas Stewart, DDS  
Bruce Whitcher, DDS

### **Members Absent:**

Stephen Casagrande, DDS

### **Staff Present:**

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

### **ROLL CALL AND ESTABLISHMENT OF QUORUM**

Dr. Huong Le, President, called the meeting to order at 8:31 a.m. Fran Burton, Secretary, called the roll and a quorum was established.

**The Board immediately went into closed session.**

**The Board returned to open session at 10:31 a.m.**

Dr. Huong Le, President, recognized members of the audience including Dr. Alan Felsenfeld from the California Dental Association (CDA), Dr. Guy Acheson from California Association of General Dentists (CAGD), Katie Dawson and Vickie Campbell from the California Dental Hygienists Association (CDHA), Lori Gagliardi, Lindsay Shubin, and Shelly Sorenson from the California Association of Dental Assisting Teachers (CADAT) and welcomed them to the meeting.

## **AGENDA ITEM 1: INTRODUCTION OF NEW BOARD MEMBERS AND OATH OF OFFICE**

Dr. Le introduced the two (2) new Board Members, Dr. Thomas Stewart from Bakersfield and Kathleen King from San Jose. She also announced the reappointment of Dr. Dominicis and Fran Burton. Dr. Le administered the oath of office to new and reappointed members. She asked Kathleen King and Dr. Thomas Stewart to say a few words. Dr. Le went on to say that the Governor appointed Dr. Ross Lai to replace Dr. Tom Olinger on the Board.

## **AGENDA ITEM 2: APPROVAL OF THE DECEMBER 3-4, 2012 FULL BOARD MEETING MINUTES**

M/S/C (Afriat/Dominicis) to approve the minutes of the December 3-4, 2012 Dental Board Meeting. Bill Lewis, CDA, stated that the American Dental Association contacted CDA to clarify that the portion of the minutes on Tuesday, December 4, 2012, Agenda Item 14 – Examination Committee Report relating to the progress of the Dental Board’s Portfolio Pathway to Licensure, the ADA stated that a more accurate reflection of ADA’s position is that “The American Dental Association is waiting for the Dental Board of California to complete their Portfolio program so they can consider it as one of the national models for a pathway to licensure”. The motion passed unanimously.

## **AGENDA ITEM 3: PRESIDENT’S REPORT**

Dr. Le reported that on February 6, 2013, she met with Fran Burton, Sarah Wallace and Karen Fischer to attend a meet and greet at the Capitol with Senator Emmerson followed by a quick drive over to the California Dental Association for a wonderful presentation by Dr. Witcher. She reported that on February 25<sup>th</sup> she met Ms. Fischer and Ms. Burton at the Capitol to meet the new Chair of the Health Committee, Assemblyman Rich Gordon. Dr. Le announced that she had recently completed her Master’s Degree from the University of the Pacific. Mr. Afriat wanted to acknowledge another colleague’s accomplishment; Dr. Steven Morrow received Loma Linda University’s “Alumni Distinguished Service” award.

## **AGENDA ITEM 4: UPDATE ON PENDING REGULATORY PACKAGES:**

In the absence of the Dental Board’s Legislative and Regulatory Analyst, Sarah Wallace, Fran Burton reported that at the May 18, 2012 meeting, the Board discussed and approved new proposed regulatory language relative to uniform standards for substance abusing licensees. The Board directed staff to initiate a rulemaking. As the rulemaking documents were being prepared, staff became aware of necessary substantive amendments to the proposed language. The Board will be reconsidering approval of the proposed language later today. If the Board accepts staff’s recommended changes, the rulemaking documents will be filed with the Office of Administrative Law on Tuesday, March 5<sup>th</sup>. The rulemaking would be published in the California Regulatory Notice Register on Friday, March 15<sup>th</sup>; the 45-day public comment period would begin on March 15<sup>th</sup> and end on April 29<sup>th</sup>. A regulatory hearing would be held on Monday, April 29<sup>th</sup>. The Board would be able to consider comments received during the public comment period and at the hearing at its next meeting in May.

Ms. Burton reported that at the August 17, 2012 meeting, the Board discussed and approved proposed regulatory language relative to examination, permit, and license fee increases for dentists. The Board directed staff to initiate a rulemaking. Staff is currently drafting the initial rulemaking documents and will be filing the proposed language with the Office of Administrative Law in the near future.

Ms. Burton stated that at the May 18, 2012 meeting, the Board discussed and approved proposed regulatory language relative to the abandonment of applications. The Board directed staff to initiate a rulemaking. At the December meeting, the Board deemed three

other regulatory packages as top priority; those regulatory packages were relative to the fee increase, the Uniform Standards for Substance Abusing Licensees, and the Portfolio Examination Requirements. Staff will continue working on the initial rulemaking documents in priority order.

**AGENDA ITEM 5: DISCUSSION AND POSSIBLE ACTION REGARDING RECONSIDERATION OF PROPOSED LANGUAGE AND INITIATION OF A RULEMAKING TO AMEND §1018 AND ADOPT §1018.01 OF TITLE 16 OF THE CALIFORNIA CODE OF REGULATIONS RELEVANT TO UNIFORM STANDARDS FOR SUBSTANCE ABUSING LICENSEES**

Board members were asked to review the revision and to ask for clarification if necessary. There were no additional questions. M/S/C (Afriat/Morrow) to accept the recommended revised proposed regulatory language relevant to the Uniform Standards for Substance-Abusing Licensees and direct staff to take all steps necessary to initiate the formal rulemaking process including noticing proposed language for 45-day public comment, setting proposed language for public hearing and authorizing the Executive Officer to make any non-substantive changes to the rulemaking package. If, after the close of the 45-day public comment period and public regulatory hearing, no adverse comments are received, authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process and adopt the proposed amendments to §1018 and proposed addition of §1018.01 of Title 16 of the California Code of Regulations. There was no public comment. The motion passed unanimously.

**AGENDA ITEM 6: DISCUSSION AND POSSIBLE ACTION REGARDING THE SUBCOMMITTEE'S REVIEW OF § 1005 OF TITLE 16 OF THE CALIFORNIA CODE OF REGULATIONS RELEVANT TO THE MINIMUM STANDARDS FOR INFECTION CONTROL CONDUCTED BY THE DENTAL BOARD OF CALIFORNIA AND THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA**

Karen Fischer, Interim Executive Officer, together with Lori Hubble, Executive Officer Dental Hygiene Committee of California, reported that a subcommittee was formed consisting of one representative from the Dental Board, Dental Assisting Council and the Dental Hygiene Committee of California to conduct the required annual review of the regulation relative to the minimum standards for infection control.

Ms. Fischer reported that the subcommittee met on February 4, 2013 via teleconference to review Section 1005 and established a consensus to bring the following findings forward to the Board and Committee for review. The Executive Officers of the Board and Committee worked to form a consensus on staff recommendations regarding the subcommittee's findings.

The subcommittee noted that Section 1005 requires all dental health care personnel to comply with infection control precautions and enforce the minimum precautions established in Section 1005 to protect patients and dental health care personnel and to minimize the transmission of pathogens in health care settings as mandated by the California Division of Occupational Safety and Health (Cal/OSHA). Section 1005 does not preclude any of the DBC's or the DHCC's licensees from complying with laws and regulations governed by other State and Federal agencies (i.e., Cal/OSHA).

The subcommittee established a consensus that Section 1005(a)(12)(C), relative to the definition for "Other Potentially Infectious Material (OPIM)", may need to be revised to clarify the definition relating to HIV, HBV and HCV. The subcommittee questioned if the

current definition contradicts universal precautions. The subcommittee determined that this finding should be forwarded to the Board and the Committee for consideration.

The definition currently found Section 1005(a)(12)(C) was derived from the Cal/OSHA definition to ensure dental offices are in compliance with Cal/OSHA's regulations.

At this time, staff did not recommend that the Board or the Committee amend the language currently found in Section 1005(a)(12)(C) as this language is consistent with Cal/OSHA's definition of OPIM. However, should the CDC or Cal/OSHA amend their definitions in the future, the Board and Committee may find it necessary to amend the definition of OPIM found in Section 1005(a)(12)(C) at that time.

The subcommittee established a consensus that Section 1005(b)(8), relative to gloves, may need to be revised to specify that gloves are required to be puncture-resistant. The subcommittee members noted that there have been some instances when dental health care personnel have not utilized puncture-resistant gloves when processing sharp instruments, needles, and devices. The subcommittee determined that this finding should be forwarded to the Board and the Committee for consideration.

Currently, Section 1005(b)(8) specifies that when processing contaminated sharp instruments, needles, and devices, dental health care personnel shall wear heavy-duty utility gloves to prevent puncture wounds.

At this time, staff did not recommend that the Board or the Committee amend the language currently found Section 1005(b)(8) relating to gloves. Staff did not believe it necessary, at this time, to amend the language as the current language is clear that the heavy duty gloves are to be worn to prevent puncture wounds, thus implying the gloves be "puncture-resistant". Adding the term "puncture-resistant" would be considered duplication. Staff recommended keeping note of this subcommittee finding and including it as part of a future regulatory proposal at a time when the Board and the Committee deem it necessary to amend Section 1005.

M/S/C (Burton/King) to accept staff's recommendations, which do not pose a threat to public safety, that no formal regulatory amendments be promulgated at this time. However, staff will maintain records of this subcommittee's review and findings for consideration by the Board, the Dental Assisting Council and the Dental Hygiene Committee of California during future annual reviews. There was no public comment. The motion passed unanimously.

**AGENDA ITEM 7: DISCUSSION AND POSSIBLE ACTION REGARDING BOARD POLICY  
DECISION TO AUTHORIZE THE USE OF ALL IMAGE RECEPTORS TO CAPTURE  
RADIOGRAPHS DURING RADIATION SAFETY INSTRUCTION AND CERTIFICATION  
PROVIDED BY EDUCATIONAL PROGRAMS AND COURSES IN COMPLIANCE WITH  
CALIFORNIA CODE OF REGULATIONS, TITLE 16, SECTIONS 1014 AND 1014.1**

Karen Fischer, Interim Executive Officer, reported that the California Association of Dental Assisting Teachers (CADAT) submitted proposed regulatory amendments to the California Code of Regulations, Title 16, Sections 1014 and 1014.1 relative to radiation safety courses for the Dental Assisting Council (Council) to review and provide recommendations to the Board to promulgate a formal rulemaking. Those proposed amendments were reviewed by an appointed subcommittee of the Council and will be considered by the full Council at this meeting.

During discussions with representatives of CADAT, it became evident that the current regulatory requirements regarding traditional film and computer digital radiographic equipment found in Sections 1014 and 1014.1 was not conducive to the technologically advanced environment currently used by dental professionals. During the December 2012 Board meeting public comment agenda item, representatives of CADAT raised concerns regarding the current radiographic technology used by programs and courses during instruction in radiation safety as being outside the scope of the currently effective regulatory requirements. Additionally, CADAT submitted a letter to the Board requesting this issue be placed on the February agenda.

Lori Gagliardi, on behalf of CADAT requested that the Dental Board adopt a formal policy interpretation of California Code of Regulations, Title 16, Sections 1014 and 1014.1 to authorize the use of all “image receptors” (e.g. traditional film, digital device, etc.) to capture radiographs during radiation safety instruction and certification provided by educational programs and courses and deem the use of all “image receptors” in compliance with the laboratory and clinical instruction requirements until the proposed amendments to Sections 1014 and 1014.1 become effective in accordance with the Administrative Procedure Act to replace the word “film” in its regulations with the word “image receptor”.

Spencer Walker, Senior Legal Counsel, advised the Board that doing so would be an underground regulation. However, upon adoption of the proposed regulations, the issue will be resolved. Programs being approved will still be required to comply with the current law until the issue can be resolved in updated regulations. Dr. Morrow stated that radiation safety needs to be consistent no matter what device is used to acquire the image. M/S/C (Morrow/King) to direct staff to treat this issue as a very low level Enforcement matter. There was no public comment. The motion passed unanimously.

## **COMMITTEE/COUNCIL MEETINGS**

The Full Board reconvened at 3:01 p.m.

Roll was called and a quorum established.

### **AGENDA ITEM 8: Report on the January 16, 2013 Meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permits; and Update on the Board’s Report to the Legislature January 1, 2013**

Dr. Whitcher, Board liaison, reported that the Board’s Report to the Legislature was reviewed at the January 16, 2013 meeting of the Elective Facial Cosmetic Surgery (EFCS) Permit Credentialing Committee. The EFCS committee recommended accepting the report.

Dr. Whitcher reported that the EFCS committee met in closed session to review three (3) applications, one of which was deferred to a future meeting because the Committee requested the applicant submit additional information. The Committee’s Recommendations to the Board were as follows:

1. Applicant: Dr. Jeffrey D. Politz. - Requested unlimited privileges for Category II (cosmetic soft tissue contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

***The Committee recommended the Board issue Dr. Jeffrey D. Politz a permit limited to the following Category II procedures: facial fillers and facial neurotoxins.***

2. Applicant: Dr. Sanford L. Ratner. - Requested unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but not limited to, rhinoplasty and otoplasty).

***The Committee recommended the Board issue Dr. Sanford L. Ratner a permit limited to the following Category I procedures: Genioplasty and chin implants.***

M/S/C (Afriat/Morrow) to accept the Committee's recommendation to issue applicant one (1), Dr. Jeffrey D. Politz, a permit limited to the following Category II procedures: facial fillers and facial neurotoxins. There was no public comment. The motion passed unanimously.

M/S/C (Morrow/McCormick) to accept the Committee's recommendation to issue applicant two (2), Dr. Sanford L. Ratner a permit limited to the following Category I procedures: Genioplasty and chin implants. There was no public comment. The motion passed unanimously.

M/S/C (Burton/Afriat) to accept the Committee's recommendation to accept the Board's report to the Legislature. There was no public comment. The motion passed unanimously.

#### **AGENDA ITEM 9: Update on the Patient Protection and Affordable Care Act**

Fran Burton reported that the California Health Benefits Exchange, now known as Covered California, issued its first annual report regarding implementation of the provisions of the federal Patient Protection and Affordable Care Act (PPACA) to Governor Brown in January 2013.

She went on to report that on February 13, 2013, Covered California issued a press release announcing standard benefit plans for consumers.

Ms. Burton informed the Board that staff is currently tracking legislation related to health benefits and changes to Medi-Cal eligibility and will keep the Board apprised of any changes impacting dentistry in the State of California.

Dr. Le, Board President, re-established the Access to Care Committee. She appointed Fran Burton as the Chair and asked Board members who are interested in serving on this committee to contact Karen Fischer, Interim Executive Officer, or herself in the next couple of weeks.

#### **AGENDA ITEM 10: Discussion and Possible Action Regarding Changing the Dates and Locations of Dental Board Meetings in 2013**

There was discussion regarding the proposed changes. During Closed Session the Board agreed to hold an additional meeting, April 4, 2013 in Sacramento.

The Board agreed to the following dates and locations:

May 16-17  
August 26-27  
November 21-22

Oakland  
Sacramento  
Los Angeles



#### **AGENDA ITEM 16: Enforcement Committee Report**

Steven Afriat, Chair, reported that the Enforcement Committee approved the December 3, 2012 minutes. He stated that staff gave a report on the Enforcement unit's projects and improvements. Statistics and status were reviewed and it was noted that there is a larger caseload in the south. Additional staff is being added in the south. There was discussion surrounding the appointment of a new Diversion Evaluation Committee member. The committee agreed to recommend that the Board approve the appointment of Dr. Gregory Pluckhan to the Diversion Evaluation Committee. M/S/C (Burton/Dominicis) to accept the Enforcement Committee report and to approve Dr. Gregory Pluckhan as a new Diversion Evaluation Committee member. There was no public comment. The motion passed unanimously.

#### **AGENDA ITEM 17: Legislative and Regulatory Committee Report**

Fran Burton, Chair, reported that the minutes of the December 3, 2012 Legislative and Regulatory Committee meeting were approved unanimously. She stated that six (6) bills were reviewed and discussed. The consensus of the Committee was to take no action on any of the bills at this time as they are so new. M/S/C (Afriat/McCormick) to approve the committee recommendation to watch all bills reviewed. There was no public comment. The motion passed unanimously.

#### **AGENDA ITEM 18: Examination Committee Report**

Dr. Morrow, Vice Chair, reported that the December 3, 2012 minutes were approved unanimously. He stated that a report was submitted by the Office of Professional Examination Services (OPES) regarding the review of Western Regional Examiners Board (WREB). The final report should be submitted by the end of the fiscal year (June 30, 2013). Dr. McCormick gave a report on WREB activities. Dr. Morrow gave update on the progress of the Portfolio pathway to licensure. M/S/C (Afriat/McCormick) to accept the Examination Committee report. There was no public comment. The motion passed unanimously.

#### **AGENDA ITEM 19: Licensing, Certification & Permits Committee Report**

Dr. Suzanne McCormick, Chair, reported that the December 3, 2012 minutes were approved unanimously. She stated that the statistics that were provided were reviewed and discussed. The need for Evaluators and Evaluator Calibration Training Courses was discussed. She reported that Dr. Whitcher suggested the possibility of a web-based or online training course to try to recruit evaluators from areas that may be underserved due to inaccessibility. Dr. McCormick stated that the committee is considering forming a subcommittee to evaluate the methods by which the calibration course is given and the recruitment of evaluators.

Ms. King commented that within the data by county she would like to see the ratio of dentists per population by 1000's.

Dr. Guy Acheson commented that the California Dental Association used to calibrate the certification courses. He stated that there has been tremendous improvement since Dr. Whitcher took over the calibration process.

M/S/C (Morrow/Afriat) to accept the Licensing, Certification and Permits Committee report. There was no public comment. The motion passed unanimously.

## **AGENDA ITEM 20: Dental Assisting Council Report**

Judith Forsythe, Council Chair, reported that a quorum was established and the December 3, 2013 Dental Assisting Council minutes were approved. She stated that April Alameda, Dental Assisting Unit Manager, gave an update regarding the status of the dental assisting programs and courses, and an overview of the licensure and permit statistics. Ms. Forsythe reported that the Council agreed to schedule a separate Dental Assisting Council meeting aside from the Board meeting. The Council also voted to recommend the Board approve and adopt the Council's amended regulations and ask the Board to move forward with the regulatory process. Fran Burton asked for clarification regarding the Council's discussion to require a two (2) hour Dental Practice Act course and a basic life support (CPR) course prior to taking the Radiation Safety Course.

Dr. Whitcher explained that one of the items proposed for discussion in the original Board packet was whether or not the 8-hour Infection Control course should be required prior to taking the Radiation Safety Course. The Council agreed that the 8-hour Infection Control course should be a prerequisite. He further explained that there was another discussion surrounding whether or not the two (2) hour Dental Practice Act course should be required prior to taking the Radiation Safety Course but the Council rejected that proposal. Dr. Whitcher stated that at this point the directive is for staff to put together all the amendments and bring it back at the May meeting for the Council to review and make recommendations to the Board. There was discussion regarding the requirement for Infection Control prior to the Radiation Safety course and the possibilities surrounding this requirement that may create a barrier to licensure. There was more discussion regarding the issue of public safety and the possibility that without the requirement of Infection Control prior to Radiation Safety, a student may be putting objects into people's mouths before they have the benefit of Infection Control knowledge. Dr. Whitcher mentioned that there is a provision for infection control within the course, relevant to radiation safety technology. The question is; is that adequate? Dr. Le stated that she would like to review the provision for infection control in the Radiation Safety course regulations prior to adopting the amendments. Spencer Walker, Senior Legal Counsel, stated that the Board would have to table this, additional information would have to go before the Council for consideration and if necessary, the Council would make additional recommendations. He stated that the recommendation that the Council made today would be tabled. Lori Gagliardi, CADAT, commented that her group supports the proposal to make the 8-hour Infection Control course a prerequisite to the Radiation Safety course. There was lengthy discussion about the pros and cons of this issue.

Dr. Whitcher asked that staff draft all the changes into an understandable document for the Council and Board to review in order to make an informed decision before directing staff to move forward with the regulatory process. Mr. Walker clarified that this item would have to go back to the Dental Assisting Council for their recommendation before coming back before the Full Board.

M/S/C (Afriat/King) to accept the report and continue the regulatory matter to the May meeting. Dr. Whitcher commented that he felt at a severe disadvantage being handed amendments at the last minute with no time for study or review. There was no public comment. The motion passed unanimously.

M/S/C (Afriat/Morrow) to recess the meeting until 8:30 a.m. the next day. There was no public comment. The motion passed unanimously.



## **Approval of Meeting Minutes**

**Friday, March 1, 2013**



## **Dental Board of California Meeting Minutes**

**Friday, March 1, 2013**

Holiday Inn on the Bay

1355 North Harbor Drive, San Diego, CA, 92101

**DRAFT**

### **Members Present:**

Huong Le, DDS, President  
Fran Burton, Vice President  
Steve Afriat, Public Member  
Luis Dominicus, DDS  
Judith Forsythe, RDA  
Kathleen King, Public Member  
Suzanne McCormick, DDS  
Steven Morrow, DDS  
Thomas Stewart, DDS  
Bruce Whitcher, DDS President

### **Members Absent:**

Stephen Casagrande, DDS

### **Staff Present:**

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

Dr. Le, Dental Board President, called the meeting to order at 8:30 a.m. Roll was called and a quorum established.

Dr. Le recognized guests in the audience: Janice Shintaku-Enkoji, Department of Consumer Affairs Fiscal Officer, Michele Hurlbutt, Dental Hygiene Committee of California President and James Fischer, MD (husband of the Interim Executive Officer of the Dental Board of California).

Dr. McCormick reported that during Closed Session, the Licensing, Certification and Permits Committee considered two (2) applications for a license to replace a cancelled license. One was for a dentist with the initials MLE, the other was for a Registered Dental Assistant (RDA) with the initials RMK. The LCP committee asked that the Board accept their recommendation to grant licenses to replace cancelled licenses to both applicants. M/S/C (Afriat/Forsythe) to accept the LCP Committee's recommendation to grant new licenses to applicant MLE and applicant RMK. The motion passed unanimously.

#### **AGENDA ITEM 11: INTERIM EXECUTIVE OFFICER'S REPORT**

Karen Fischer, Interim Executive Officer, thanked the Board for the opportunity and stated that she is enjoying the challenge. Ms. Fischer reviewed some of her background. She reported that there are three (3) new Board members; Dr. Ross Lai, who will be attending the next Board meeting, Dr. Thomas Stewart and Ms. Kathleen King. She went on to say that in the absence of an assistant Executive Officer and someone to fill her role, Managers have taken on additional projects and rallied to keep the Board running as efficiently as possible during the transition. Ms. Fischer gave an update on the many other items that management and staff are working on. She reported on the two (2) new regulations that recently went into effect. Ms. Fischer mentioned the possibility of going paperless for the Board meeting packets. She also gave an update on the phone situation and solutions that are being implemented.

#### **AGENDA ITEM 12: BUDGET REPORTS: DENTAL FUND & DENTAL ASSISTING FUND**

Karen Fischer, Interim Executive Officer, reported that the Board has spent roughly \$5.1 million of its current year Dentistry budget appropriation. Approximately \$2.6 million was spent for Personnel Services; and roughly \$2.5 million for Operating Expense & Equipment (OE&E). Based on these expenditures, the Board is projected to revert back to the Dentistry Fund approximately \$600,000.

The Board has spent roughly \$822,000 of its current year Dental Assisting budget appropriation. Approximately \$258,000 was spent for Personnel Services; and roughly \$563,000 for Operating Expense & Equipment (OE&E). Based on these expenditures, the Board has projected an over expenditure, *due to the increase in Attorney General (AG) costs*, of \$104,836.

Ms. Fischer wanted to reiterate for the record that she and the former Executive Officer, Richard DeCuir, had submitted a request for an augmentation in the amount of \$105,000, for the Dental Assisting Fund to cover the additional and ongoing costs related to the Attorney General (AG) budget line item for enforcement. There has been a temporary suspension of submitting low priority Registered Dental Assistant (RDA) enforcement cases to the Attorney General since December 1, 2012.

Janice Shintaku-Enjokli, Fiscal Officer for the Department of Consumer Affairs, reported that the request for augmentation by the Dental Board is currently being reviewed at the Department of Finance. The outcome should be known and related to Ms. Fischer within a week.

Ms. Shintaku-Enjokli answered questions regarding the budget.

#### **AGENDA ITEM 13(A): DISCUSSION AND POSSIBLE ACTION TO RECONSIDER STAFF'S RECOMMENDATION FOR APPROPRIATE FEE INCREASE TO DENTISTRY TO SUSTAIN BOARD EXPENDITURES**

Karen Fischer, Interim Executive Officer remarked that staff met with the Budget Office and it was determined that instead of fee increases to all categories of Dental licensure, the fee increase would apply only to initial and renewal Dental license fees. They determined that additional workload studies would need to be conducted before moving forward with fee increases in the other areas of licensure and examinations. Janice Shintaku-Enjokli explained that Ms. Fischer and the Budget Office reviewed the information previously provided to validate the need for a fee increase for initial licensure and renewals. The Budget Office is in support of the increase to the statutory cap of \$450. Additionally, Ms. Shintaku-Enjokli indicated that the Board may need to look at a statutory change to raise the cap for renewals because the workload analysis already prepared shows that raising the renewal fee above \$450 could be justified at this time.

Ms. Fischer emphasized to the Board that the Government Code states that if the Executive Officer knowingly overspends the budget (s)/he can be held personally and professionally liable.

**AGENDA ITEM 13(B): DISCUSSION AND POSSIBLE ACTION TO RECONSIDER INITIATION OF A RULEMAKING TO AMEND CALIFORNIA CODE OF REGULATIONS, TITLE 16, § 1021 RELEVANT TO LICENSE FEES FOR DENTISTS**

M/S/C (Afriat/Dominicis) to recall the board's previous action to initiate a formal rulemaking to raise the initial licensure and renewal fees for dentists to the statutory cap of \$450 and all other licensing and permit fees, and to instead, move that the Board initiate a formal rulemaking to only increase the initial licensure and renewal fees to the cap at this time.

Steve Afriat asked if retired, inactive, and delinquent fees are being considered as well. Ms. Shintaku-Enkojli explained that these fees are calculated as percentages of the renewal fee.

Dr. Alan Felsenfeld, California Dental Association (CDA) speaking as a licensed dentist in this state and on behalf of my colleagues, stated that the need for the fee increase was understood but with that increase is the hope for an even better Dental Board with better service to its members and enforcement stepped up.

Mr. Afriat asked if he could amend his motion to include the inactive/retired license fees or is that something that has to be looked at separately? Spencer Walker, senior legal counsel, stated that it would have to be looked at separately because it relates to an inactive license. Mr Afriat requested that we agendize the inactive/retired license fee increase in the future.

Kathleen King asked if the motion they were about to vote on meant that there would be a fee increase this year and maybe an increase next year also or are we going to the max? Dr. Le stated that we are going to the maximum so if any more increases are needed there would have to be statutory change to increase the maximum fee.

Mr. Walker restated the amended motion: "to recall the Board's previous action to raise the initial licensure and renewal fees for dentists to the statutory cap of \$450.00 and all other licensing and permit fees for dentists, and to instead, move forward with formal rulemaking to only increase initial licensure and renewal fees to \$450 and delinquency fees at this time." The motion passed unanimously.

**AGENDA ITEM 14: UPDATE FROM THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA (DHCC)**

Michelle Hurlbutt, newly elected President of the Dental Hygiene Committee of California (DHCC), reported that as a new Committee, DHCC does not have any regulations so they have been working on their regulatory packages since 2009. They are awaiting implementation of the BreEZe project to streamline their operations. She stated that they will be meeting in May and updating their Strategic Plan. She invited Dr. Le to attend their meeting on May 3, 2013. Ms. Hurlbutt reported that the DHCC has launched the inaugural issue of their newsletter which is posted on their website.

**AGENDA ITEM 15: UPDATE FROM THE DEPARTMENT OF CONSUMER AFFAIRS EXECUTIVE OFFICE**

There were no representatives available from the Department of Consumer Affairs to provide an update.

**PUBLIC COMMENT:**

Bill Lewis, California Dental Association (CDA), reported that CDA will not be pursuing the issue of Dental Labs legislatively this year. He stated that there were a couple of resolutions that came out of CDA's House of Delegates meeting last November. CDA would like to have some discussion with the Board and/or staff regarding the legality of Dentists participating in Groupon. He went on to state that the second resolution that was passed had to do with student participation at Sponsored

Free Health Care events specifically CDA Cares. Dr. Morrow commented that students being supervised by faculty may participate in these events.

Michelle Hurlbutt, Dental Hygiene Committee of California (DHCC) commented that DHCC would like the Board to look into the possibility of adding Dentists to the list of providers who can supervise staff at CLIA waiver facilities.

M/S/C (Afriat/Morrow) to adjourn the meeting. The motion passed unanimously.

The meeting adjourned at 9:42 a.m.

DRAFT





## **Approval of Meeting Minutes**

**Thursday, April 4, 2013**

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 www.dbc.ca.gov



**Dental Board of California**

**Meeting Minutes**

**Thursday, April 4, 2013**

Department of Consumer Affairs

1747 North Market Blvd., Hearing Room, Sacramento, CA 95834

**DRAFT**

**Members Present:**

Huong Le, DDS, President  
Fran Burton, Secretary  
Steven Afriat, Public Member  
Stephen Casagrande, DDS  
Judith Forsythe, RDA  
Kathleen King, Public Member  
Ross Lai, DDS  
Suzanne McCormick, DDS  
Steven Morrow, DDS  
Thomas Stewart, DDS  
Bruce Whitcher, DDS

**Members Absent:**

Luis Dominicus, DDS

**ROLL CALL AND ESTABLISHMENT OF A QUORUM**

Dr. Huong Le, President, called the meeting to order at 10:00 a.m. Fran Burton, Secretary called the roll and a quorum was established.

**AGENDA ITEM 1: Election of Dental Board Officer – Secretary**

M/S/C (Whitcher/ McCormick) to nominate Dr. Steven Morrow for the office of Secretary of the Dental Board. The motion was approved and the vote was unanimous to appoint Dr. Morrow Secretary of the Dental Board. Dr. Morrow abstained from the voting.

**AGENDA ITEM 2: Discussion and Possible Action Regarding the Subcommittee's Recommendation to Appoint a Member to the Dental Assisting Council**

Judy Forsythe, Chair of the Dental Assisting Council reported that four applications were received for the vacant position on the Dental Assisting Council. One applicant did not qualify as they were not a licensed RDA and another applicant was not a faculty member of an approved RDA program. Ms. Forsythe reported that the subcommittee reviewed the two remaining applications and recommended Michele Jawad to fill the vacancy. M/S/C (Forsythe/Afriat) to accept the subcommittee's recommendation and approve Michele Jawad as the new Dental Assisting Council member. Her term will be four (4) years.

Kathleen King, Public member asked why there were so few candidates. Ms. Forsythe explained that it is hard for most RDA's to make the time commitment necessary to serve on the Council. LaDonna Drury-Klein representing CADAT concurred adding that RDA educators are extremely busy at this time of year preparing their students for examinations.

There was discussion as to how the Board could attract more applicants in the future.

The motion passed unanimously.

**The Board went into Closed Session to Deliberate and Take Action on Personnel Matters:**

**a) Interview Candidates for Executive Officer Position**

**b) Select and Appoint an Executive Officer**

The Board returned to open session at 1:30 p.m.

**Announcement Regarding Closed Session**

The Board announced that it had unanimously chosen Karen M. Fischer as the Board's new Executive Officer pending approval from the Director of the Department of Consumer Affairs.

**PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA**

There was no public comment.

The Board adjourned at 2:00 p.m.

DRAFT



## **Agenda Item 2**

### **Presidents Report**

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 [www.dbc.ca.gov](http://www.dbc.ca.gov)



## MEMORANDUM

<b>DATE</b>	May 16, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 2:</b> President's Report

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



## **Agenda Item 3**

### **Update on Virtual Dental Home Project**



## MEMORANDUM

<b>DATE</b>	April 30, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 3:</b> Update of the Virtual Dental Home Project

Dr. Paul Glassman, Project Director, will be giving an update regarding the Virtual Dental Home Project which began with the OSHPD Pilot Project (HWPP #172) relating to training current allied dental personnel for new duties in community settings.

Dr. Paul Glassman is Professor of Dental Practice and Director of Community Oral Health at the University of the Pacific, Arthur A. Dugoni, School of Dentistry in San Francisco. In addition, he is a former President of the Special Care Dentistry Association, a national organization of oral health and other professionals dedicated to improving oral health for people with special needs and older adults. He is also Co-Director of the Statewide California Pipeline Program, Director of the Pacific Center for Special Care and Director of the California Statewide Task Force on Oral Health for People with Disabilities and Aging Californians.

Dr. Glassman has had many years of dental practice experience treating complex patients and has published and lectured extensively in the areas of Hospital Dentistry, Dentistry for Patients with Special Needs, Dentistry for Individuals with Medical Disabilities, Dentistry for Patients with Dental Fear, and Geriatric Dentistry. He has a long career working with special populations in a variety of practice and community settings. He has developed and acted as PI for many community-service demonstration and research programs designed to improve oral health for people with disabilities and other underserved populations.

Dr. Glassman also has many years of experience in developing and managing advanced dental education programs in general dentistry. He has directed GPR and AEGD programs and served on numerous committees for the Commission on Dental Accreditation. In addition, he has developed distance education programs for use in dental schools, continuing education and residency education environments.





**Agenda Item 4a**

**Portfolio Report**



## MEMORANDUM

<b>DATE</b>	May 7, 2013
<b>TO</b>	Dental Board Members
<b>FROM</b>	Dawn Dill, Manager, Licensing and Examination Unit Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 4(a)</b> Portfolio Report

Presentation of Final Portfolio Pathway to Licensure Report by Norman Hertz, Ph.D., Applied Psychologist at Progeny Systems Corporation.

Discussion Regarding the Portfolio Pathway to Licensure Report.

In an effort to go "green", an electronic copy of the consultant's final report can be found on the Board's website:

[http://www.dbc.ca.gov/about\\_us/materials/meeting\\_materials.shtml](http://www.dbc.ca.gov/about_us/materials/meeting_materials.shtml)

# DEVELOPMENT AND VALIDATION OF A PORTFOLIO EXAMINATION FOR INITIAL DENTAL LICENSURE

***Submitted to:***

Dental Board of California  
2005 Evergreen Street  
Suite 1550  
Sacramento, California 95815



***Date:***

May 1, 2013

***Prepared by:***

PSI Services LLC  
2950 North Hollywood Way  
Suite 200  
Burbank, California 91505

## EXECUTIVE SUMMARY

This report describes major aspects of the Portfolio Examination that are essential to implementation for six subject matter areas: oral diagnosis and treatment planning, direct restoration, indirect restoration, removable prosthodontics, endodontics and periodontics.

The report includes the procedures used to define the competencies to be tested, provides background research that underlies the Portfolio Examination, describes the establishment of minimum clinical experiences and development of clinical competency examinations. Because the portfolio is an examination, it must meet the Standards for Educational and Psychological Testing (1999) to ensure that it is fair, unbiased, and legally defensible. The purpose of applying the Standards to the validation process is to ensure that the Portfolio Examination can provide evidence that entry level dentists possess the minimum competencies necessary to protect public health and safety.

The most important step in establishing the validity of the Portfolio Examination was to define the competencies to be tested in the examination. Separate focus groups of key faculty from six Board approved dental schools were convened to identify minimum clinical experiences and clinical competency examination content for oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, endodontics, and periodontics. Basically, focus group participants identified the competencies to be assessed in a systematic way beginning with an outline of major competency domains and ending with detailed rating (grading) scales for evaluating candidate performance. All participants provided input in a systematic, iterative fashion, until consensus is achieved. The competencies identified from this process served as the framework for the training and calibration procedures for examiners and audit procedures for evaluating the efficacy of the process.

- Section 6 lists the major competencies and the subcomponents within each competency.
- Section 7 describes basis for the evaluation system and procedures required to design it.
- Sections 8, 9, 10, 11, 12, and 13 describe the minimum clinical experiences, patient parameters and scoring (rating) criteria.
- Section 14 describes the procedures for training and calibrating examiners.
- Section 15 describes procedures that for establishing audit procedures for ensuring that the examination accomplishes its objectives.

The foundation of the Portfolio Examination is already in place at the dental schools. All six dental schools---University of Pacific, University of California San Francisco, Loma

Linda, University of Southern California, University of California Los Angeles and Western University of Health Sciences---had a great deal of consistency in their evaluation system. The schools use similar criteria to evaluate students' performance and use similar procedures to calibrate their faculty according to performance criteria. This finding had important implications for the implementation of the Portfolio Examination because the evaluation systems currently used by the dental schools will not require major changes.

The only difference between the current systems and the Portfolio Examination is that the competencies and the system to evaluate them would be standardized across schools. Therefore, the Portfolio Examination process will be implemented within the dental schools without additional resources. It is anticipated that the students will find the Portfolio Examination as a reasonable alternative pathway for initial licensure.

In summary, the dental schools reached consensus in identifying critical competencies to be measured in the Portfolio Examination, thereby standardizing the competencies to be measured, providing the framework for the evaluation (grading) system, training and calibration procedures for examiners, and audit procedures for evaluating the efficacy of the process.

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## SECTION 1 – INTRODUCTION

### OVERVIEW

The Portfolio Examination captures the strength of traditional portfolios used to assess learning progress and has the additional advantage of being integrated within the current educational process and within the context of a treatment plan of a patient of record. Instead of developing a traditional portfolio and having it evaluated, the Portfolio Examination requires documentation of clinical cases which are competency evaluations of required procedures assembled in either paper or electronic format. Candidates are evaluated in real time during the normal course of patient treatment and normal course of clinical training.

The Portfolio Examination was approached with the understanding that the outcome would directly impact predoctoral dental education at every dental school in California and could provide the framework for evaluating predoctoral dental competencies in dental schools across the nation.

The overarching principle for development of the Portfolio Examination pathway was consumer protection. The consultants worked closely with dental school faculty to derive the framework and content of the examination; moreover, procedures were conducted in an objective and impartial manner with the public's health, safety, and welfare as the most important concern.

First, consultants met with deans and dental school faculty who represented major domains of practice as well as legislative sponsors from the California Dental Association to present the Portfolio Examination concept and answer faculty questions regarding impact on their respective programs. Second, consultants conducted separate face-to-face meetings with representative faculty from each of the Board approved dental schools to individually present the concept and discuss their concerns. Third, consultants conducted discipline-specific focus groups of faculty<sup>1</sup>, e.g., oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, periodontics, and endodontic, to develop the content for the examination.

From these meetings, consultants gained an understanding of the predoctoral dental competencies that were critical to development of the Portfolio Examination and creating supporting documentation that would be used in the formulation of Assembly Bill 1524. The consultants also conducted an extensive review of written documentation of each school's competency examinations to gain insights into the procedures used in competency examinations and associated scoring systems.

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<sup>1</sup> Face-to-face focus groups were conducted at the University of the Pacific, the University of California San Francisco, the University of Southern California, and Western University of Health Sciences.

## UTILIZATION OF EXPERTS

Committees of subject matter experts knowledgeable in the six subject areas, including section chairs, department chairs and/or other faculty who were knowledgeable in the six subject areas of interest, were consulted throughout the process to provide expertise regarding the competencies acquired in their respective programs and the competencies that should be assessed in the examination.

## PSYCHOMETRIC STANDARDS

The Standards for Educational and Psychological Testing (1999) set forth by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education serve as the benchmark for evaluating all aspects of credentialing, including professional and occupational credentialing. The Standards are used by the measurement profession as the psychometric standards for validating all examinations, including licensing and certification examinations.

Whenever applicable, specific Standards will be cited as they apply to definition of examination content, rating scales, calibration of raters, and auditing procedures to link the particulars of the Portfolio Examination to psychometric practice.

## LEGAL STANDARDS

Because the Portfolio Examination is a state licensure examination, it must also meet legal standards as explicated in Sections 12944 of the California Government Code and Section 139 of the California Business and Professions Code. Section 12944 relates to establishment of qualifications for licensure that do not adversely affect any class by virtue of race, creed, color, national origin/ancestry, sex, gender, gender identity, gender expression, age, medical condition, genetic information, physical disability, mental disability, or sexual orientation. Section 139 of the California Business and Professions Code states occupational licensure examination programs must be based upon occupational (job/practice) analyses and examination validation studies.

## SECTION 2 – HISTORY

### EXISTING PATHWAYS

The Dental Board of California (hereafter, the Board) currently offers two pathways that predoctoral dental students may choose to obtain initial licensure:

- A clinical and simulation examination administered by the Western Regional Examining Board, or,
- A minimum of 12 months of a general practice residency (GPR) or advanced education in general dentistry (AEGD) program approved by the American Dental Association's Commission on Dental Accreditation.

All applicants are required to successfully complete the written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations and an examination in California law and ethics.

### AUTHORIZATION OF THE PORTFOLIO EXAMINATION PATHWAY

Assembly Bill 1524, introduced in February 2009, eliminated the clinical and written examination offered by the Board. Provisions of the bill allow the Board to offer the portfolio examination as an alternative to initial licensure for general dentists in addition to other pathways available to students graduating from dental schools in California, i.e., the Western Regional Examining Board (WREB) examination and "Licensure by Credential" (PGY-1).

*"...The bill would abolish the clinical and written examination administered by the Board. The bill would replace the examination with an assessment process in which an applicant is assessed while enrolled at an in-state dental school utilizing uniform standards of minimal clinical experiences and competencies and at the end of his or her dental program."*

### REQUIREMENTS FOR PORTFOLIO EXAMINATION

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

*1632. (a) The Board shall require each applicant to successfully complete the written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.*

*1632. (b) The Board shall require each applicant to successfully complete an examination in California law and ethics developed and administered by the Board. The Board shall provide a separate application for this examination.....the only other requirement for taking this examination shall be certification from the dean of the qualifying dental school attended by the applicant that the applicant has graduated, or will graduate, or is expected to graduate.*

*1632. (c) The Board shall require each applicant to have taken and received a passing score .....on the portfolio assessment (examination) of the applicant's fitness to practice dentistry while the applicant is enrolled in a dental school program at a Board approved school in California. This assessment shall utilize uniform standards minimal clinical experiences and competencies. The applicant shall pass a final assessment at the end of his or her dental school program.*

## OTHER REQUIREMENTS

Students who participate in the portfolio examination pathway must:

- (a) Be in good academic standing in their institution at the time of portfolio examination and be signed off by the dean of their respective schools.
- (b) Have no pending ethical issues at the time of the portfolio examination and must be signed off by the dean of their respective schools.

## SECTION 3 – BACKGROUND RESEARCH

### PSYCHOMETRIC ISSUES

Use of Portfolio as an examination. Portfolio assessment can provide a powerful approach to assessing a range of curriculum outcomes not easily assessed by other methods and provides a more in-depth picture of student competence than the snapshot obtained in a traditional examination (Davis, Friedman Ben-David, Harden, Howie, Ker, McGhee, Pippard & Snadden, 2001, p. 364). Furthermore, the real value of portfolio assessment is that it provides a basis for judgment of the student's professional fitness to practice (p. 364).

Some researchers comment that if portfolios are used for summative (examination) rather than formative (learning) purposes, the portfolios must meet stringent psychometric requirements including standardization, rater training with structured guidelines for making decisions, and large numbers of examiners to average out rater effects (Driessen, van der Vleuten, Schuwirth, Tartwijk & Vermunt, 2005, p. 215). Davis and Ponnampersuma (2005, p. 282) note that the one of the advantages of portfolio is that it can be standardized and used in summative assessment.

Validity of inferences made. Friedman Ben-David, Davis, Harden, Howie, Ker, and Pippard (2001) note that the validity of the inferences made about the portfolio depend on the reliability of the test. If the test scores or ratings suffer from low interrater agreement or poor sampling, inferences cannot be made. Moreover, there should be a clear definition of the purpose of the portfolio and identification of the competencies to be assessed. Webb, Endacott, Gray, Jasper, McMullan and Scholes (2003) and McMullan (2003) cite several criteria that should be used to evaluate portfolio assessments, namely, explicit grading criteria, evidence from a variety of sources, internal quality assurance processes, and external quality assurance processes.

Content validation by job analysis. Content validity is important in developing an examination for initial licensure (Chambers, 2004) such that there should be a validation process that inquires whether tasks being evaluated should be representative of tasks critical to safe and effective practice. A recent paper by Patterson, Ferguson, and Thomas (2008) calls for validation by using a job analysis to identify core and specific competencies.

Use in dental licensure. A recent paper entitled "Point/Counterpoint: Do portfolio assessments have a place in dental licensure?" addresses many of these issues specifically as they pertain to the purpose of licensure rather than education (Hammond & Buckendahl, 2006; Ranney & Hambleton, 2006).

Hammond and Buckendahl do not support the use of portfolios for dental licensure. They cite two issues as important in considering the use of portfolio assessments for licensure purposes. First, standardizing the training and evaluation across a broad range of locations would be difficult. Second, demonstrations of abilities in past records would need to be verified so that there is an evaluation of the current range of competencies. These authors contend that the portfolio does not provide an assessment of minimum skills that is administered independent of the training program to support licensure decisions; and therefore, provides no external validation and verification of the students' competence. Moreover, there may be measurement error, or low reliability, within the system as a result of errors in content sampling, number of observations of performance, number of examiners rating the student's performance, assumptions of unidimensional relationships between items, lack of interrater agreement, and reliance on pairs rather than triads of examiners for all students.

In an opposing point of view in the same article, Ranney and Hambleton (2006), support the use of portfolios for dental licensure. According to these authors, testing agencies have published little or no data to allow an assessment of reliability or validity of their examinations. Variability in the reliability of clinical licensure examinations and pass rates among testing agencies may reflect lack of reliability or validity in the examination process, and, omission of skills necessary to practice safely at the entry level, not just changes in student populations. The authors recognize that several criteria would need to be met before portfolio assessment could be implemented. The most important of these criteria are: administration by independent parties, inclusion of a full continuum of student competencies for comprehensive evaluation, and, evaluating competence within the context of a treatment plan designed to meet the patient's oral health care needs. In their discussion, the authors believe that portfolio assessments could work if the developers considered which tasks to measure, how the tasks would be scored, calibration protocols for examiners, and how performance expectations would be set.

## INITIAL LICENSURE REQUIREMENTS IN OTHER JURISDICTIONS

According to the American Association of Dental Examiners "Composite" issued in January 2009, virtually all states and U. S. territories require applicants to pass an examination administered by the National Board of Dental Examiners.

- Forty-seven jurisdictions accepted a regional clinical examination, e.g., WREB, SRTA, CRDTS or national clinical, e.g., ADEX, ADLEX.
- Four jurisdictions, other than California, administered a state clinical examination.
- Forty-three jurisdictions administered a jurisprudence examination.
- Four states, other than California, granted licensure after completion of an accredited, 12-month, postgraduate residency program.
- Six states allow applicants to take any state or regional clinical examination. Virginia explicitly states that the clinical examination must use live patients.



- Two states (Montana and Utah) accept California's (former) clinical examination.

Table 1 – Summary of existing requirements for initial licensure<sup>2</sup>

State	National Board	Regional clinical	State clinical	Jurisprudence	Other
AL	Y	N	Y	Y	
AK	Y	Y (WREB)	N	Y	
AZ	Y	Y (WREB)	N	Y	
AR	Y	Y (SRTA)	N	Y	
CA	Y	Y (WREB)	Y	Y	PGY-1
CO	Y	Y (CRTDS)	N	Y	
CT	Y	Y (NERB OR DSCE)	N	N	PGY-1
DE	Y	N	Y	Y	DOR
District of Columbia	Y	Y	Y	Y	
FL	Y	N	Y	Y	
GA	Y	Y (CRDTS)	N	Y	
HI	Y	N	N	N	ADEX
ID	Y	Y (WREB, CRDTS)	N	Y	ADEX
IL	Y	N	N	N	ADEX
IN	Y	Y (WREB, SRTA, CRDTS, NERB)	N	Y	
IA	Y	Y (CRDTS, WREB)	N	Y	ADEX
KS	Y	Y (WREB, SRTA, CRDTS, NERB, CITA)	Y	Y	
KY	Y	Y (SRTA, WREB, CRDTS, NERB)	N	Y	ADEX not accepted
LA	Y	Y (CITA, CRDTS, NERB, SRTA, WREB)	N	Y	ADEX
ME	Y	Y (NERB)	N	Y	
MD	Y	Y (NERB)	N	Y	
MA	Y	Y	N	Y	
MI	Y	Y (NERB, DSCE)	--	--	
MN	Y	Y (NDEB, WREB)	N	Y	PGY-1, ADLEX, ADEX
MS	Y	Y	N	Y	
MO	Y	Y (Any state or regional examination)	N	Y	
MT	Y	Y (WREB, CRDTS, WREB, SRTA, NERB)	N	Y	State clinical examinations from CA, DE, FL, and NV

<sup>2</sup> Examination acronyms for states which specified regional examinations: ADEX = American Board of Dental Examiners; ADLEX = American Dental Licensing Examination; CITA = Council of Interstate Testing Agencies; CRTDS = Central Regional Dental Testing Service; DOR = Dental Operating Rooms at Naval dental facilities; DSCE = Dental Simulated Clinical Examination; NERB = North East Regional Board; NDEB = National Dental Examining Board of Canada; SRTA = Southern Regional Testing Agency; WREB = Western Regional Examining Board

State	National Board	Regional clinical	State clinical	Jurisprudence	Other
NE	Y	Y (CRDTS, NERB)	N	Y	
NV	Y	N	--	Y	ADEX; no licensure by credential
NH	Y	Y (NERB)	N	Y	
NJ	Y	Y (NERB)	N	Y	ADEX
NM	Y	Y (WREB, CRDTS)	N	Y	
NY	Y	N	N	N	CDA approved residency; one-time jurisprudence examination
NC	Y	Y (CITA)	N	Y	Sterilization/infection control examination
ND	Y	Y (NERB, CRDTS)	N	Y	ADEX
OH	Y	Y (CRDTS, SRTA, WREB, NERB)	N	Y	
OK	Y	Y (WREB)	N	Y	
OR	Y	Y	N	Y	Accepts any state or regional examination
PA	Y	Y (NERB)	N	N	ADLEX
Puerto Rico	Y	CITA	Y	Y	CITA in lieu of state clinical examination
RI	Y	Y (NERB)	N	N	
SC	Y	Y (SRTA, CRDTS)	N	Y	ADLEX
SD	Y	Y (CRDTS, WREB)	N	Y	Accepts any state or regional examination for licensure by credential
TN	Y	Y (SRTA, WREB)	N	N	
TX	Y	Y	--	Y	Accepts any state or regional examination for licensure by credential
UT	Y	Y (WREB, SRTA, NERB, CRDTS)	N	N	California state examination, Hawaii examination
VT	Y	Y (NERB, WREB, SRTA, CRDTS, CITA)	N	Y	
VA	Y	Y (SRTA, WREB, DRDTS, NERGE, CITA)	--	Y	Accepts any state or regional examination for licensure by credential (only if live patients used)
U. S. Virgin Islands	--	--	--	--	

State	National Board	Regional clinical	State clinical	Jurisprudence	Other
WA	Y	Y	N	Y	PGY-1; Accepts any state or regional examination
WV	Y	Y	N	Y	Any state or regional examination
WI	Y	Y (CRDTS, WREB, NERB)	N	Y	ADEX I and II
WY	Y	Y (CRDTS, WREB, NERB)	N	Y	Part IV of ADEX

## COMPARISON OF REQUIREMENTS IN THE U.S. AND CANADA

In their 2001 review of dental education and licensure, the Council on Dental Education of the American Dental Association (ADA) compared practices for initial dental licensure in the United States and Canada. Their findings indicate that initial licensure in the United States and Canada are very similar; however, Canada relies on the use of the Objective Structured Clinical Examination (OSCE), which requires students to answer multiple-choice questions about radiographs, case histories, and/or models in a series of stations. In the OSCE, simulated patients (manikins) rather than actual patients are used as subjects for examination procedures.

Table 2 – Comparison of practices in U. S. and Canada for initial licensure

Requirement	United States	Canada
Graduation from an accredited program	Yes; program is accredited by the ADA Commission on Dental accreditation	Yes; program is accredited by the Commission on Dental Accreditation of Canada
Written examination	Yes: National Dental Board Examinations (NDBE) Parts I and II	Yes; National Dental Examining Board of Canada Written Examination (NDEB)
Clinical examination	<ul style="list-style-type: none"> <li>Regionally administered clinical examinations Central Regional Testing Services (CRTS); Northeast Regional Examining Board (NERB), Southern Regional Testing Agency (SRTA), Western Regional Examining Board (WREB) offered once to multiple times, depending on the testing agency</li> <li>10 states (CA, DE, FL, HI, IN, LA, MS, NC, NV plus Puerto Rico and the Virgin Islands) offer state administered examinations</li> <li>Each state determines which clinical examination results are accepted for the purpose of licensure</li> <li>All states require completion of both written and clinical examinations before being eligible for licensure</li> <li>Some states also require additional criteria such as proof of malpractice insurance, certification in Basic Life Support, or a jurisprudence examination</li> </ul>	<ul style="list-style-type: none"> <li>OSCE offered three times a year</li> <li>Quebec requires an NDEB certificate or a provincial examination.</li> <li>Some provinces require completion of an ethics examination</li> </ul>

## EXISTING COMPETENCY EXAMINATIONS

As expected, all of the California schools included competencies which met minimum standards set forth by the Commission on Dental Accreditation for predoctoral dental education programs (2008, Standard 2-25, p. 15): “At a minimum graduates must be competent in providing oral health care with the scope of general dentistry, as defined by the school, for the child, adolescent, adult, and geriatric patient, including:

- a) Patient assessment and diagnosis;
- b) Comprehensive treatment planning;
- c) Health promotion and disease prevention;
- d) Informed consent;
- e) Anesthesia, and pain and anxiety control;
- f) Restoration of teeth;
- g) Replacement of teeth;
- h) Periodontal therapy;
- i) Pulpal therapy;
- j) Oral mucosal disorders;
- k) Hard and soft tissue surgery;
- l) Dental emergencies;
- m) Malocclusion and space management; and,
- n) Evaluation of the outcomes of treatment.”

Key faculty from five Board approved schools<sup>3</sup> were interviewed regarding the clinical dimensions of practice assessed in competency examinations within their predoctoral programs. All of the schools provided a list of the clinical competencies assessed during predoctoral training. A list of each school’s competency examination is presented in the Tables 3, 4, 5, 6 and 7.

Table 3 – Competency examinations: Loma Linda University

<i>Comprehensive diagnosis and treatment planning</i>	<ul style="list-style-type: none"> <li>• Oral diagnosis examination</li> <li>• Radiology interpretation (FMX pathology)</li> <li>• Radiology interpretation (normal and errors)</li> <li>• Radiology techniques</li> </ul>
<i>Direct restoration</i>	<ul style="list-style-type: none"> <li>• Class II composite resin</li> <li>• Class II amalgam</li> <li>• Class III composite</li> </ul>
<i>Indirect restoration</i>	<ul style="list-style-type: none"> <li>• Full gold crown, partial coverage crown, full coverage ceramic crown, fixed partial denture <u>or</u> multiple tooth restoration</li> </ul>
<i>Removable prosthodontics</i>	<ul style="list-style-type: none"> <li>• Rest seat preparation</li> <li>• RPD design</li> <li>• CD setup</li> </ul>
<i>Periodontics</i>	<ul style="list-style-type: none"> <li>• Preclinical OSCE (5)</li> <li>• Scaling and root planning (2)</li> <li>• Oral health care (2)</li> </ul>
<i>Endodontics</i>	<ul style="list-style-type: none"> <li>• Endodontic qualifying examination (to treat patients in clinic)</li> <li>• Endodontic section of Fall mock board</li> <li>• Endodontic qualifying examination (to take WREB)</li> </ul>

<sup>3</sup> When the Portfolio process began, there were five Board approved dental schools.

Table 4 – Competency examinations: University of California Los Angeles

<i>Comprehensive diagnosis and treatment planning</i>	<ul style="list-style-type: none"> <li>• Oral diagnosis</li> <li>• Head and neck examination</li> <li>• Treatment planning</li> <li>• Caries management by risk assessment</li> </ul>
<i>Direct restoration</i>	<ul style="list-style-type: none"> <li>• Class II amalgam (2)</li> <li>• Class II composite (1)</li> <li>• Class III composite or Class V composite (2)</li> <li>• Two buildups (core, pin, prefabricated post and core, <u>or</u> dowel core)</li> </ul>
<i>Indirect restoration</i>	<ul style="list-style-type: none"> <li>• Two restorations (PFM, bonded ceramic, full gold crown <u>or</u> partial veneer crown)</li> </ul>
<i>Removable prosthodontics</i>	<ul style="list-style-type: none"> <li>• Complete denture</li> <li>• Immediate full denture</li> <li>• Removable partial denture</li> <li>• Reline</li> </ul>
<i>Periodontics</i>	<ul style="list-style-type: none"> <li>• Periodontal diagnosis and treatment plan</li> <li>• Periodontal instrumentation</li> <li>• Re-evaluation of Phase I therapy</li> <li>• Periodontal surgery</li> </ul>
<i>Endodontics</i>	<ul style="list-style-type: none"> <li>• Endodontic case portfolio</li> </ul>

Table 5 – Competency examinations: University of California San Francisco

<i>Comprehensive diagnosis and treatment planning</i>	<ul style="list-style-type: none"> <li>• Medical/dental history taking</li> <li>• Infection control</li> <li>• Practice management</li> <li>• Oral diagnosis and treatment planning OSCE</li> <li>• Caries risk assessment</li> <li>• Complete oral examination/treatment planning</li> <li>• Radiology</li> <li>• Emergency</li> <li>• Baseline skills attainment</li> <li>• Pediatric comprehensive oral examination</li> <li>• Outcomes of care</li> </ul>
<i>Direct restoration</i>	<ul style="list-style-type: none"> <li>• Class I composite or preventive resin restoration</li> <li>• Class I amalgam</li> <li>• Class II amalgam</li> <li>• Class II composite</li> <li>• Class III or IV composite</li> <li>• Class V composite, glass ionomer <u>or</u> amalgam</li> <li>• Pediatric restorative</li> </ul>
<i>Indirect restoration</i>	<ul style="list-style-type: none"> <li>• Mounted diagnostic cast</li> <li>• Die trimming</li> <li>• Casting (PFM, all gold, <u>or</u> all ceramic crown)</li> </ul>
<i>Removable prosthodontics</i>	<ul style="list-style-type: none"> <li>• Removable prosthodontics (partial <u>or</u> full denture)</li> </ul>
<i>Periodontics</i>	<ul style="list-style-type: none"> <li>• Instrument sharpening</li> <li>• Instrument identification and adaptation</li> <li>• Scaling and root planning</li> </ul>
<i>Endodontics</i>	<ul style="list-style-type: none"> <li>• Single-root root canal</li> <li>• Multi-root root canal on typodont</li> </ul>

Table 6 – Competency examinations: University of the Pacific

<i>Comprehensive diagnosis and treatment planning</i>	<ul style="list-style-type: none"> <li>• Oral diagnosis and treatment planning</li> </ul>
<i>Direct restoration</i> <sup>4</sup>	<ul style="list-style-type: none"> <li>• Class I resin</li> <li>• Class II resin</li> <li>• Class II amalgam</li> <li>• Class III resin</li> <li>• Class V resin</li> </ul>
<i>Indirect restoration</i>	<ul style="list-style-type: none"> <li>• All cases evaluated for case management, buildup (if needed), preparation and temporization</li> <li>• Crown preparation and crown (FVM, PFM <u>or</u> all ceramics)</li> <li>• CMOE (cementation)</li> <li>• Impression</li> </ul>
<i>Removable prosthodontics</i>	<ul style="list-style-type: none"> <li>• Complete denture, immediate complete denture <u>or</u> other removable prosthetic device</li> </ul>
<i>Periodontics</i>	<ul style="list-style-type: none"> <li>• Periodontal oral diagnosis and treatment planning</li> <li>• Periodontal diagnostic competency</li> <li>• Calculus detection and root planing</li> <li>• Instrument sharpening</li> <li>• Periodontal re-evaluation</li> </ul>
<i>Endodontics</i>	<ul style="list-style-type: none"> <li>• Endodontic radiographic technique</li> <li>• Cleaning and shaping (single canal)</li> <li>• Coronal access anterior</li> <li>• Coronal access posterior</li> <li>• Obturation (single canal)</li> </ul>

<sup>4</sup>All direct restoration cases are evaluated for case management, preparation and restoration. Typically Class III and Class V resins are performed in the anterior segments; several posterior Class II restorations are completed including a mandatory mock board scenario—mixed between amalgam and resin

Table 7 – Competency examinations: University of Southern California

Competency domain	Specific competencies
<i>Comprehensive diagnosis and treatment planning</i>	<ul style="list-style-type: none"> <li>• Oral radiology (OSCE in radiology)</li> <li>• Physical evaluation</li> <li>• Ultrasonic instrumentation/ultrasonic scaler</li> <li>• OSCE in vital signs, extra- and intraoral examination and infection control</li> </ul>
<i>Direct restoration</i>	<ul style="list-style-type: none"> <li>• Class II amalgam</li> <li>• Composite restoration (Class II, III, IV, <u>or</u> V)</li> </ul>
<i>Indirect restoration</i>	<ul style="list-style-type: none"> <li>• Crown preparation (PFM, full gold, partial veneer gold, <u>or</u> ceramic)</li> <li>• Crown cementation (PFM, full gold, partial veneer gold, <u>or</u> ceramic)</li> </ul>
<i>Removable prosthodontics</i>	<ul style="list-style-type: none"> <li>• Preliminary Impression</li> <li>• Outline tray(s)/ custom tray(s)</li> <li>• Final impression(s)</li> <li>• Final survey</li> <li>• Framework try-in (retention/occlusion)</li> <li>• Jaw record(s)/ tooth selection</li> <li>• Teeth try-in/ remount jig</li> <li>• Prosthesis placement/ clinical remount</li> <li>• Final adaptation and articulation</li> </ul>
<i>Periodontics</i> <sup>5</sup>	<ul style="list-style-type: none"> <li>• Diagnosis and comprehensive treatment planning</li> <li>• Ultrasonic instrumentation for scaling and root planning</li> <li>• Scaling and root planning</li> <li>• Mock board examination (WREB compatible)</li> </ul>
<i>Endodontics</i>	<ul style="list-style-type: none"> <li>• Access</li> <li>• Instrumentation</li> <li>• Obturation</li> </ul>

## CALIBRATION OF CLINIC EXAMINERS IN SCHOOLS

During visits to the dental school clinics and interviews with faculty, it was clear that the dental schools did an exceptional job in calibrating their examiners and were consistent in their methodology to ensure that common criteria were used to evaluate students' performance on competency examinations. The faculty were calibrated and re-calibrated to ensure consistency in their evaluation of the student competencies and the processes used by the dental schools for assessing competencies was very similar. In every case, minimum competency was built into the rating scales used to evaluate the students in their competency examinations.

The general rule was that two examiners must concur on failing grades. If there is disagreement between the two examiners, a third examiner was asked to grade the student. One school specifically mentioned that examiners were designated full-time faculty who were familiar with the grading criteria and the logistics of competency examinations. Other schools mentioned that their examiners (part-time and full-time faculty) were provided extensive materials to read and review prior to hands-on training with experienced examiners. These materials included detailed examiner training manuals, detailed slide

<sup>5</sup> Diagnosis and comprehensive treatment planning, ultrasonic instrumentation, scaling and root planing are performed in the junior year; mock board examination performed in the senior year

presentations (Powerpoint), sample cases, and sample documentation. Hands-on training and calibration sessions were conducted to ensure that the examiners understood the evaluation system and how to use it.



## SECTION 4 – THE PORTFOLIO EXAMINATION

### DEFINITION

Albino, Young, Neumann, Kramer, Andrieu, Henson, Horn, and Hendricson (2008, p. 164) define clinical competency examinations as performance examinations in which students perform designated tasks and procedures on a patient without instructor assistance. The process of care and the products are assessed by faculty observers typically guided by rating scales.

Here, the Portfolio Examination can be conceptualized as a series of examinations administered in a multiple patient encounters in six subject areas. Candidates are rated according to standardized rating scales by faculty examiners who are formally trained in their use.

The Portfolio Examination is a performance examination that assesses skills in commonly encountered situations, which includes components of the clinical examination administered by a traditional testing agency. Performance is measured during competency evaluations conducted in the schools by calibrated examiners who are members of the dental school faculty. Thus, the Portfolio Examination involves hands-on performance evaluations of clinical skills as evaluated within the candidate's program of dental education.

### PREMISE

The Portfolio Examination is an alternative examination that each individual school may elect at any time to implement or decline to implement.

The Portfolio Examination allows candidates to build a portfolio of completed clinical experiences and clinical competency examinations in six subject areas over the normal course of clinical training. Both clinical experiences and clinical competency examinations are performed on patients of record within the normal course of treatment. The primary difference between clinical experiences and clinical competency examinations is that the clinical competency examinations are performed independently without faculty intervention unless patient safety issues are imminent.

The Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a California Board approved dental school. A student may elect to begin the Portfolio Examination process during the clinical training phase of their dental education, with the approval of his/her clinical faculty.

The Portfolio Examination follows a similar structure for candidate evaluation that currently exists within the schools to assess minimum competence. The faculty observes the treatment provided and evaluates candidates according to

standardized criteria developed by a consensus of key faculty from all of the dental schools. Each candidate prepares and submits a portfolio of documentation that provides proof of completion of competency evaluations for specific procedures in six subject areas: oral diagnosis and treatment planning, direct restoration (amalgam/composite), indirect restoration (fixed prosthetics), removable prosthodontics, endodontics and periodontics.

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

## DISTINGUISHING CHARACTERISTICS

There are 10 distinguishing characteristics of the Portfolio Examination:

- *First*, the Portfolio Examination is considered a performance examination that assesses candidates' skills in commonly encountered clinical situations. Consequently, the Portfolio Examination must meet legal standards (Sections 12944 of the Government Code, Section 139 of the Business and Professions Code) and psychometric standards set forth by the Standards for Educational and Psychological Testing.
- *Second*, the Portfolio Examination is a summative assessment of a candidate's competence to practice independently. Therefore, candidates perform clinical procedures without faculty intervention in the competency examinations. If a candidate commits a critical error at any time during a competency examination, the examination is terminated immediately in the interests of patient safety.
- *Third*, it includes components of clinical examinations similar to other clinical examinations, and, is administered in a manner that is similar to other clinical examinations encountered in the candidates' course of study. The multiple clinical examinations allow for an evaluation of the full continuum of competence. No additional resources are required from candidates, schools or the Board.
- *Fourth*, treatments for candidates' clinical experience and competency examinations are rendered on patients of record. This means that candidates' competence is not evaluated in an artificial or contrived situation, but on patients who require dental interventions as a normal course of treatment and

their progress can be monitored beyond the scope of the clinical experiences or competency examinations.

- *Fifth*, candidates must complete a minimum number of clinical experiences as required for each of six competency domains.
- *Sixth*, readiness for the Portfolio competency examinations is determined by the clinical faculty at the institution where the candidate is enrolled.
- *Seventh*, each of the schools will designate faculty as Portfolio competency examiners and is responsible for administering a Board approved standardized calibration training course for said examiners. The schools are also responsible for the calibration of Portfolio examiners' performance to ensure consistent implementation of the examination and a standardized examination experience for all candidates.
- *Eighth*, candidates' performance is measured according to the information provided in competency evaluations conducted in the schools by clinical faculty within the predoctoral program of education.
- *Ninth*, it produces documented data for outcomes assessment of results, thereby allowing for verification of validity evidence. The data provides the foundation of periodic audits of each school conducted by the Board to ensure that each school is implementing the Portfolio Examination according to the standardized procedures.
- *Tenth*, there are policies and procedures in place to treat candidates fairly and professionally, with timely and complete communication of examination results.

## RE-EXAMINATION

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

## ROLE OF THE BOARD

Oversight of the Portfolio Examination is maintained by the Board. The Portfolio Examination includes a mechanism to administer the program and grant the

license, as well as maintain authority to monitor school compliance with the standardized examination process.

## ROLE OF THE SCHOOLS

Schools are responsible for selection and calibration of Portfolio examiners. Faculty who wish to become a Portfolio examiner will be required to submit credentials to document their qualifications and experience in conducting examinations in an objective manner. Faculty who are selected as Portfolio examiners are required to participate in Board approved calibration training courses for the competency domain of interest, e.g., oral diagnosis and treatment planning, endodontics, etc.

Schools are also responsible to maintaining the calibration of Portfolio examiners by regularly providing opportunities for re-calibration as needed.

## SECTION 5 – CONTENT VALIDATION PROCESS

### APPLICABLE STANDARDS

Since criterion related evidence is generally not available for use in making licensure decisions, validation of licensure and certification tests rely mainly on expert judgments that the test adequately represents the content domain of the occupation or specialty. Here, content related validity evidence from a job analysis supports the validity of the Portfolio Examination as a measure of clinical competence. The Standards contain extensive discussion of validity issues.

*“Test design generally starts with an adequate definition of the occupation or specialty, so that persons can be clearly identified as engaging in the activity.” (p. 156)*

*“Often a thorough analysis is conducted of the work performed by people in the profession or occupation to document the tasks and abilities that are essential to practice. A wide variety of empirical approaches is used, including delineation, critical incidence techniques, job analysis, training needs assessments, or practice studies and surveys of practicing professionals. Panels of respected experts in the field often work in collaboration with qualified specialists in testing to define test specifications, including the knowledge and skills needed for safe, effective performance, and an appropriate way of assessing that performance.” (p. 156)*

*“Credentialing tests may cover a number of related but distinct areas. Designing the testing program includes deciding what areas are to be covered, whether one or a series of tests is to be used, and how multiple test scores are to be combined to reach an overall decision.” (p. 156-157)*

There are also specific standards that address the use of job analysis to define the competencies to be tested in the Portfolio Examination.

*Standard 14.8*

“Evidence of validity based on test content requires a thorough and explicit definition of the content domain of interest. For selection, classification, and promotion, the characterization of the domain should be based on a job analysis.” (p. 160)

“The content domain to be covered by a credentialing test should be defined clearly and justified in terms of the importance of the content for credential-worthy performance in an occupation or profession. A rationale should be provided to support the claim that the knowledge or skills being assessed are required for credential-worthy performance in an occupation and are consistent with the purpose for which the licensing or certification program was instituted” (p. 161)

## METHODOLOGY

The methodology used to validate the content of the competency examinations comprising the Portfolio Examination is a commonly used psychometric procedure called job (aka practice) analysis. Job analysis data is typically obtained through multiple sources including interviews, observations, survey questionnaires, and/or focus groups.

This methodology has been used extensively in the measurement field and is described in detail in many publications in the psychometric literature as a “table-top job analysis,” e.g., Department of Energy (1994). Basically, focus groups identify the competencies to be assessed in a systematic way beginning with an outline of major competency domains and ending with a detailed account of major and specific competencies organized in outline fashion. All participants provide input in a systematic, iterative fashion, until consensus is achieved.

## PROCESS

Separate focus groups of subject matter experts from six Board approved dental schools were convened to define the content for the Portfolio Examinations for six competency domains to be assessed in the Portfolio Examination: oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, endodontics, and periodontics.

The content was developed at two levels of analysis. The first level of analysis was to develop a consensus at a broad level regarding the major competencies to be assessed. The faculty indicated that the competencies were acceptable to the schools as the basis for the Portfolio Examination. They further understood that the major competencies were likely to be included in proposed legislation in order to implement the Portfolio Examination.

The second level of analysis produced detailed procedures for measuring specific subcomponents within each of the six competency domains. The detailed procedures were used to develop the Portfolio Examination.

## PROCEDURE

The procedure was conducted systematically in several steps:

<b>Step 1</b> <b><i>Orient focus group</i></b>	<ul style="list-style-type: none"><li>• Present participants with an outline of topics to be covered for a given competency domain</li><li>• Orient participants as to the goal of the process and how the results will be used</li></ul>
<b>Step 2</b> <b><i>Review subject matter</i></b>	<ul style="list-style-type: none"><li>• Have participants explain how their program currently conducts competency examinations</li><li>• Review the topics involved in a given competency domain, e.g., periodontics, endodontics, etc.</li></ul>
<b>Step 3</b> <b><i>Identify major competencies</i></b>	<ul style="list-style-type: none"><li>• Identify major competencies to be assessed</li><li>• Discuss implications of the competencies at each participant's program until consensus is reached</li></ul>
<b>Step 4</b> <b><i>Identify specific competencies</i></b>	<ul style="list-style-type: none"><li>• Identify specific competencies within each content domain to be assessed</li><li>• Discuss implications of the competencies at each participant's program until consensus is reached</li></ul>
<b>Step 5</b> <b><i>Sequence competencies</i></b>	<ul style="list-style-type: none"><li>• Sequence the competencies until consensus is reached</li></ul>
<b>Step 6</b> <b><i>Develop competency statements</i></b>	<ul style="list-style-type: none"><li>• Rephrase each competency in terms of a consistent format that includes an action verb and direct object (c. f., Chambers &amp; Gerrow, 1994)</li></ul>
<b>Step 7</b> <b><i>Refine competencies</i></b>	<ul style="list-style-type: none"><li>• Make final edits to the wording of the competencies until consensus is reached</li></ul>
<b>Step 8</b> <b><i>Re-evaluate competencies</i></b>	<ul style="list-style-type: none"><li>• Discuss the list of major and specific competencies until consensus is reached</li></ul>

## SECTION 6 – MAJOR COMPETENCIES ASSESSED

The Portfolio Examination is comprised of performance examinations in six competency domains identified by the focus groups using a “table-top job analysis” methodology described in Section 5. The competencies and their subcomponent competencies provide the most fundamental type of validity evidence for the Portfolio Examination, that is, content validity. The subcomponents of each major competency domain are presented below.

Table 8 – Major competencies and subcomponents to be assessed

<b>ORAL DIAGNOSIS AND TREATMENT PLANNING</b>	<ul style="list-style-type: none"> <li>I. Medical issues that impact dental care</li> <li>II. Treatment modifications based on medical conditions</li> <li>III. Patient concerns/chief complaint</li> <li>IV. Dental history</li> <li>V. Significant radiographic findings</li> <li>VI. Clinical findings</li> <li>VII. Risk level assessment</li> <li>VIII. Need for additional diagnostic tests/referrals</li> <li>IX. Findings from mounted diagnostic casts</li> <li>X. Comprehensive problem list</li> <li>XI. Diagnosis and interaction of problems</li> <li>XII. Overall treatment approach</li> <li>XIII. Phasing and sequencing of treatment</li> <li>XIV. Comprehensiveness of treatment plan</li> <li>XV. Treatment record</li> </ul>
<b>DIRECT RESTORATION</b>	<ul style="list-style-type: none"> <li>I. Case presentation</li> <li>II. Outline and extensions</li> <li>III. Internal form</li> <li>IV. Operative environment</li> <li>V. Anatomical form</li> <li>VI. Margins</li> <li>VII. Finish and function</li> </ul>
<b>INDIRECT RESTORATION</b>	<ul style="list-style-type: none"> <li>I. Case presentation</li> <li>II. Preparation</li> <li>III. Impression</li> <li>IV. Provisional</li> <li>V. Candidate evaluation of laboratory work</li> <li>VI. Pre-cementation</li> <li>VII. Cementation and finish</li> </ul>



<b>REMOVABLE PROSTHODONTICS</b>	<ul style="list-style-type: none"> <li>I. Patient evaluation</li> <li>II. Treatment plan and sequencing</li> <li>III. Preliminary impressions</li> <li>IV. RFP design (if applicable)</li> <li>V. Tooth modification (if applicable)</li> <li>VI. Border molding and final impressions</li> <li>VII. Framework try-in</li> <li>VIII. Jaw relation records</li> <li>IX. Trial dentures</li> <li>X. Insertion of removable prosthesis</li> <li>XI. Post insertion (1 week)</li> <li>XII. Laboratory services for prosthesis</li> </ul>
<b>ENDODONTICS</b>	<ul style="list-style-type: none"> <li>I. Pretreatment clinical testing and radiographic imaging</li> <li>II. Endodontic diagnosis</li> <li>III. Endodontic treatment plan</li> <li>IV. Anesthesia and pain control</li> <li>V. Caries removal, removal of failing restorations, evaluation of restorability, site isolation</li> <li>VI. Access opening</li> <li>VII. Canal preparation technique</li> <li>VIII. Master cone fit</li> <li>IX. Obturation technique</li> <li>X. Completion of case</li> </ul>
<b>PERIODONTICS</b>	<ul style="list-style-type: none"> <li>I. Review medical and dental history</li> <li>II. Radiographic findings</li> <li>III. Comprehensive periodontal data collection</li> <li>IV. Evaluate periodontal etiology/risk factors</li> <li>V. Comprehensive periodontal diagnosis</li> <li>VI. Treatment plan</li> <li>VII. Calculus detection</li> <li>VIII. Effectiveness of calculus removal</li> <li>IX. Periodontal re-evaluation</li> </ul>

## SECTION 7 – EVALUATION SYSTEM

A standardized evaluation system was developed to evaluate candidates' performance in the competency examinations. The competencies and their subcomponents defined in Section 6 provided the framework for the evaluation system that assesses the candidates' competencies in the procedures. Faculty from six Board approved dental schools were involved in the process so that the final evaluation system represented rating criteria applicable to candidates regardless of predoctoral programs.

The evaluation system is designed to be used for summative decisions (high stakes, pass/fail decisions) rather than formative decisions (compilation of daily work with faculty feedback for learning purposes). The evaluation system provides quantitative validity evidence for determining clinical competence in terms of numeric scores.

### APPLICABLE STANDARDS

The evaluation system must meet psychometric criteria to provide the measurement opportunity for success for all candidates.

- |                       |   |
|-----------------------|---|
| <i>Standard 3.20</i>  | "The instructions presented to test takers should contain sufficient detail so that test takers can respond to a task in the manner that the test developer intended. When appropriate, sample material, practice or sample questions...should be provided to test takers prior to the administration of the test or included in the testing material as part of the standard administration instructions." (p. 47) |
| <i>Standard 3.22</i>  | "Procedures for scoring and, if relevant, scoring criteria should be presented by the test developer in sufficient detail and clarity to maximize the accuracy of scoring. Instructions for using rating scales or for deriving scores obtained by coding, scaling, or classifying constructed responses should be clear." (p. 47)  |
| <i>Standard 14.17</i> | "The level of performance required for passing a credentialing test should depend on the knowledge and skills necessary for acceptable performance in the occupation or profession and should not be adjusted to regulate the number or proportion of persons passing the test." (p. 162)   |

## BEHAVIORALLY ANCHORED RATING SCALES

Behaviorally anchored rating scales have unique measurement properties which have been used extensively in medical and dental education as a tool to assess performance. They rely on critical incidents of behavior which may be classified into dimensions unique and independent of each other in their meaning. Each performance dimension is arrayed on a continuum of behaviors and examiners must select the behaviors that most closely describe the candidate's performance.

There were several steps to develop behaviorally anchored rating scales for the Portfolio Examination evaluation system:

1. Use the competencies and their associated subcomponents defined by the table-top job analysis discussed in Section 5 as the framework for the evaluation system, e.g., comprehensive oral diagnosis and treatment planning, direct restoration, indirect restoration, removable prosthodontics, endodontics, periodontics.
2. Generate critical incidents of ineffective and effective behavior.
3. Create performance dimensions that describe the qualities of groups of critical incidents (Flanagan, 1954).
4. Define performance dimensions in terms of numeric ratings, e.g., 1 to 5, 1 to 7, 1 to 9.
5. Retranslate (reclassify) the critical incidents to ensure that the incidents describe the performance dimensions.
6. Identifying several incidents for each performance dimension.
7. Refine standardized criteria for each of the competency domains and their subcomponent competencies.
8. Establish minimum acceptable competence criteria (passing criteria) for competency examinations.

## MINIMUM COMPETENCE

The passing standard for all of the competency examinations is built into the rating scales when the grading criteria are developed. The rating criteria for minimum competence was developed by representative faculty who have a solid conceptual understanding of standardized rating criteria and how the criteria will be applied in an operational setting.

## SECTION 8 – ORAL DIAGNOSIS /TREATMENT PLANNING

### PURPOSE

The competency examination for oral diagnosis and treatment planning (ODTP) is designed to assess the candidate's ability to identify and evaluate patient data and clinical findings; formulate diagnoses; and plan treatment interventions from a multidisciplinary perspective.

### MINIMUM CLINICAL EXPERIENCES

The documentation of oral diagnosis and treatment planning clinical experiences will include a minimum of 20 patient cases.

Clinical experiences for ODTP include:

- Comprehensive oral evaluations,
- Limited (problem-focused) oral evaluations, and,
- Periodic oral evaluation

Each examination, ODTP clinical experience requires medical and dental history, identified problem(s), diagnoses, treatment plans, and informed consent.

### OVERVIEW

- Fifteen (15) scoring factors.
- Initiation and completion of one (1) multidisciplinary Portfolio competency examination.
- Treatment plan must involve at least three (3) of the following six disciplines:
  - > Periodontics
  - > Endodontics
  - > Operative (direct and indirect restoration)
  - > Fixed and removable prosthodontics
  - > Orthodontics
  - > Oral surgery

### PATIENT PARAMETERS

- Maximum of ASA II.
- Missing or will be missing two or more teeth, NOT including third molars.
- At least moderate periodontitis (probing depths of 5 mm or more).

## SCORING

Scoring points for ODTP are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

## ELEMENTS OF THE ODTP PORTFOLIO

The ODTP portfolio may include, but is not limited to the following:

- a) Medical history for dental treatment provided to patients. The medical history must include: an evaluation of past illnesses and conditions, hospitalizations and operations, allergies, family history, social history, current illnesses and medications, and their effect on dental condition.
- b) Dental history for dental treatment provided to clinical patients. The dental history must include: age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts.
- c) Documentation of a comprehensive examination for dental treatment provided to patients includes:
  - (1) Interpretation of radiographic series
  - (2) Performance of caries risk assessment
  - (3) Determination of periodontal condition
  - (4) Performance of a head and neck examination, including oral cancer screening.
  - (5) Screening for temporomandibular disorders
  - (6) Assessment of vital signs
  - (7) Performance of a clinical examination of dentition
  - (8) Performance of an occlusal examination
- d) Documentation the candidate evaluated data to identify problems. The documentation of the data evaluation includes:
  - (1) Chief complaint
  - (2) Medical problem
  - (3) Stomatognathic problems
  - (4) Psychosocial problems
- e) Documentation the candidate worked up the problems and developed a tentative treatment plan. The documentation of the work-up and tentative treatment plan includes:

- (1) Problem definition, e.g., severity/chronicity and classification
- (2) Determination if additional diagnostic tests are needed
- (3) Development of a differential diagnosis
- (4) Recognition of need for referral(s)
- (5) Pathophysiology of the problem
- (6) Short term needs
- (7) Long term needs
- (8) Determination interaction of problems
- (9) Development of treatment options
- (10) Determination of prognosis
- (11) Patient information regarding informed consent

f) Documentation the candidate developed a final treatment plan. The documentation includes:

- (1) Rationale for treatment.
- (2) Problems to be addressed, or any condition that puts the patient at risk in the long term.
- (3) Determination of sequencing with the following framework:
  - Systemic: medical issues of concern, medications and their effects, effect of diseases on oral condition, precautions, treatment modifications
  - Urgent: Acute pain/infection management, urgent esthetic issues, further exploration/additional information, oral medicine consultation, pathology
  - Preparatory: Preventive interventions, orthodontic, periodontal (Phase I, II), endodontic treatment, caries control, other temporization
  - Restorative: operative, fixed, removable prostheses, occlusal splints, implants
  - Elective: esthetic (veneers, etc.) any procedure that is not clinically necessary, replacement of sound restoration for esthetic purposes, bleaching
  - Maintenance: periodontic recall, radiographic interval, periodic oral examination, caries risk management

## ODTP SCORING CRITERIA

### FACTOR 1: MEDICAL ISSUES THAT IMPACT DENTAL CARE

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies and evaluates all medical issues</li> <li>Explains dental implications of systemic conditions</li> <li>Identifies and assesses patient medications</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> item that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> items that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> items that would cause potential harm</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Misses medical or medication items that would cause potential harm</li> </ul>

### FACTOR 2: TREATMENT MODIFICATIONS BASED ON MEDICAL CONDITIONS

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all treatment modifications</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> item that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> items that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> items that would cause potential harm</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Misses treatment modifications that would cause potential harm</li> </ul>

### FACTOR 3: PATIENT CONCERNS/CHIEF COMPLAINT

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all patient concerns including chief complaint</li> </ul>	<ul style="list-style-type: none"> <li>Identifies chief complaint <u>but</u> misses <u>one</u> patient concern</li> </ul>	<ul style="list-style-type: none"> <li>Identifies chief complaint <u>but</u> misses <u>two</u> patient concerns</li> </ul>	<ul style="list-style-type: none"> <li>Identifies chief complaint <u>but</u> misses <u>more than two</u> patient concerns</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Chief complaint NOT identified</li> </ul>

**FACTOR 4: DENTAL HISTORY**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all parameters in dental history</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> parameter in dental history</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> parameters in dental history</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> parameters in dental history</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Neglects to address dental history</li> </ul>

**FACTOR 5: SIGNIFICANT RADIOGRAPHIC FINDINGS**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all radiographic findings</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> radiographic finding that does NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> radiographic findings that do NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> radiographic findings that do NOT substantially alter treatment plan</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Misses radiographic findings that substantially alters treatment plan</li> </ul>

**FACTOR 6: CLINICAL FINDINGS**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all clinical findings</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> clinical finding that does NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> clinical findings that do NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> clinical findings that do NOT substantially alter treatment plan</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Misses clinical findings that substantially alter treatment plan</li> </ul>

**FACTOR 7: RISK LEVEL ASSESSMENT**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Risk level (risk factors/indicators and protective factors) identified</li> <li>Relevance of risk level identified</li> </ul>	<ul style="list-style-type: none"> <li>Risk level and relevance of risk level identified <u>but</u> misses <u>one</u> item (risk factors/indicators and protective factors)</li> </ul>	<ul style="list-style-type: none"> <li>Risk level and relevance of risk level identified <u>but</u> misses <u>two</u> items (risk factors/indicators and protective factors)</li> </ul>	<ul style="list-style-type: none"> <li>Risk level identified <u>but</u> misses <u>more than two</u> items (risk factors/indicators and protective factors)</li> <li>Relevance of risk level NOT identified</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Risk level NOT identified</li> </ul>



**FACTOR 8: NEED FOR ADDITIONAL DIAGNOSTIC TESTS/REFERRALS**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Prescribes/acquires all clinically necessary diagnostic test and referrals with comprehensive rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies need for clinically necessary diagnostic tests and referrals with limited rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies need for additional diagnostic tests and referrals without rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies need for additional diagnostic tests and referrals without rationale <u>and</u> prescribes non-contributory test or referrals</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Does NOT identify clinically necessary diagnostic tests or referrals</li> </ul>

**FACTOR 9: FINDINGS FROM MOUNTED DIAGNOSTIC CASTS**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Casts and mounting reflect patient's oral condition</li> <li>Identifies all diagnostic findings from casts</li> </ul>	<ul style="list-style-type: none"> <li>Casts and mounting reflect patient's oral condition</li> <li>Misses <u>one</u> diagnostic finding that does NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>Casts and mounting reflect patient's oral condition <u>but</u> misses <u>two</u> diagnostic findings that do NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>Casts and mounting reflect patient's oral condition <u>but</u> misses <u>more than two</u> diagnostic findings that do NOT substantially alter treatment plan</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Casts and mounting do NOT reflect patient's oral condition</li> <li>Misses diagnostic cast findings that substantially alter treatment plan</li> </ul>

**FACTOR 10: COMPREHENSIVE PROBLEM LIST**

4	3	2	1	0
<ul style="list-style-type: none"> <li>All problems listed</li> </ul>	<ul style="list-style-type: none"> <li><u>One</u> problem NOT identified without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li><u>Two</u> problems NOT identified without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li><u>Two or more</u> problems NOT identified without potential harm to patient</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Problems with potential for harm to patient NOT identified</li> </ul>

#### FACTOR 11: DIAGNOSIS AND INTERACTION OF PROBLEMS

4	3	2	1	0
<ul style="list-style-type: none"> <li>All diseases correctly diagnosed</li> <li>All interactions identified</li> </ul>	<ul style="list-style-type: none"> <li><u>One</u> missed diagnosis or interaction without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li><u>Two</u> missed diagnoses or interactions without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li><u>More than two</u> missed diagnoses or interactions without potential harm to patient</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Missed diagnosis or interaction resulting in potential harm to patient</li> </ul>

#### FACTOR 12: OVERALL TREATMENT APPROACH

4	3	2	1	0
<ul style="list-style-type: none"> <li>All treatment options identified within standard of care; provides rationale which is <u>optimal</u></li> </ul>	<ul style="list-style-type: none"> <li>All treatment options identified within standard of care; provides <u>acceptable</u> rationale</li> </ul>	<ul style="list-style-type: none"> <li>All treatment options identified within standard of care <u>and</u> lacks sound rationale for treatment</li> </ul>	<ul style="list-style-type: none"> <li>Incomplete treatment options <u>and</u> lacks sound rationale for treatment</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Treatment options presented are NOT within standard of care</li> </ul>

#### FACTOR 13: PHASING AND SEQUENCING OF TREATMENT

4	3	2	1	0
<ul style="list-style-type: none"> <li>Treatment optimally phased and sequenced</li> </ul>	<ul style="list-style-type: none"> <li>Treatment phased correctly but <u>one</u> procedure out of sequence with no harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>Treatment phased correctly but <u>two</u> procedures out of sequence with no harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>Treatment NOT phased correctly <u>but</u> no potential harm to patient</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Treatment NOT phased nor sequenced with potential harm to patient</li> </ul>

#### FACTOR 14: COMPREHENSIVENESS OF TREATMENT PLAN

4	3	2	1	0
<ul style="list-style-type: none"> <li>Treatment plan addresses all problems</li> <li>All treatment procedures are indicated</li> </ul>	<ul style="list-style-type: none"> <li><u>One</u> treatment procedure that is NOT indicated but will NOT result in harm to patient <u>but</u> treatment plan addresses all problems</li> </ul>	<ul style="list-style-type: none"> <li><u>Two or more</u> treatment procedures that are NOT indicated but reflect problem list <u>but</u> treatment plan addresses all problems</li> </ul>	<ul style="list-style-type: none"> <li><u>Two or more</u> treatment procedures that are NOT indicated and do NOT reflect problem list</li> <li>Treatment plan is incomplete but does NOT cause harm to patient</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Treatment plan is incomplete and causes potential harm to patient</li> <li>Treatment procedures included that are NOT indicated resulting in harm to patient</li> <li>Treatment procedures are missing from treatment plan resulting in harm to patient</li> </ul>

#### FACTOR 15: TREATMENT RECORD

4	3	2	1	0
<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and comprehensive rationale for treatment options</li> <li>Documents presentation of risks and benefits of all treatment options</li> </ul>	<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options <u>and</u> provides limited rationale</li> </ul>	<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options <u>but</u> provides no rationale</li> </ul>	<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and treatment options, <u>and</u> documents presentation of risks and benefits only for preferred option</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Does NOT summarize all data collected, diagnoses and/or treatment options</li> <li>Does NOT document presentation of risks and benefits of all treatment options</li> </ul>

## SECTION 9 – DIRECT RESTORATION

### PURPOSE

The competency examinations for direct restoration are designed to assess the candidate's independent ability to restore teeth with interproximal primary carious lesions to optimal form, function and esthetics.

### MINIMUM CLINICAL EXPERIENCES

The documentation of direct restorative clinical experiences includes 60 restorations.

The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including:

- Amalgams,
- Composites,
- Crown buildups,
- Direct pulp caps, and,
- Temporizations.

### OVERVIEW

- Seven (7) scoring factors.
- Two (2) restorations:
  - > Class II amalgam or composite; maximum one slot preparation, and,
  - > Class III or IV composite
- Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.

## PATIENT PARAMETERS

### Class II – Any permanent posterior tooth

- Treatment needs to be performed in the sequence described in the treatment plan.
- More than one test procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments.
- Caries as shown on either of the two required radiographic images of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Tooth to be treated must be in occlusion.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Tooth with bonded veneer is not acceptable.

### Class III/IV – Any permanent anterior tooth

- Treatment needs to be performed in the sequence described in the treatment plan.
- Caries as shown on the required radiographic image of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Carious lesions must involve the interproximal contact area.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Approach must be appropriate for the tooth.
- Tooth with bonded veneer is not acceptable.

## SCORING

Scoring points for direct restorations are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- A score of 3 is acceptable; minimum competence
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

## ELEMENTS OF THE DIRECT RESTORATION PORTFOLIO

The Direct Restoration portfolio may include, but is not limited to the following:

- a) Documentation of the candidate's competency to perform a class II direct restoration on a tooth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials.

The case selection must be based on minimum direct restoration criteria for any permanent posterior tooth. The treatment performed should follow the sequence of the treatment plan(s). More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs.

The tooth involved in the restoration must have caries which penetrate the dento-enamel junction and must be in occlusion. Proximal caries must be in contact with at least one adjacent tooth, a natural tooth surface or a permanent restoration; provisional restorations or removal partial dentures are not acceptable adjacent surfaces. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment.

- b) Documentation of the candidate's competency to perform a class III/IV direct restoration on a tooth containing primary carious lesions to optimal forms, function and esthetics using composite restorative material. The case selected must be on any permanent anterior tooth and treatment needs to be performed in the sequence described in the treatment plan.

More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs. The tooth involved in the restoration must have caries which penetrate the dento-enamel junction.

The tooth to be restored must have an adjacent tooth to be able to restore a proximal contact. Proximal surface of the dentition adjacent to the proposed restoration must be natural tooth structure or a permanent restoration, provisional restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth involved in the restoration must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment. The lesion is not acceptable if it is in contact with circumferential decalcification. The approach must be appropriate for the tooth. Teeth with bonded veneers are not acceptable.

## DIRECT RESTORATION SCORING CRITERIA

### FACTOR 1: CASE PRESENTATION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Obtains informed consent</li> <li>• Presents a comprehensive review of medical and dental history</li> <li>• Provides rationale for restorative procedure</li> <li>• Proposes initial design of preparation and restoration</li> <li>• Demonstrates full understanding of the procedure</li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate deviation from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors in assessing patient's medical and/or dental history</li> <li>• Unable to justify treatment</li> <li>• Proposed treatment would cause harm to patient</li> <li>• Proposed treatment not indicated</li> <li>• Misses critical factors in medical and/or dental review that affect treatment or patient well being</li> </ul>

## FACTOR 2: OUTLINE AND EXTENSIONS

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Optimal outline and extensions <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Smooth, flowing</li> <li>&gt; Does not weaken tooth</li> <li>&gt; Includes the lesion</li> <li>&gt; Breaks proximal contacts as appropriate</li> <li>&gt; Appropriate cavosurface angles</li> <li>&gt; Optimal treatment of fissures</li> <li>&gt; No damage to adjacent teeth</li> <li>&gt; Optimal extension for caries/</li> <li>&gt; decalcification</li> <li>&gt; Appropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation(s) from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate, clinically acceptable deviation(s) from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Irregular outline</li> <li>&gt; Outline weakens the tooth</li> <li>&gt; Does not include the lesion</li> <li>&gt; Contacts not broken where appropriate</li> <li>&gt; Proximal extensions excessive</li> <li>&gt; Inappropriate cavosurface angle(s)</li> <li>&gt; Inappropriate treatment of fissures</li> <li>&gt; Adjacent tooth requires major recontouring</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Irregular outline</li> <li>&gt; Outline weakens the tooth</li> <li>&gt; Does not include the lesion</li> <li>&gt; Contacts not broken where appropriate</li> <li>&gt; Proximal extensions excessive</li> <li>&gt; Inappropriate cavosurface angle(s)</li> <li>&gt; Inappropriate treatment of fissures</li> <li>&gt; Adjacent tooth requires major recontouring</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors in outline and extensions</li> <li>• Deviations from optimal that are irreversible and have a significant impact on treatment</li> <li>• Damage to adjacent tooth that requires restoration</li> </ul>



### FACTOR 3: INTERNAL FORM

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal internal form <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Optimal pulpal and axial depth</li> <li>&gt; Optimal wall relationships</li> <li>&gt; Optimal axio-pulpal line angles</li> <li>&gt; Optimal internal refinement</li> <li>&gt; All previous restorative material removed</li> <li>&gt; Optimal caries removal</li> <li>&gt; Preparation is clean and free of fluids and/or debris</li> <li>&gt; Appropriate liners and bases</li> <li>&gt; Appropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Moderate, clinically acceptable deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Excessive or inadequate pulpal or axial depth</li> <li>&gt; Inappropriate wall relationships</li> <li>&gt; Inappropriate internal line angles</li> <li>&gt; Rough or uneven internal features</li> <li>&gt; Previous restorative material present</li> <li>&gt; Inappropriate caries removal</li> <li>&gt; Fluids and/or debris present</li> <li>&gt; Inappropriate handling of liners and bases</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u>, major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Excessive or inadequate pulpal or axial depth</li> <li>&gt; Inappropriate wall relationships</li> <li>&gt; Inappropriate internal line angles</li> <li>&gt; Rough or uneven internal features</li> <li>&gt; Previous restorative material present</li> <li>&gt; Inappropriate caries removal</li> <li>&gt; Fluids and/or debris present</li> <li>&gt; Inappropriate handling of liners and bases</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Critical errors from optimal internal form</li> <li>Noncarious pulp exposure</li> </ul>

#### FACTOR 4: OPERATIVE ENVIRONMENT

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Soft tissue free of unnecessary damage</li> <li>• Proper patient comfort/pain management</li> <li>• Optimal isolation</li> <li>• Correct teeth isolated</li> <li>• Dam fully inverted</li> <li>• Clamp stable with no tissue damage</li> <li>• No leakage</li> <li>• Preparation can be accessed and visualized</li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate, clinically acceptable deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Incorrect teeth isolated</li> <li>&gt; Dam not inverted, causing leakage that may compromise the final restoration</li> <li>&gt; Clamp is not stable or impinges on tissue</li> <li>&gt; Preparation cannot be accessed or visualized to allow proper placement of restoration</li> <li>&gt; Major tissue damage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Incorrect teeth isolated</li> <li>&gt; Dam not inverted, causing leakage that may compromise the final restoration</li> <li>&gt; Clamp is not stable or impinges on tissue</li> <li>&gt; Preparation cannot be accessed or visualized to allow proper placement of restoration</li> <li>&gt; Major tissue damage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors from optimal in operative environment</li> <li>• Gross soft tissue damage</li> <li>• Gross lack of concern for patient comfort</li> </ul>

### FACTOR 5: ANATOMICAL FORM

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal anatomic form <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Harmonious and consistent with adjacent tooth structure</li> <li>&gt; Interproximal contour and shape are proper</li> <li>&gt; Interproximal contact area and position are properly restored</li> <li>&gt; Contact is closed</li> <li>&gt; Height and shape of marginal ridge is appropriate</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	Moderate, clinically acceptable deviation(s) from optimal	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Inconsistent with adjacent tooth structure</li> <li>&gt; Interproximal contour and shape are inappropriate</li> <li>&gt; Height and shape of marginal ridge is inappropriate</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Inconsistent with adjacent tooth structure</li> <li>&gt; Interproximal contour and shape are inappropriate</li> <li>&gt; Height and shape of marginal ridge is inappropriate</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that require restoration to be redone</li> </ul>

### FACTOR 6: MARGINS

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal margins</li> <li>No deficiencies or excesses</li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Moderate, clinically acceptable deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Open margin, submarginal, and/or excess restorative material</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that require restoration to be redone</li> </ul>

# **FACTOR 7: FINISH AND FUNCTION**

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal finish and function <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Smooth with no pits, voids or irregularities in restoration</li> <li>&gt; Occlusion is properly restored with no interferences</li> <li>&gt; No damage to hard or soft tissue</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	<p>Moderate, clinically acceptable deviation(s) from optimal</p>	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Significant pits, voids or irregularities in the surfaces</li> <li>&gt; Severe hyper-occlusion or hypo-occlusion</li> <li>&gt; Moderate damage to hard or soft tissue</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that require restoration to be redone</li> <li>Procedure is not completed within allotted time</li> <li>Unnecessary, gross damage to hard and soft tissue as related to finishing procedure</li> </ul>

## SECTION 10 – INDIRECT RESTORATION

### PURPOSE

The competency examination for indirect restoration is designed to assess the candidate's independent ability to restore teeth requiring an indirect restoration to optimal form, function and esthetics with a full or partial coverage ceramic, metal or metal-ceramic indirect restoration.

### MINIMUM CLINICAL EXPERIENCES

The documentation of indirect restorative clinical experiences will include a minimum of 14 restorations.

The restorations completed in the clinical experiences may be a combination of the following procedures:

- Inlays,
- Onlays,
- Crowns,
- Abutments,
- Pontics,
- Veneers,
- Cast posts,
- Overdenture copings, or,
- Dental implant restorations.

### OVERVIEW

- Seven (7) scoring factors.
- One (1) indirect restoration which may be a combination of the following procedures:
  - > Ceramic restoration must be onlay or more extensive
  - > Partial gold restoration must be onlay or more extensive
  - > Metal ceramic restoration (PFM)
  - > Full gold restoration
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.

- Requires patient management; candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

## PATIENT PARAMETERS

- Treatment needs to be performed in the sequence described in the treatment plan.
- Tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment.
- Tooth must be in occlusal contact with a natural tooth or a permanent restoration. Occlusion with a full or partial denture is not acceptable.
- The restoration must include at least one cusp.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration; temporary restorations or removable partial dentures are not acceptable adjacent surfaces.
- The candidate may not have performed any portion of the crown preparation in advance.
- Direct restorative materials which are placed to contribute to the retention and resistance form of the final restoration (buildups) may be completed ahead of time, if needed.
- Restoration must be completed on the same tooth and same patient by the same candidate.
- Validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of the existing crown.

## SCORING

Scoring points for indirect restoration is defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- A score of 3 is acceptable; minimum competence
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

## ELEMENTS OF THE INDIRECT RESTORATION PORTFOLIO

The indirect restoration portfolio may include, but is not limited to the following:

- a) Documentation of the candidate's competency to complete a ceramic onlay or more extensive indirect restorations. The treatment needs to be performed in the sequence in the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be in need of endodontic treatment. The tooth selected for restoration, must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of the onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.
- b) Documentation of the candidate's competency to complete a partial gold restoration must be an onlay or more extensive indirect restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.
- c) Documentation of the candidate's competency to perform a full gold restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead

of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

- d) Documentation of the candidate's competency to perform a metal-ceramic restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis: cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restorations must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient.
- e) A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.



## INDIRECT RESTORATION SCORING CRITERIA

### FACTOR 1: CASE PRESENTATION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Obtains informed consent</li> <li>Presents a comprehensive medical and dental review</li> <li>Provides rationale for restorative procedure</li> <li>Proposes initial design of restoration</li> <li>Provides method for provisionalization</li> <li>Demonstrates full understanding of the procedure</li> <li>Sequencing of treatment follows standards of care</li> </ul>	<ul style="list-style-type: none"> <li>Slight deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>Moderate deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal case presentation</li> <li>Provides inappropriate justification for treatment</li> <li>Sequencing of treatment does not follow standards of care</li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors in assessing patient's medical and/or dental history</li> <li>Unable to justify treatment</li> <li>Proposed treatment would cause harm to patient</li> <li>Proposed treatment not indicated</li> <li>Misses critical factors in medical and dental review that affect treatment or patient well being</li> </ul>

## FACTOR 2: PREPARATION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Meets all accepted criteria for optimal preparation:               <ol style="list-style-type: none"> <li>Occlusal /incisal reduction</li> <li>Axial reduction</li> <li>Finish lines</li> <li>Caries removal</li> <li>Pulpal protection</li> <li>Soft tissue management</li> <li>No damage to soft and hard tissues</li> <li>Resistance and retention</li> <li>Debridement</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviations from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Moderate, clinically acceptable deviations from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal but correctable without significantly changing the procedure</li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal preparation</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that are irreversible and have a significant impact on treatment</li> <li>Critical errors that require major modifications of the proposed treatment <u>such as</u>:               <ol style="list-style-type: none"> <li>Onlay that must change to full crown</li> <li>Overextension requiring crown lengthening</li> </ol> </li> </ul>

### FACTOR 3: IMPRESSION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Achieves optimal, clinically acceptable impression achieved in one attempt               <ul style="list-style-type: none"> <li>a) Impression extends beyond finish lines</li> <li>b) Detail of preparation and adjacent teeth captured accurately</li> <li>c) Free of voids in critical areas</li> <li>d) No aspect of impression technique that would result in inaccuracy</li> <li>e) Interocclusal record is accurate, if needed</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Achieves clinically acceptable impression in second attempt</li> </ul>	<ul style="list-style-type: none"> <li>Achieves clinically acceptable impression more than two attempts</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation that require retaking impression <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of unacceptable impression or interocclusal relationship</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal in impression <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of unacceptable impression or interocclusal relationship</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>failure to achieve a clinically acceptable impression after five (5) attempts</li> <li>Critical errors in impression procedure cause unnecessary tissue damage that require corrective treatment procedures</li> </ul>

#### FACTOR 4: PROVISIONAL

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Meets all accepted criteria for optimal provisional:               <ol style="list-style-type: none"> <li>Occlusal form and function</li> <li>Proximal contact</li> <li>Axial contours</li> <li>Marginal fit</li> <li>External surfaces smooth and polished without pits, voids, or debris</li> <li>Optimal internal adaptation</li> <li>Retention</li> <li>Esthetics</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviations from optimal have minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Moderate deviations from accepted criteria have minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal that can be corrected <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of major deviation that can be corrected</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations that have significant impact on treatment <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of major deviation that can be corrected</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that are clinically unacceptable</li> </ul>

### FACTOR 5: CANDIDATE EVALUATION OF LABORATORY WORK

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Verifies that restoration meets all accepted criteria</li> <li>Verifies errors in restoration and proposes changes, if needed</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of major deviation from optimal that can be corrected</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of <u>multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that require restoration to be redone</li> </ul>

### FACTOR 6: PRE-CEMENTATION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Meets all accepted criteria for pre-cementation:               <ol style="list-style-type: none"> <li>Occlusal form and function</li> <li>Proximal contact</li> <li>Axial contours</li> <li>Marginal fit</li> <li>External surfaces smooth and polished without pits, voids, or debris</li> <li>Optimal internal adaptation</li> <li>Retention</li> <li>Esthetics</li> <li>Patient acceptance</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of major deviation that can be corrected</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of <u>multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Lack of recognition of critical errors which <u>cannot</u> be corrected</li> </ul>

## FACTOR 7: CEMENTATION AND FINISH

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Meets all accepted criteria for optimal cementation               <ol style="list-style-type: none"> <li>Occlusal form and function</li> <li>Proximal contact</li> <li>Axial contours</li> <li>Marginal fit</li> <li>External surfaces smooth and polished without pits, voids, or debris</li> <li>Optimal internal adaptation</li> <li>Retention</li> <li>Esthetics</li> <li>All excess cement removed</li> <li>No unnecessary tissue trauma</li> <li>Appropriate postoperative instructions</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviations from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Moderate deviations from accepted criteria; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from accepted that can be corrected</li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors which require restoration to be redone</li> <li>Procedure is not completed within allotted time</li> <li>Unnecessary, gross damage to hard and soft tissue as related to finishing</li> </ul>

## SECTION 11 – REMOVABLE PROSTHODOTICS

### PURPOSE

The competency examination for removable prosthodontics is designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a prosthesis from diagnosis and treatment planning to delivery of the prosthetic device and post-insertion follow-up.

### MINIMUM CLINICAL EXPERIENCES

The documentation of oral of removable prosthodontic clinical experiences shall include five (5) prostheses.

One of the five prostheses may be used as a Portfolio competency examination provided that it is completed in an independent manner with no faculty intervention.

A prosthesis is defined to include any of the following:

- Full denture,
- Partial denture (cast framework),
- Partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth),
- Immediate treatment denture, or,
- Overdenture retained by natural or dental implants.

### OVERVIEW

- Twelve (12) scoring factors.
- One (1) of the following prosthetic treatments from start to finish on the same patient:
  - > Denture or overdenture for a single edentulous arch, or,
  - > Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch
- An immediate or interim denture.
- No patient sharing; cannot split patients between candidates
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.
- Case complexity is not a criteria.

## PATIENT PARAMETERS

Procedures may be performed on patients with supported soft tissue, implants or natural tooth retained overdentures.

## SCORING

Scoring points for removable prosthodontics are defined as follows:

- A score of 1 is unacceptable with gross errors
- A score of 2 is unacceptable with major errors
- A score of 3 is minimum competence with moderate errors that do not compromise outcome
- A score of 4 is acceptable with minor errors that do not compromise outcome
- A score of 5 is optimal with no errors evident

## ELEMENTS OF THE REMOVABLE PROSTHODONTICS PORTFOLIO

- a) Documentation the candidate developed a diagnosis, determined treatment options and prognosis for the patient to receive a removable prosthesis. The documentation may include, but is not limited to the following:
  - Evidence the candidate obtained a patient history, (e.g. medical, dental and psychosocial).
  - Evaluation of the patient's chief complaint.
  - Radiographs and photographs of the patient.
  - Evidence the candidate performed a clinical examination, (e.g. hard/soft tissue charting, endodontic evaluation, occlusal examination, skeletal/jaw relationship, VDO, DR, MIP).
  - Evaluation of existing prosthesis and the patient's concerns.
  - Evidence the candidate obtained and mounted a diagnostic cast.
  - Evidence the candidate determined the complexity of the case based on ACP classifications.
  - Evidence the patient was presented with treatment plan options and assessment of the prognosis, (e.g. complete dentures, partial denture, overdenture, implant options, FPD).
  - Evidence the candidate analyzed the patient risks/benefits for the various treatment options.
  - Evidence the candidate exercised critical thinking and made evidence –based treatment decisions.
- b) Documentation of the candidate's competency to successfully restore edentulous spaces with removable prosthesis. The documentations may include but is not limited to the following:



- Evidence the candidate developed a diagnosis and treatment plan for the removable prosthesis.
  - Evidence the candidate obtained diagnostic casts.
  - Evidence the candidate performed diagnostic wax-up/survey framework designs.
  - Evidence the candidate performed an assessment to determine the need for pre-prosthetic surgery and made the necessary referral.
  - Evidence the candidate performed tooth modifications and/or survey crowns, when indicated.
  - Evidence the candidate obtained master impressions and casts.
  - Evidence the candidate obtained occlusal records.
  - Evidence the candidate performed a try-in and evaluated the trial dentures.
  - Evidence the candidate inserted the prosthesis and provided the patient with post-insertion care.
  - Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).
- c) Documentation of the candidate's competency to manage tooth loss transitions with immediate or transitional prostheses. The documentation may include, but is limited to the following:
- Evidence the candidate developed a diagnosis and treatment plan that identified teeth that could be salvaged and or teeth that needed extraction.
  - Evidence the candidate educated the patient regarding the healing process, denture experience, and future treatment need.
  - Evidence the candidate developed prosthetic phases which included surgical plans.
  - Evidence the candidate obtained casts (preliminary and final impressions).
  - Evidence the candidate obtained the occlusal records.
  - Evidence the candidate did try-ins and evaluated trial dentures.
  - Evidence the candidate competently managed and coordinated the surgical phase.
  - Evidence the candidate provided the patient post insertion care including adjustment, relines and patient counseling.
  - Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).
- d) Documentation of the candidate's competency to manage prosthetic problems. The documentation may include, but is not limited to the following:
- Evidence the candidate competently managed real or perceived patient problems.

- Evidence the candidate evaluated existing prosthesis.
  - Evidence the candidate performed uncomplicated repairs, relines, re-base, re-set or re-do, if needed.
  - Evidence the candidate made a determination if specialty referral was necessary.
  - Evidence the candidate obtained impressions/records/information for laboratory use.
  - Evidence the candidate competently communicated needed prosthetic procedure to laboratory technician.
  - Evidence the candidate inserted the prosthesis and provided the patient follow-up care.
  - Evidence the candidate performed in-office maintenance, (e.g. prosthesis cleaning, clasp tightening and occlusal adjustments).
- e) Documentation the candidate directed and evaluated the laboratory services for the prosthesis. The documentation may include, but is not limited to the following:
- Complete laboratory prescriptions sent to the dental technician.
  - Copies of all communications with the laboratory technicians.
  - Evaluations of the laboratory work product, (e.g. frameworks, processed dentures).

## REMOVABLE PROSTHODONTICS SCORING CRITERIA

### FACTOR 1: PATIENT EVALUATION AND DIAGNOSIS

5	4	3	2	1
<ul style="list-style-type: none"> <li>Evaluation and diagnosis is comprehensive and discriminating</li> <li>Recognizes significant diagnostic implications of all findings</li> </ul>	<ul style="list-style-type: none"> <li>Recognizes significant diagnostic implications but misses some findings that do NOT affect diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>Recognizes significant findings <u>but</u> there are errors in findings or judgment that do NOT compromise diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>Does NOT recognize significant findings or diagnostic implications</li> <li>Diagnosis is jeopardized</li> </ul>	<ul style="list-style-type: none"> <li><u>Gross</u> errors in evaluation or judgment</li> <li><u>Gross</u> errors in diagnosis</li> </ul>

### FACTOR 2: TREATMENT PLAN AND SEQUENCING

5	4	3	2	1
<ul style="list-style-type: none"> <li>Presents/ formulates all treatment options and understands clinical nuances of each option</li> <li>Presents comprehensive treatment plan based on clinical evidence, patient history and direct examination</li> <li>Performs risk-based analysis to present appropriate treatment options and prognosis</li> <li>Demonstrates critical thinking as evidenced in steps in treatment plan</li> <li>No errors in planning and sequencing</li> </ul>	<ul style="list-style-type: none"> <li>Presents/formulates most treatment options and understands rationale of each option</li> <li>Treatment plan is appropriate some contributing factors NOT considered</li> <li><u>Minor</u> errors that do NOT affect planning and sequencing</li> </ul>	<ul style="list-style-type: none"> <li>Presents/formulates appropriate treatment options with less than ideal understanding of chief complaint, diagnosis, and prognosis</li> <li><u>Moderate</u> errors that do NOT compromise planning and sequencing</li> </ul>	<ul style="list-style-type: none"> <li>Does NOT address patient's chief complaint</li> <li>Treatment plan NOT based on diagnosis</li> <li><u>Major</u> errors in evidenced based, critical thinking, risk-based, and prognostic assessment</li> <li>Treatment sequence inappropriate</li> </ul>	<ul style="list-style-type: none"> <li>Treatment plan NOT based on diagnostic findings or prognostic information</li> <li>Treatment plan grossly inadequate</li> <li>Treatment sequence grossly inappropriate</li> </ul>

**FACTOR 3: PRELIMINARY IMPRESSIONS**

5	4	3	2	1
<ul style="list-style-type: none"><li>Perform and recognize adequate capture of anatomy; free of distortions and voids</li></ul>	<ul style="list-style-type: none"><li>Performs impression with <u>minor</u> errors that do NOT affect final outcome</li></ul>	<ul style="list-style-type: none"><li>Performs impression with <u>moderate</u> errors that do NOT compromise final outcome</li></ul>	<ul style="list-style-type: none"><li>Performs impression with <u>major</u> errors, <u>or</u> fails to recognize that final outcome is compromised</li></ul>	<ul style="list-style-type: none"><li>Inadequate capture of anatomy or gross distortion/voids</li><li>Fails to recognize that subsequent steps are impossible</li></ul>

**FACTOR 4: RPD DESIGN (IF APPLICABLE)**

5	4	3	2	1
<ul style="list-style-type: none"><li>Design demonstrates understanding of biomechanical and esthetic principles</li><li>Casts are surveyed accurately</li><li>Design is drawn with detail</li></ul>	<ul style="list-style-type: none"><li>Design demonstrates understanding of biomechanical and esthetic principles with <u>minor</u> errors</li><li>Minor errors in cast survey and design</li></ul>	<ul style="list-style-type: none"><li>Design is functional but includes rests, clasp assembly or major connector that are NOT first choices</li><li><u>Moderate</u> errors in survey and design</li><li>Moderate errors in understanding of RPD design principles</li></ul>	<ul style="list-style-type: none"><li>Demonstrates lack of understanding of biomechanical or esthetic principles</li><li><u>Major</u> errors in cast survey and design</li></ul>	<ul style="list-style-type: none"><li>Design is grossly inappropriate</li><li>Inaccurate survey</li><li>Illegible drawing</li></ul>

**FACTOR 5: TOOTH MODIFICATION (IF APPLICABLE)**

5	4	3	2	1
<ul style="list-style-type: none"><li>• Parallel guiding planes</li><li>• Optimal size and location of rest preparations</li><li>• Conservative recontouring of abutment teeth for optimal location of clasp and to optimize occlusal plane</li><li>• Survey crowns as needed</li></ul>	<ul style="list-style-type: none"><li>• <u>Minor</u> deficiencies in tooth modification; RPD fit and service unaffected</li></ul>	<ul style="list-style-type: none"><li>• <u>Moderate</u> deficiencies in tooth modifications but no compromise in RPD fit and service</li></ul>	<ul style="list-style-type: none"><li>• <u>Major</u> errors in tooth modifications leading to compromised RPD fit and service</li><li>• Tooth modifications may require restorations</li></ul>	<ul style="list-style-type: none"><li>• RPD abutment teeth are grossly over-prepared</li></ul>

**FACTOR 6: BORDER MOLDING AND FINAL IMPRESSIONS**

5	4	3	2	1
<ul style="list-style-type: none"><li>Obtain optimal vestibular extension and peripheral seal</li><li>Perform and recognize adequate capture of anatomy</li><li>Impression free of distortions/voids</li></ul>	<ul style="list-style-type: none"><li>Border molding and/or impression have <u>minor</u> errors that do NOT affect final outcome</li></ul>	<ul style="list-style-type: none"><li>Border molding and/or impression have <u>moderate</u> deviations that do NOT compromise final outcome</li></ul>	<ul style="list-style-type: none"><li>Border molding and/or impression have <u>major</u> errors that affect final outcome</li></ul>	<ul style="list-style-type: none"><li>Border molding and/or impression do NOT adequately capture of anatomy or gross distortion/voids so that final outcome impossible</li></ul>

**FACTOR 7: FRAMEWORK TRY-IN (IF APPLICABLE)**

5	4	3	2	1
<ul style="list-style-type: none"><li>Perform and recognize functional and occlusal adjustment</li><li>Complete seating of framework is achieved</li><li>Determine sequence for establishing denture-base support</li></ul>	<ul style="list-style-type: none"><li><u>Minor</u> deficiencies in ability to recognize and correct minor discrepancies in framework fit but do NOT affect RPD service</li></ul>	<ul style="list-style-type: none"><li><u>Moderate</u> deficiencies in ability to recognize or correct discrepancies in framework fit but no significant compromise to RPD service</li></ul>	<ul style="list-style-type: none"><li><u>Major</u> errors in framework fit NOT recognized</li><li>Errors in judgment regarding sequence of correction</li></ul>	<ul style="list-style-type: none"><li><u>Gross</u> errors in framework fit NOT recognized</li><li>Unable to determine sequence of correction</li></ul>

### FACTOR 8: JAW RELATION RECORDS

5	4	3	2	1
<ul style="list-style-type: none"> <li>Smooth record bases with appropriate peripheral extensions/thickness</li> <li>Smoothly contoured wax rim establishes esthetic parameters</li> <li>Vertical dimension is physiologically appropriate</li> <li>Accurately captures centric relation</li> <li>Relates opposing casts without interference</li> </ul>	<ul style="list-style-type: none"> <li><u>Minor</u> discrepancies in jaw relation records that do NOT adversely affect prosthetic service</li> </ul>	<ul style="list-style-type: none"> <li><u>Moderate</u> discrepancies in jaw relation records that do NOT compromise prosthetic service; records do NOT require repeating</li> </ul>	<ul style="list-style-type: none"> <li><u>Major</u> errors in jaw relation records that adversely affect prosthetic service; records should be redone</li> </ul>	<ul style="list-style-type: none"> <li><u>Gross</u> errors in jaw relation records with poor understanding and judgment; records should be redone</li> </ul>

### FACTOR 9: TRIAL DENTURES

5	4	3	2	1
<ul style="list-style-type: none"> <li>Recognizes optimal <u>esthetic</u> (midline, incisal length, tooth mold and shade, arrangement), <u>occlusal</u> (MIP=CR, VDO &lt; VDR, bilateral posterior contact), <u>speech and contour</u> aspects of trial dentures</li> <li>Deviations from the optimal are corrected or managed appropriately</li> </ul>	<ul style="list-style-type: none"> <li><u>Minor</u> deficiencies in ability to recognize and correct discrepancies in esthetics, vertical dimension, occlusion, phonetics and contour</li> </ul>	<ul style="list-style-type: none"> <li><u>Moderate</u> deficiencies in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which do NOT compromise final outcome</li> </ul>	<ul style="list-style-type: none"> <li><u>Major</u> errors in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which adversely affect final outcome</li> </ul>	<ul style="list-style-type: none"> <li>Demonstrates inability to recognize or correct gross errors which will result in failure of final outcome</li> </ul>

# **FACTOR 10: INSERTION OF REMOVABLE PROSTHESIS**

5	4	3	2	1
<ul style="list-style-type: none"> <li>Optimize definitive prosthesis, recognizing errors and correcting if necessary, including the following:               <ul style="list-style-type: none"> <li>&gt; Tissue fit</li> <li>&gt; Prosthetic support, stability and retention</li> <li>&gt; RPD extension base tissue support</li> <li>&gt; Vestibular extension and bulk</li> <li>&gt; Occlusion; clinical remount required</li> <li>&gt; Phonetics</li> <li>&gt; Contours and polish</li> <li>&gt; Patient home care instructions</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Minor</u> discrepancies in judgment and/or performance of optimizing prosthesis fit and function; no adverse affect on prosthesis service</li> </ul>	<ul style="list-style-type: none"> <li><u>Moderate</u> discrepancies in judgment and performance of optimizing prosthesis fit/function; no compromise on prosthesis service</li> </ul>	<ul style="list-style-type: none"> <li><u>Major</u> errors in judgment and performance of optimizing prosthesis fit/function</li> <li>Prosthesis service adversely affected; may require significant correction of prosthesis</li> </ul>	<ul style="list-style-type: none"> <li><u>Gross</u> errors in judgment and performance results in failure of prosthesis with no possibility to correct; prosthesis must be redone</li> </ul>



**FACTOR 11: POST-INSERTION (1 WEEK)**

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Perform an appropriate recall sequence to evaluate and diagnose prosthesis problem and make adjustments until patient is satisfied with fit, form and function of new prosthesis</li> <li>• Enroll patient in maintenance program</li> <li>• Demonstrate familiarity with common prosthesis complications and solutions</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Minor</u> discrepancies in ability to evaluate and solve prosthesis problems; no affect on patient comfort and function</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Moderate</u> discrepancies in ability to evaluate and solve prosthesis problems that do NOT compromise patient comfort and function</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Major</u> errors in ability to evaluate and solve prosthesis problems that adversely affect patient comfort and function</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Gross</u> errors in ability to evaluate and solve prosthesis problems</li> <li>• Patient confidence is compromised</li> </ul>

# **FACTOR 12: LABORATORY SERVICES FOR PROSTHESIS**

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Prescription clearly communicates desired laboratory work and materials</li> <li>• Complies with infection control protocols between clinic and laboratory environments</li> <li>• Accurately evaluates laboratory work products</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services has <u>minor</u> errors that do NOT adversely affect prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services has <u>moderate</u> discrepancies that do NOT compromise prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services, has <u>major</u> errors that adversely affect prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services has <u>gross</u> errors that result in prosthesis failure</li> </ul>

## SECTION 12 – ENDODONTICS

### PURPOSE

The competency examination for endodontics is designed to assess the candidate's independent ability to demonstrate clinical skills in all aspects of a case from diagnosis to completion of conventional nonsurgical endodontic interventions.

### MINIMUM CLINICAL EXPERIENCES

- Ten (10) scoring factors.
- One (1) clinical case.
- Requires patient management; therefore, candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

### OVERVIEW

The documentation of endodontic clinical experiences on patients must include five (5) canals or any combination of canals in three separate teeth.

### PATIENT PARAMETERS

- Any tooth to completion by the same candidate clinician on the same patient.
- Completed case is defined as a tooth with an acceptable and durable coronal seal.

### SCORING

Scoring points for endodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

## ELEMENTS OF THE ENDODONTICS PORTFOLIO

The Endodontics portfolio may include, but is not limited to the following:

- a) Documentation the candidate applied case selection criteria for endodontic cases. The Portfolio must contain evidence the cases selected met American Association of Endodontics case criteria for minimum difficulty such that treated teeth have uncomplicated morphologies, have signs and symptoms of swelling and acute inflammation and have not had previous complete or partial endodontic therapy.
  - Candidates determine a diagnostic need for endodontic therapy.
  - Candidates performed charting and diagnostic testing.
  - Candidates took and interpreted radiographs of the patient oral condition.
  - Candidates made a pulpal diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the pulpal diagnosis was within approved parameters (within normal limits, reversible pulpitis, irreversible pulpitis, necrotic pulp).
  - Candidates make a periapical diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the periapical diagnosis was within approved parameters (within normal limits, asymptomatic apical periodontitis, symptomatic apical periodontitis, acute apical abscess, chronic apical abscess).
  - Evidence the candidate developed an endodontic treatment plan that included trauma treatment, management of emergencies and referrals when indicated.
- b) Documentation the candidate performed pretreatment preparation for endodontic treatment. Documentation may include, but is not limited to the following:
  - Evidence the candidate competently managed the patient's pain.
  - Evidence the candidate removed caries and failed restorations.
  - Evidence the candidate determined the tooth restorability.
  - Evidence the candidate achieved isolation.
- c) The candidate competently performed access opening. Documentation may include, but is not limited to the following:
  - Evidence the candidate created the indicated outline form.
  - Evidence the candidate created straight line access.
  - Evidence the candidate maintained structural integrity.
  - Evidence the candidate completed un-roofing of pulp chamber.
  - Evidence the candidate identified all canal systems.

- d) Documentation the candidate performed proper cleaning and shaping techniques. Documentation may include, but is not limited to the following:
- Evidence the candidate maintained canal integrity.
  - Evidence the candidate preserved canal shape and flow.
  - Evidence the candidate applied protocols for establishing working length.
  - Evidence the candidate managed apical control.
  - Evidence the candidate applied disinfection protocols.
- e) Documentation the candidate performed proper obturation protocols. Documentation may include, but is not limited to evidence the candidate applied obturation protocols, including selection and fitting of master cone, determination of canal condition before obturation, and verification of sealer consistency and adequacy of coating.
- f) Documentation the candidate demonstrated proper length control of obturation, including achievement of dense obturation of filling material, obturation achieved to a clinically appropriate coronal height.
- g) Documentation the candidate competently completed the endodontic case including evidence that the candidate achieved coronal seal to prevent re-contamination and the candidate created diagnostic, radiographic and narrative documentation.
- h) Documentation the candidate provided recommendations for post-endodontic treatment, including evidence that the candidate recommended final restoration alternatives and provided the patient with recommendations for outcome assessment and follow-up.

## ENDODONTICS SCORING CRITERIA

### FACTOR 1: PRETREATMENT CLINICAL TESTING AND RADIOGRAPHIC IMAGING

4	3	2	1	0
<ul style="list-style-type: none"> <li>Clinical tests and radiographic imaging completed and recorded accurately</li> <li>Radiographic images are of diagnostic quality</li> </ul>	<ul style="list-style-type: none"> <li>Clinical tests and radiographic imaging completed and recorded accurately with minor discrepancies</li> </ul>	<ul style="list-style-type: none"> <li>Some clinical tests and radiographic images are lacking <u>but</u> diagnosis can be determined</li> </ul>	<ul style="list-style-type: none"> <li>Some clinical tests and radiographic images are lacking <u>and</u> diagnosis is questionable</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Clinical tests and radiographic images are lacking and diagnosis CANNOT be determined</li> <li>Radiographic images are missing or are NOT of diagnostic quality</li> </ul>

### FACTOR 2: ENDODONTIC DIAGNOSIS

4	3	2	1	0
<ul style="list-style-type: none"> <li>Establishes correct pulpal and periapical diagnosis with accurate interpretation of clinical tests and radiographic images</li> </ul>	<ul style="list-style-type: none"> <li>Establishes correct pulpal and periapical diagnosis with accurate interpretation, <u>but</u> missing <u>one</u> clinical test and/or radiographic image</li> </ul>	<ul style="list-style-type: none"> <li>Establishes correct pulpal and periapical diagnosis with adequate interpretation, <u>but</u> missing <u>multiple</u> clinical tests and radiographic images that do NOT impact diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>Establishes inaccurate pulpal or periapical diagnosis, <u>and</u> missing <u>multiple</u> clinical tests and radiographic images that impact diagnosis</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Demonstrates lack of understanding of endodontic diagnosis</li> <li>No clinical tests were done</li> </ul>

### FACTOR 3: ENDODONTIC TREATMENT PLAN

4	3	2	1	0
<ul style="list-style-type: none"> <li>Prognosis of treatment outcomes determined</li> <li>Comprehensive evaluation of medical and dental history</li> <li>Selects appropriate treatments based on clinical evidence</li> <li>Understands complexities of the case such that all treatment risks identified</li> <li>Informed consent obtained including alternative treatments</li> </ul>	<ul style="list-style-type: none"> <li>Prognosis of treatment outcomes determined <u>and</u> adequate evaluation of medical and dental history</li> <li>Selects appropriate treatment(s)</li> <li>Significant treatment risks identified</li> <li>Informed consent obtained</li> </ul>	<ul style="list-style-type: none"> <li>Prognosis of treatment outcomes determined <u>and</u> minimal evaluation of <u>one</u> of the following: <ul style="list-style-type: none"> <li>&gt; Medical or dental history</li> <li>&gt; Appropriate treatment(s) selected,</li> <li>&gt; Most treatment risks identified,</li> <li>&gt; Informed consent obtained</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Prognosis of treatment outcomes unclear</li> <li>Inadequate evaluation of medical and dental history despite appropriate treatments selected</li> <li>Key treatment risks NOT identified</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Demonstrates lack of evaluation of relevant medical and dental history</li> <li>Inappropriate treatment planning</li> <li>No treatment risks identified</li> <li>No informed consent obtained</li> <li>Demonstrates inappropriate case selection</li> <li>Prognosis of treatment outcomes NOT determined</li> </ul>

### FACTOR 4: ANESTHESIA AND PAIN CONTROL

4	3	2	1	0
<ul style="list-style-type: none"> <li>Thorough knowledge of technique and materials used</li> <li>Monitors vital signs and patient response throughout anesthesia</li> <li>Anesthesia administration effective</li> </ul>	<ul style="list-style-type: none"> <li>Thorough knowledge of technique</li> <li>Profound anesthesia achieved</li> <li>Monitors patient response throughout anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>Can proceed with treatment without faculty assistance</li> <li>Adequate anesthesia achieved</li> </ul>	<ul style="list-style-type: none"> <li>Elements of anesthesia or pain control absent <u>but</u> patient care NOT compromised</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Incorrect anesthetic technique</li> <li>Inadequate pain control and patient care is compromised</li> <li>Requires faculty assistance</li> </ul>

**FACTOR 5: CARIES REMOVAL, REMOVAL OF FAILING RESTORATIONS, EVALUATION OF RESTORABILITY, SITE ISOLATION**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Complete removal of visible caries</li> <li>Removal of failing restoration</li> <li>Establishes complete structural restorability</li> <li>Achieves complete isolation with rubber dam</li> </ul>	<ul style="list-style-type: none"> <li>No visible caries <u>and</u> failing restorations removed</li> <li>Establishes significant aspects of structural restorability <u>and</u> achieves effective isolation with rubber dam</li> </ul>	<ul style="list-style-type: none"> <li>No visible caries present</li> <li>Establishes likely restorability <u>and</u> achieves adequate isolation with rubber dam</li> </ul>	<ul style="list-style-type: none"> <li>Caries removal compromised that potentially impacts procedure</li> <li>Compromised coronal seal</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Gross visible caries</li> <li>Failing restoration present</li> <li>Nonrestorable excluding medical indications</li> <li>Ineffective isolation</li> </ul>

**FACTOR 6: ACCESS OPENING**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimum outline and access form with no obstructions</li> <li>All canals identified</li> <li>Roof and pulp horns removed</li> </ul>	<ul style="list-style-type: none"> <li>Slight underextension of outline form but walls smooth <u>but</u> all canals identified <u>and</u> roof and pulp horns removed</li> </ul>	<ul style="list-style-type: none"> <li>Moderate under- or overextension of outline form, minor irregularities for wall smoothness <u>but</u> all canals identified <u>and</u> roof and pulp horns removed</li> </ul>	<ul style="list-style-type: none"> <li>Crown integrity compromised by overextension but tooth remains restorable</li> <li>All canals identified <u>but</u> minor roof and pulp horns remain</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Tooth is NOT restorable after access procedure or perforation</li> <li>Structural compromise</li> <li>Canal(s) missed or unidentified</li> </ul>



## FACTOR 7: CANAL PREPARATION TECHNIQUE

4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimum canal length determination and preparation within 0.5-1.0 mm of radiographic apex</li> <li>Maintenance of original canal position and integrity</li> </ul>	<ul style="list-style-type: none"> <li>Adequate canal length determination and preparation within 1.5 mm short of radiographic apex</li> <li>Mild deviations of original canal shape</li> </ul>	<ul style="list-style-type: none"> <li>Acceptable canal length determination and preparation within 2 mm short of working length</li> <li>Moderate deviations of original canal shape</li> </ul>	<ul style="list-style-type: none"> <li>Canal length and preparation shorter than original working length</li> <li>Canal length &gt; 2 mm short or 1 mm long of radiographic apex</li> <li>Severe deviations of original canal shape but treatable</li> <li>Separated instrument that does NOT prevent canal preparation</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Working length determination &gt; 2 mm short or long of radiographic apex</li> <li>Sodium hypochlorite accident</li> <li>Canal perforated or NOT treatable</li> <li>Separated instrument preventing canal preparation</li> </ul>

## FACTOR 8: MASTER CONE FIT

4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimum cone fit and length verified within 0.5-1.0 mm of radiographic apex</li> <li>Maintenance of canal position and integrity as demonstrated in cone fit</li> </ul>	<ul style="list-style-type: none"> <li>Adequate cone fit and length verified within 1.5 mm short of radiographic apex</li> <li>Mild deviations of original canal shape</li> </ul>	<ul style="list-style-type: none"> <li>Acceptable cone fit and length verified within 2 mm short of radiographic apex</li> <li>Moderate deviations of original canal shape</li> <li>Achieves tugback before lateral obturation</li> </ul>	<ul style="list-style-type: none"> <li>Cone length determination &gt; 2 mm short or long from radiographic apex</li> <li>Cone fit &gt; 2 mm short or &gt; 1 mm long of radiographic apex</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Master cone too small or too large and/or cone fit &gt;2 mm short or long of radiographic apex</li> </ul>

### FACTOR 9: OBTURATION TECHNIQUE

4	3	2	1	0
<ul style="list-style-type: none"> <li>Achieves dense fill within 0.5-1.0 mm short of radiographic apex</li> <li>None or minor overextension of sealer</li> <li>No solid core material overextended</li> </ul>	<ul style="list-style-type: none"> <li>Achieves dense fill within the apical two-thirds and less than 1.5 mm short of radiographic apex</li> <li>Less than 1 mm of sealer extruded</li> </ul>	<ul style="list-style-type: none"> <li>Achieves dense fill in apical third without voids</li> <li>Solid core material 1.5- 2.0 mm short or 1 mm long of radiographic apex</li> <li>1-2 mm of sealer extruded</li> </ul>	<ul style="list-style-type: none"> <li>Apical third has slight to moderate voids</li> <li>Solid core material 2-3 mm short or 1-2 mm long</li> <li>More than 2 mm of sealer extruded</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Solid core material greater than 3 mm short or greater than 2 mm long of radiographic apex and/or significant voids throughout fill</li> </ul>

### FACTOR 10: COMPLETION OF CASE

4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimum coronal seal placed prior to permanent restoration</li> <li>Optimum evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes</li> <li>Evidence of comprehensive and inclusive post-operative instructions</li> </ul>	<ul style="list-style-type: none"> <li>Effective coronal seal placed prior to permanent restoration</li> <li>Thorough evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes <u>and</u> evidence of post-operative instructions</li> </ul>	<ul style="list-style-type: none"> <li>Acceptable durable coronal seal placed</li> <li>Acceptable documentation; e.g., radiographs, clinical notes, assessment of outcomes <u>and</u> evidence of post-operative instructions</li> </ul>	<ul style="list-style-type: none"> <li>Acceptable coronal seal placed with limited longevity</li> <li>Evidence of incomplete documentation</li> <li>Evidence of incomplete post-operative instructions</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Poor coronal seal</li> <li>Prognosis likely impacted by iatrogenic treatment factors</li> <li>Improper or no documentation</li> <li>No evidence of post-operative instruction</li> </ul>

## SECTION 13 – PERIODONTICS

### PURPOSE

The competency examination for periodontics is designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a case from treatment planning to patient management.

### MINIMUM CLINICAL EXPERIENCES

The documentation of periodontal clinical experiences shall include 25 cases. A periodontal experience may include, but is not limited to:

- An adult prophylaxis,
- Treatment of periodontal disease such as scaling and root planning,
- Any periodontal surgical procedure, and,
- Assisting on a periodontal surgical procedure when performed by a faculty or an advanced dental education candidate in periodontics

The combined clinical periodontal experience must include a minimum of five (5) quadrants of scaling and root planing procedures.

### OVERVIEW

- Nine (9) scoring factors.
- One (1) case to be scored in three parts:
  - Part A. Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan
  - Part B. Calculus detection, effectiveness of calculus removal
  - Part C. Periodontal re-evaluation
- Ideally, all three parts are to be performed on the same patient.
- In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.

### PATIENT PARAMETERS

- a) Examination, diagnosis and treatment planning
  - Minimum twenty (20) natural teeth with at least 4 molars.

- At least one probing depth of 5 mm or greater must be present on at least four (4) of the teeth, excluding third molars, with at least two of these teeth with clinical attachment loss of 2 mm or greater.
- Full mouth assessment or examination.
- No previous periodontal treatment at this institution, and no nonsurgical or surgical treatment within past 6 months.

b) Calculus detection and periodontal instrumentation (scaling and root planing)

- Minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which must be a molar.
- Third molars can be used but they must be fully erupted.
- At least one probing depth of 5 mm or greater must be present on at least two (2) of the teeth that require scaling and root planing.
- Minimum of six (6) surfaces of clinically demonstrable subgingival calculus must be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus must be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual.  
If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.

c) Re-evaluation

- Candidate must be able to demonstrate a thorough knowledge of the case.
- Candidate must perform at least two (2) quadrants of scaling and root planing on the patient being reevaluated.
- Candidate must perform at least two documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing should have been completed within an interval of 6 weeks or less.
- Minimum twenty (20) natural teeth with at least four (4) molars
- Baseline probing depth of at least 5 mm on at least four (4) of the teeth, excluding third molars.

## SCORING

Scoring points for periodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

## ELEMENTS OF THE PERIODONTICS PORTFOLIO

- a) Documentation the candidate performed a comprehensive periodontal examination. The comprehensive periodontal examination may include, but is not limited to the following:
- (1) Evidence the candidate reviewed the patient's medical and dental history.
  - (2) Evidence the candidate evaluated the patient's radiographs.
  - (3) Evidence the candidate performed extra- and intra-oral examinations of the patient.
  - (4) Evidence the candidate performed comprehensive periodontal data collection.
    - Evidence the candidate evaluated the patient's plaque index, probing depths, bleeding on probing, suppurations, cemento-enamel junction to the gingival margin (CEJ-GM), clinical attachment level tooth mobility and furcations
    - Evidence the candidate performed an occlusal assessment
- b) Documentation the candidate diagnosed and developed a periodontal treatment plan that documents the following:
- (1) The candidate determined the periodontal diagnosis.
  - (2) The candidate formulated an initial periodontal treatment plan that demonstrated the candidate:
    - Determined to treat or refer the patient.
    - Discussed with patient the etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient-specific oral hygiene instructions.
    - Determined non-surgical periodontal therapy.
    - Determined need for re-evaluation.
    - Determined recall interval.
- c) Documentation the candidate performed nonsurgical periodontal therapy that he/she:
- (1) Detected supra- and subgingival calculus
  - (2) Performed periodontal instrumentation:
    - Removed calculus
    - Removed plaque
    - Removed stains
  - (3) Demonstrated that the candidate did not inflict excessive soft tissue trauma
  - (4) Demonstrated that the candidate provided the patient with anesthesia

d) Documentation the candidate performed periodontal re-evaluation

- (1) Evidence the candidate evaluated effectiveness of oral hygiene
- (2) Evidence the candidate assessed periodontal outcomes:
  - Reviewed the medical and dental history
  - Reviewed the patient's radiographs
  - Performed comprehensive periodontal data collections ( e. g. , evaluation of plaque index, probing depths, bleeding on probing, suppurations, cemento-enamel junction to the gingival margin (CEJ-GM), clinical attachment level, furcations, and tooth mobility
- (3) Evidence the candidate discussed with the patient his/her periodontal status as compared to the baseline, patient-specific oral hygiene instructions and modifications of specific risk factors
- (4) Evidence the candidate determined further periodontal needs including need for referral to a periodontist and periodontal surgery.
- (5) Evidence the candidate established a recall interval for periodontal treatment.

## PERIODONTICS SCORING CRITERIA

### FACTOR 1: REVIEW MEDICAL AND DENTAL HISTORY (Part A)

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Demonstrates complete knowledge and understanding of implications to dental care</li> <li>• Provides clear presentation of case</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrates complete understanding of implications to dental care <u>but</u> presentation could be improved</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes significant findings</li> <li>• Misses some information <u>but</u> minimal impact on patient care</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes medical conditions <u>but</u> fails to place in context of dental care</li> <li>• Unaware of medications or required precautions for dental appointment</li> <li>• Lack of information compromises patient care</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Lacks current information</li> <li>• Endangers patient</li> <li>• Does NOT include vital signs</li> <li>• Leaves questions regarding medical or dental history unanswered</li> <li>• Does NOT identify need for medical consult</li> </ul>

### FACTOR 2: RADIOGRAPHIC FINDINGS (Part A)

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Identifies and interprets all radiographic findings</li> </ul>	<ul style="list-style-type: none"> <li>• Identifies and interprets significant radiographic findings</li> </ul>	<ul style="list-style-type: none"> <li>• Interprets radiographic findings with minor deviations that do NOT substantially alter treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Misses significant radiographic findings</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Grossly misinterprets radiographic findings</li> <li>• Fails to identify non-diagnostic radiographs</li> <li>• Presents with outdated radiographs</li> </ul>

**FACTOR 3: COMPREHENSIVE PERIODONTAL DATA COLLECTION (Part A - applies to one quadrant selected by examiner)**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Provides accurate assessment of all parameters in quadrant</li> </ul>	<ul style="list-style-type: none"> <li>Deviations of pocket depth up to 1 mm</li> <li>Correctly identifies all furcations</li> <li>Correctly identifies all tooth mobility</li> <li>Correctly identifies gingival recession</li> <li>Correctly identifies areas with no attached gingiva</li> </ul>	<ul style="list-style-type: none"> <li>Not more than <u>one</u> deviation of 2 mm or more in pocket depth</li> <li>Correctly identifies Class II or III furcations involvement</li> <li>Incorrectly identifies tooth mobility by one step in no more than <u>one</u> tooth</li> <li>Over/underestimates gingival recession by <math>\leq 1</math> mm on any surface</li> <li>Recognizes concept of clinical attachment level and differentiate from probing pocket depth</li> </ul>	<ul style="list-style-type: none"> <li><u>More than one deviation</u> of 2 mm or more in pocket depth</li> <li>Fails to correctly identify Class II or III furcations involvement</li> <li>Fails to identify areas with no attached gingiva</li> <li>Overestimates Class 0 and 1 furcations</li> <li>Over/underestimates tooth mobility by two steps on any tooth</li> <li>Fails to correctly identify Grade 2 or 3 mobility</li> <li>Over/underestimates gingival recession by more than 2 mm on any surface</li> <li>Performs incomplete periodontal examination</li> <li>Fails to recognize concept of clinical attachment level and differentiate from probing pocket depth</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Performs periodontal examination which has no diagnostic value</li> <li>Provides inaccurate assessment of key parameters</li> </ul>



**FACTOR 4: EVALUATE PERIODONTAL ETIOLOGY/RISK FACTORS (Part A)**

4	3	2	1	0
<ul style="list-style-type: none"><li>Identifies all systemic, local etiologic and risk factors</li></ul>	<ul style="list-style-type: none"><li>Misses <u>one</u> risk factor</li></ul>	<ul style="list-style-type: none"><li>Misses <u>two</u> risk factors <u>but</u> treatment is NOT substantially impacted</li></ul>	<ul style="list-style-type: none"><li>Misses risk factors which compromise treatment planning and patient care</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Fails to identify all risk factors</li></ul>

**FACTOR 5: COMPREHENSIVE PERIODONTAL DIAGNOSIS (Part A)**

4	3	2	1	0
<ul style="list-style-type: none"><li>Provides accurate and complete diagnosis based on comprehensive clinical examination and findings</li><li>Demonstrates comprehensive understanding of periodontal diagnosis</li></ul>	<ul style="list-style-type: none"><li>Provides accurate and complete diagnosis based on clinical examination and findings pertinent to the case</li></ul>	<ul style="list-style-type: none"><li>Differentiates between periodontal health, gingivitis and periodontitis</li><li>Makes acceptable diagnosis with minimal deviations from ideal but treatment NOT impacted</li></ul>	<ul style="list-style-type: none"><li>Fails to diagnose periodontitis</li><li>Makes diagnosis with critical deviations from optimal</li><li>Provides a diagnosis which lacks rationale</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Fails to make a diagnosis</li><li>Provides diagnosis which is grossly incorrect</li></ul>

**FACTOR 6: TREATMENT PLAN (Part A)**

4	3	2	1	0
<ul style="list-style-type: none"><li>Provides comprehensive and clinically appropriate treatment plan including clear description of etiology, benefits of treatment, alternatives, and risk factors</li></ul>	<ul style="list-style-type: none"><li>Provides comprehensive and clinically appropriate treatment plan including clinically appropriate alternative treatment plan (if any)</li><li>Provides adequate description of risks and benefits of treatment and alternatives</li></ul>	<ul style="list-style-type: none"><li>Provides clinically appropriate treatment plan but fails to address some factors that are unlikely to affect outcome</li><li>Does NOT provide clear description of risks and benefits of treatment and alternatives</li></ul>	<ul style="list-style-type: none"><li>Provides treatment plan which fails to address relevant factors which are likely to affect outcome</li><li>Provides incomplete periodontal treatment plan that is below the standard of care and adversely affects outcome</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Provides clinically inappropriate treatment plan which could harm the patient</li></ul>

**FACTOR 7: CALCULUS DETECTION (Part B)**

4	3	2	1	0
<ul style="list-style-type: none"><li>Demonstrates complete detection of all subgingival calculus present in quadrant(s)</li></ul>	<ul style="list-style-type: none"><li>Incorrectly identifies absence or presence of <u>one</u> area of clinically demonstrable subgingival calculus</li></ul>	<ul style="list-style-type: none"><li>Incorrectly identifies absence or presence of <u>two</u> areas of clinically demonstrable subgingival calculus</li></ul>	<ul style="list-style-type: none"><li>Misses <u>three</u> areas of clinically demonstrable subgingival calculus</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Misses or incorrectly identifies four or more areas of clinically demonstrable subgingival calculus</li></ul>

**FACTOR 8: EFFECTIVENESS OF CALCULUS REMOVAL (Part B)**

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Demonstrates complete removal of all calculus plaque and stains from tooth surfaces</li> <li>• Does NOT cause any tissue trauma</li> <li>• Does NOT cause any patient discomfort</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrates complete removal of all other deposits except for stains in pits and fissures</li> <li>• Minimizes patient discomfort</li> </ul>	<ul style="list-style-type: none"> <li>• Misses <u>one</u> area of clinically demonstrable subgingival calculus</li> <li>• Demonstrates removal of all other deposits <u>but</u> some remaining minor stains on accessible surfaces</li> <li>• Provides sufficient pain management for treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Misses <u>two</u> areas of clinically demonstrable subgingival calculus</li> <li>• Causes major tissue trauma</li> <li>• Leaves moderate plaque and supragingival calculus</li> <li>• Inadequate pain management</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Misses three areas of clinically demonstrable subgingival calculus</li> <li>• Leaves heavy stain, plaque, supragingival calculus</li> <li>• No pain management</li> </ul>

**FACTOR 9: PERIODONTAL RE-EVALUATION (Part C)**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all clinical changes of periodontal condition and describes the biological basis of changes</li> <li>Evaluates patient's oral hygiene, provides patient-specific oral hygiene instruction, <u>and</u> educates patient on the significance of plaque removal and periodontal disease treatment</li> <li>Evaluates and determines all of the patient's <u>specific</u> periodontal needs with detailed rationale for further periodontal procedures</li> </ul>	<ul style="list-style-type: none"> <li>Identifies all clinical changes of periodontal condition</li> <li>Evaluates and determines specific needs for periodontal care with rationale for further periodontal procedures</li> <li>Accurately assesses all of patient's oral hygiene problems</li> <li>Provides oral hygiene instructions that addresses all of patient's needs</li> <li>Evaluates and determines all of the patient's <u>specific</u> periodontal needs <u>without</u> detailed rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies most clinical changes of periodontal condition but fails to identify minor changes</li> <li>Accurately assesses most of patient's oral hygiene problems</li> <li>Provides oral hygiene instructions that only address most of the patient's needs</li> <li>Evaluates and determines <u>general</u> needs for periodontal care including recall intervals and referral, if indicated</li> </ul>	<ul style="list-style-type: none"> <li>Fails to identify persistent signs and symptoms of periodontal disease</li> <li>Fails to present an oral hygiene plan</li> <li>Makes recommendation for further periodontal treatment that is inappropriate and demonstrates lack of understanding of patient's periodontal needs</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Fails to recognize any clinical change in periodontal condition</li> <li>Did NOT assess patient's oral hygiene care or needs</li> <li>Has NOT evaluated and/or determined patient's periodontal needs</li> <li>Fails to recognize need for referral</li> </ul>

## SECTION 14 – EXAMINER TRAINING AND CALIBRATION

In order to meet the standard required for psychometrically sound examinations, training and calibration procedures must be linked back to the competencies defined by a job analysis and to the evaluation system. All the schools must calibrate their faculty to the same rating criteria. Again, faculty from six Board approved dental schools must be involved in the process to ensure those faculty apply the same standards to candidates' performance. It is very important for the Board to be aware of threats to the validity of the examination that arise from improper training and calibration. If the examiners are improperly trained and calibrated, the examiners would compromise the Portfolio Examination's ability to produce results that warrant valid conclusions about candidates' clinical competence.

### APPLICABLE STANDARDS

- |                     |   |
|---------------------|---|
| <i>Standard 5.1</i> | “Test administrators should follow carefully the standardized procedures for administration and scoring as specified by the test developer, unless the situation or a test taker's disability dictates an exception should be made.” (p. 63)  |
| <i>Standard 5.8</i> | “Test scoring services should document the procedures that were followed to assure accuracy of scoring. The frequency of scoring errors should be monitored and reported to users of the service on reasonable request. Any systematic source of scoring errors should be corrected.” (p. 64) |
| <i>Standard 5.9</i> | “When test scoring involves human judgment, scoring rubrics should specify criteria for scoring. Adherence to established scoring criteria should be monitored and checked regularly. Monitoring procedures should be documented.” (p. 65)  |

### EXAMINER SELECTION CRITERIA

The Board has outlined a process for selection of dental school faculty who wish to serve as a portfolio examiner. Each portfolio examiner is required to undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods:

- a) At the beginning of each school year, each school submits the names, credentials and qualifications of the dental school faculty to be appointed by the Board as Portfolio examiners. Documentation of qualifications must include but

is not limited to, evidence the dental school faculty examiner satisfies the dental school criteria and standards established by his/her school to conduct Portfolio competency examinations. The school faculty examiner must have documented experience in conducting examinations in an objective manner.

- b) In addition to the names, credentials and qualifications, the Board approved school must submit documentation the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements. Changes to the list of school faculty examiners must be reported to the Board. The school must provide the Board an annual updated list of their faculty examiners.
- c) The Board reserves the right to approve or disapprove dental school faculty who wish to serve as Portfolio examiners.

## STANDARDIZED TRAINING PROCESS

Examiners are required to attend standardized, Board approved training "calibration" sessions offered at their schools. Each training course will be presented by designated Portfolio examiners at their respective schools and require the prospective examiners to participate in both didactic and hands-on activities.

Didactic training component. During didactic training, designated Portfolio examiners will present an overview of the examination and its evaluation (grading) system through lecture, review of examiner training manual, slide presentations (Powerpoint), sample documentation, sample cases, etc., prior to participating in the actual rating of candidates.

Hands-on component. Training activities have multiple examples of performance that clearly relate to the specific judgments that examiners are expected to provide during the competency examinations. Hands-on training sessions includes an overview of the rating process, clear examples of rating errors, examples of how to mark the grading forms, a series of several sample cases for examiners to hone their skills, and numerous opportunities for training staff to provide feedback to individual examiners.

Monitoring calibration of examiners. Calibration of examiners will be conducted regularly to maintain common standards as an ongoing process. Examiners are provided feedback about their performance and how their scoring varies from their fellow examiners. Examiners whose error rate exceeds a prespecified percentage error will be re-calibrated. If any examiner is unable to be re-calibrated, the Board would dismiss the examiner from the Portfolio Examination process.

## TYPES OF RATING ERRORS

Rating errors are systematic biases which may affect the examiner's ability to provide a fair and objective evaluation of candidates. Several common rating errors can interfere with the rating process by diminishing the accuracy, effectiveness and fairness of the ratings (Cascio, 1992).

Rating errors can be avoided by systematically applying the established grading criteria that clearly define acceptable and unacceptable performance. Basically, examiners should use their professional judgment in applying the grading criteria for each grading factor and rate the candidates' performance accordingly.

1. **FIRST IMPRESSIONS.** First impressions can have a lasting and troublesome effect on the evaluation process. During the first few minutes of the examination, the examiner may form a favorable or unfavorable impression of the candidate. The end result is that the examiner may distort or ignore various aspects of candidates' performance.
2. **HALO/HORN EFFECT.** Halo or horn effect is a broader example of the type of influence which occurs during first impressions. Halo refers to positive overgeneralization based on a positive aspect of performance. Horn refers negative overgeneralization based on a negative aspect of performance. Thus, if the candidate exhibits good or poor performance for one grading factor, the ratings for all factors are distorted.
3. **STEREOTYPING.** Stereotyping refers to unfair bias towards a candidate without being aware of the bias. There is a tendency to generalize, favorably or unfavorably, across groups and ignore individual differences. Examiners should be aware of individual differences of candidates rather than generalizations about a group of people.
4. **SIMILARITY EFFECTS.** Similarity effects are the tendency of examiners to rate candidates more favorably if because the candidates perform tasks in the same style or use the same process as they do.
5. **CONTRAST EFFECTS.** Contrast effects are the result of evaluating the candidate relative to other candidates rather than applying the established grading criteria.
6. **CENTRAL TENDENCY.** Central tendency is the inclination to "play it safe" and rate candidates in the middle even when candidate performance merits higher or lower ratings.
7. **NEGATIVE AND POSITIVE LENIENCY.** Leniency (level) error is the tendency of an examiner to rate candidates lower or higher on a consistent basis rather than base ratings on the candidate's performance.

8. FRAME OF REFERENCE. Frame of reference error occurs when examiners compare candidate performance to their personal standards of care.
9. RECENCY EFFECT. Recent information is better remembered and receives greater weight in forming a judgment than earlier presented information.

#### CROSS TRAINING OF EXAMINERS

Training sessions will be conducted on an ongoing basis in both northern and southern California, with the expectation that examiners participating in the Portfolio Examination process will have ample opportunities to participate in competency examinations conducted at a school other than their own. It may not be necessary to have examiners from other schools rate each and every candidate; however, periodic participation of examiners from outside schools can strengthen the credibility of the process and ensure objectivity of ratings.



## SECTION 15 – AUDIT PROCESS

This Audit Process is designed to serve multiple purposes. First it will provide information for auditors who will conduct site visits on behalf of the Dental Board of California (Board). The purpose of the site visits is to determine if the participating dental schools are following the procedures established for the evaluation and calibration system set forth by the Board for the Portfolio Examination. Second, it will provide information on which participating dental schools can conduct a self-assessment of its adherence to the Board's examination procedures. Third, it will provide a protocol for collecting documentation that will serve as validity evidence for the examination.

During an audit, in-depth information is obtained about the administrative and psychometric aspects of the Portfolio Examination, much like the accreditation process. An audit team comprised of faculty from the dental schools and persons designated by the Board would verify compliance with accepted professional testing standards, e.g., Standards for Educational and Psychological Testing, as well as verifying that the portfolios have been implemented according to the goals of the portfolio process.

### APPLICABLE STANDARDS

*Standard 3.15*      “When using a standardized testing format to collect structured behavior samples, the domain, test design, test specifications and materials should be documented as for any other test. Such documentation should include a clear definition of the behavior expected of the test takers, the nature of expected responses, and any materials or directions that are necessary to carry out the testing.” (p. 46)

### ROLE OF THE BOARD

The Board has several responsibilities with regard to the audit of the examination:

- Oversight of audit process.
- Establishment of grading standards necessary for public protection.
- Developing audit protocols and criteria for assessing schools' compliance with the evaluation system and calibration process.
- Hands-on training for auditors in the evaluation system.

- Selecting auditors who can maintain the independence between themselves and the Portfolio Examination process.

## ROLE OF AUDIT TEAM

The audit team is responsible for verification of the examination process and examination results, and, collection and evaluation of specific written documentation which respond to a set of standardized audit questions and summarizing the findings in a written report. A site visit can be conducted to verify portfolio documentation and clear up unresolved questions.

The audit team would be comprised of persons who can remain objective and neutral to the interests of the school being audited. The audit team should be knowledgeable of subject matter, psychometric standards, psychometrics and credentialing testing.

The audit team should be prepared to evaluate the information provided in a written report to the Board that documents the strengths and weaknesses of each school's administrative process.

## DOCUMENTATION FOR VALIDITY EVIDENCE

Each candidate will have a portfolio of completed, signed rating (grade) sheets which provide evidence that clinical competency examinations in the six areas of practice have been successfully completed.

In addition to the signed rating (grade) sheets, there is content-specific documentation that must be provided. A list of acceptable documentation is presented on the following page.

It is anticipated that audit team will be presented with a representative sample of documentation from the candidate competency examinations.

Table 9 – Content-specific documentation

<b>ORAL DIAGNOSIS AND TREATMENT PLANNING</b>	<ul style="list-style-type: none"> <li>• Full workup of case</li> </ul>
<b>DIRECT RESTORATION</b>	<ul style="list-style-type: none"> <li>• Restorative diagnosis and treatment plan</li> <li>• Preoperative radiographs, e.g., original lesion in Class II, III, IV</li> <li>• Postoperative radiographs including final fill</li> </ul>
<b>INDIRECT RESTORATION</b>	<ul style="list-style-type: none"> <li>• Restorative diagnosis and treatment plan</li> <li>• Preoperative radiographs</li> <li>• Postoperative radiographs including successfully cemented crown or onlay</li> </ul>
<b>REMOVABLE PROSTHODONTICS</b>	<ul style="list-style-type: none"> <li>• Removable prosthodontic diagnosis and treatment plan</li> <li>• Preoperative radiographs illustrating treatment condition</li> <li>• Preoperative and postoperative intraoral photographs of finished appliance</li> </ul>
<b>PERIODONTICS</b>	<ul style="list-style-type: none"> <li>• Periodontal diagnosis and treatment plan</li> <li>• Charted pocket readings</li> <li>• Preoperative radiographs including subgingival calculus</li> <li>• Postoperative radiographs</li> <li>• Follow-up report</li> </ul>
<b>ENDODONTICS</b>	<ul style="list-style-type: none"> <li>• Endodontic diagnosis and treatment plan</li> <li>• Preoperative radiographs of treatment site</li> <li>• Postoperative radiographs of treatment site</li> </ul>

## SCHEDULE FOR AUDITS

For the first two years, the Board will send audit teams to each of the participating dental schools and conduct an audit of Portfolio competency examinations or until the Board is satisfied that the schools are in compliance with the standardized processes of the Portfolio Examination.

In subsequent years, the Board will conduct audits of the Portfolio competency examinations every two years (biennially).

## AUDIT CHECKLIST

<b>RESOURCES</b>	<ul style="list-style-type: none"> <li>Who is responsible for training Board approved Portfolio examiners?</li> <li>Who is responsible for training dental school staff to assign final scaled scores and prepare final score reports and other required documentation to the Board?</li> <li>What quality control procedures are in place to ensure that the final scaled scores and score reports are accurate?</li> </ul>
<b>NAMES AND QUALIFICATIONS OF EXAMINERS</b>	<ul style="list-style-type: none"> <li>What is the process for identifying faculty to serve as Portfolio examiners?</li> <li>What are the qualifications of Board approved Portfolio examiners?</li> </ul>
<b>TRAINING AND CALIBRATION OF EXAMINERS</b>	<ul style="list-style-type: none"> <li>What procedures are used to train Portfolio examiners?</li> <li>Are scoring benchmarks clearly established during training?</li> <li>What procedures are used to maintain calibration of Portfolio examiners?</li> <li>How are disagreements between examiners handled?</li> </ul>
<b>TEST SECURITY</b>	<ul style="list-style-type: none"> <li>What procedures are in place to permit auditors to view patient information for the purposes of the audit?</li> <li>What procedures are in place to maintain the security of the Portfolio examination materials before, during and after each competency examination?</li> <li>What procedures are in place to maintain security of final scoring procedures and final scores?</li> </ul>
<b>QUALITY OF DOCUMENTATION</b>	<ul style="list-style-type: none"> <li>Is the quality of the documentation consistent with accepted standards of care for each type of competency examination?</li> <li>Are comments routinely available on the grading worksheets to justify an examiner's ratings?</li> </ul>
<b>PERFORMANCE STATISTICS</b>	<ul style="list-style-type: none"> <li>What procedures are in place to produce reliability statistics for Portfolio examiners?</li> <li>What procedures are in place to maintain pass/fail statistics?</li> </ul>
<b>INCIDENT REPORTS</b>	<ul style="list-style-type: none"> <li>What procedures are in place to handle incidents that may arise during the implementation of competency examinations of the Portfolio Examination?</li> </ul>
<b>UNSUCCESSFUL CANDIDATES</b>	<ul style="list-style-type: none"> <li>What procedures are in place for candidates who fail a competency examination and who wish to pursue the Portfolio Examination pathway to initial licensure?</li> </ul>

## AUDIT SITE VISIT REPORT

Following each audit site visit, the Board's audit team will prepare a formal report of its findings. The report is confidential and will be shared only with the

participating school whose Portfolio competency examinations were the focus of the report.

The intent of the audit site visit report is to determine if the participating schools are following the standardized procedures of the Portfolio Examination and provide feedback with regard to implementation of the competency examinations.

The audit site visit report may be structured to include:

- Audit objectives and scope
- Period of time included in the audit
- Audit methods
- Auditors' findings
- Auditor recommendations

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## **APPENDIX A - CONSULTANT BACKGROUND**

## **ROBERTA N. CHINN, PH.D**

### **PSYCHOMETRICIAN**

Dr. Roberta Chinn is a psychometrician at PSI. She has more than 23 years of experience in the measurement field. She received her Bachelor of Science degree from the University of California at Davis in psychology, her Master of Arts degree from the University of the Pacific in experimental psychology, and her Ph.D. in experimental and cognitive psychology from Louisiana State University.

Prior to joining PSI in 2011, Dr. Chinn was the Assistant Director of Psychometric Services at Comira, a general partner at HZ Assessments, a private psychometric consulting firm that she co-founded in 2001, and a senior measurement consultant at the Office of Examination Resources at the California Department of Consumer Affairs for nearly 12 years. During her tenure at Consumer Affairs, she handled sensitive aspects of examination programs for more than 30 boards and was instrumental in the development of standardized practical examinations, applied law and ethics examinations, and standardized oral examinations.

She has developed licensing and certification examinations in Arizona, California, Colorado, District of Columbia, Oregon, and Washington as well as for national credentialing organizations (e.g., Commission on Dietetic Registration of the Academy of Nutrition and Dietetics, Appraisal Qualifications Board, National Council of Architect Registration Boards). She has extensive experience in government settings and has conducted validation studies, developed licensing and certification examinations, and/or established cut scores for over 60 professions including commercial and residential appraisers, court reporters, predoctoral and postdoctoral dentists, dental auxiliaries, specialist dietitians, structural engineers, engineering geologists, environmental site assessors, fiduciaries, hydrogeologists, pest control personnel, clinical psychologists, ship pilots, pharmacists, clinical psychologists, speech-language pathologists and veterinarians. She specializes in the development of multiple-choice, performance and oral examinations and has developed innovative methods to streamline procedures for job (practice) analyses and examination development. Her research on alternative item types for competency assessment was recently published in *Evaluation in the Health Professions* and research on practice analysis was recently published in the *Journal of Enteral and Parental Nutrition*.

She has chaired and presented at the annual meetings of the Council on Licensure, Enforcement and Regulation and the National Council on Measurement in Education and has also co-authored several technical papers and journal articles. She is a member of the American Psychological Association, the American Educational Research Association, the National Council on Measurement in Education, and the Council on Licensure, Enforcement and Regulation.

## **NORMAN R. HERTZ, PH.D.**

### **APPLIED PSYCHOLOGIST**

Dr. Hertz is an Applied Psychologist at Progeny Systems Corporation. He is a licensed psychologist with over 30 years of experience in the measurement field. He received his Bachelor of Arts degree from Baylor University in psychology, his Master of Science degree in psychology and his Ph.D. in industrial-organizational psychology from the University of Memphis.

Prior joining Progeny in 2011, he was the Director of Psychometric Services at Comira, the managing partner of HZ Assessments, a private psychometric consulting firm that he co-founded after his retirement from the California Department of Consumer Affairs in 2001, and the Chief of the Office of Examination Resources at the California Department of Consumer Affairs. He has provided psychometric expertise to national and international organizations and has developed licensing and certification examinations for several western states including Arizona, California, Colorado, District of Columbia, Oregon and Washington. He has extensive experience in private industry and government settings and has conducted validation studies, developed licensing and certification examinations, and established cut scores for more than 60 professions, ranging from the construction trades to medical specialties. He has provided litigation support for numerous examinations including legal document preparers, court reporters, and ship pilots. His service on the psychometric oversight committee for the American Institute of Certified Public Accountants was incorporated into the examination development and scoring processes used in the present day.

During his 15-year tenure at the California Department of Consumer Affairs, he handled the most sensitive aspects of examination programs for more than 30 boards including expert witness testimony for state legislative committees, state regulatory boards, and consultant-auditor for national organizations such as the National Council of State Boards of Nursing, National Council of Architect Registration American Institute of Certified Public Accountants, Boards, National Association of Boards of Pharmacy, National Board of Examiners in Optometry.

He has chaired and presented at the annual meetings of the Council on Licensure, Enforcement and Regulation and the National Council on Measurement in Education and has also co-authored several technical papers and journal articles. He is a member of the American Psychological Association, the Society for Industrial Organizational Psychology, the American Educational Research Association, the National Council on Measurement in Education, and the Council on Licensure, Enforcement and Regulation.



## **Agenda Item 4b**

### **Portfolio Regulations and Handbook Review**



## MEMORANDUM

<b>DATE</b>	May 7, 2013
<b>TO</b>	Dental Board Members
<b>FROM</b>	Dawn Dill, Manager, Licensing and Examination Unit Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 4(b)</b> Update on Portfolio Regulations and Handbook Review

The drafts of the Candidate Handbook and Examiner Training Manuals were finalized on April 8, 2013. Upon completion of the draft handbook, staff developed draft regulations for legal review.

Legal counsel completed the initial review of the regulations and has submitted the draft regulations to staff for clarification and/or correction. Staff will continue to work with legal counsel to finalize the draft regulations for submission to the Board at a future meeting to begin the rulemaking file.

In an effort to go “green”, electronic copies of the handbooks can be found on the Board’s website:

[http://www.dbc.ca.gov/about\\_us/materials/meeting\\_materials.shtml](http://www.dbc.ca.gov/about_us/materials/meeting_materials.shtml)



## **Agenda Item 4b**

### **Examiner Training Manual**

# PORTFOLIO EXAMINATION EXAMINER TRAINING MANUAL 2013



**Final Draft 4/8/13  
Dental Board of  
California**

**2005 Evergreen Street  
Suite 1550  
Sacramento, California 95815  
(916) 263-2300  
[www.dbc.ca.gov](http://www.dbc.ca.gov)**



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# Chapter 1 – Introduction

This Examiner Training Manual is designed to provide information for examiners who will assess candidates' competencies in standardized competency examinations.

The manual includes detailed information about the Portfolio Examination ("Portfolio") and its evaluation system including patient criteria, subject matter areas assessed by the examination and grading criteria. Designated Portfolio examiners from each of the six dental schools are expected to follow the standardized procedures and rating (grading) criteria set forth in this manual.

## Chapter 2 – Background

### ***Premise***

The Portfolio Examination allows candidates to build a portfolio of completed clinical experiences and clinical competency examinations in six subject areas over the normal course of clinical training. Both clinical experiences and clinical competency examinations are performed on patients of record within the normal course of treatment. The primary difference between clinical experiences and clinical competency examinations is that the clinical competency examinations are performed independently without faculty intervention unless patient safety issues are imminent.

The Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a California Board approved dental school. A student may elect to begin the Portfolio Examination process during the clinical training phase of their dental education, with the approval of his/her clinical faculty.

The Portfolio Examination follows a similar structure for candidate evaluation that currently exists within the schools to assess minimum competence. The faculty observes the treatment provided and evaluates candidates according to standardized criteria developed by a consensus of key faculty from all of the dental schools. Each candidate prepares and submits a portfolio of documentation that provides proof of completion of competency evaluations for in six subject matter areas: oral diagnosis and treatment planning, direct restoration (amalgam/composite), indirect restoration (fixed prosthetics), removable prosthodontics, endodontics and periodontics.

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

The Portfolio Examination is an alternative examination that each individual school may elect at any time to implement or decline to implement.

## ***Distinguishing characteristics***

There are 10 distinguishing characteristics of the Portfolio Examination:

- *First*, the Portfolio Examination is considered a performance examination that assesses candidates' skills in commonly encountered clinical situations. Consequently, the Portfolio Examination must meet legal standards (Sections 12944 of the Government Code, Section 139 of the Business and Professions Code) and psychometric standards set for by the Standards for Educational and Psychological Testing.
- *Second*, the Portfolio Examination is a summative assessment of a candidate's competence to practice independently. Therefore, candidates perform clinical procedures without faculty intervention in the competency examinations. If a candidate commits a critical error at any time during a competency examination, the examination is terminated immediately in the interests of patient safety.
- *Third*, it includes components of clinical examinations similar to other clinical examinations, and, is administered in a manner that is similar to other clinical examinations encountered in the candidates' course of study. The multiple clinical examinations allow for an evaluation of the full continuum of competence. No additional resources are required from candidates, schools or the Board.
- *Fourth*, treatments for candidates' clinical experience and competency examinations are rendered on patients of record. This means that candidates' competence is not evaluated in an artificial or contrived situation, but on patients who require dental interventions as a normal course of treatment and their progress can be monitored beyond the scope of the clinical experiences or competency examinations.
- *Fifth*, candidates must complete a minimum number of clinical experiences as required for each of six competency domains.
- *Sixth*, readiness for the Portfolio competency examinations is determined by the clinical faculty at the institution where the candidate is enrolled.
- *Seventh*, each of the schools will designate faculty as Portfolio competency examiners and is responsible for administering a Board approved standardized calibration training course for said examiners. The schools are also responsible for the calibration of Portfolio examiners' performance to ensure consistent implementation of the examination and a standardized examination experience for all candidates.

- *Eighth*, candidates' performance is measured according to the information provided in competency evaluations conducted in the schools by clinical faculty within the predoctoral program of education.
- *Ninth*, it produces documented data for outcomes assessment of results, thereby allowing for verification of validity evidence. The data provides the foundation of periodic audits of each school conducted by the Board to ensure that each school is implementing the Portfolio Examination according to the standardized procedures.
- *Tenth*, there are policies and procedures in place to treat candidates fairly and professionally, with timely and complete communication of examination results.

## ***Summative assessment***

As mentioned earlier, the Portfolio Examination is considered a summative assessment to make an overall judgment about a candidate's fitness to practice independently. This means that candidates perform clinical procedures without faculty intervention unless there are patient safety issues.

## ***Development***

The Portfolio Examination has been developed by psychometric consultants for the Dental Board of California in collaboration with committees of dental faculty knowledgeable in the six subject areas. The Portfolio Examination meets the Standards for Educational and Psychological Testing (1999) set forth by the American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. The Standards are used as a benchmark by the measurement profession as the psychometric standards for validating all examinations, including licensing and certification examinations.

Because the Portfolio Examination is a state licensure examination, it also meet legal standards as explicated in Sections 12944 of the California Government Code and Section 139 of the California Business and Professions Code. Section 12944 relates to establishment of qualifications for licensure that do not adversely affect any class by virtue of race, creed, color, national origin/ancestry, sex, gender, gender identity, gender expression, age, medical condition, genetic information, physical disability, mental disability, or sexual orientation. Section 139 of the California Business and Professions Code states occupational licensure examination programs must be based upon occupational (job/practice) analyses and examination validation studies.

## Chapter 3 – Overview of Portfolio

### ***Summary of requirements***

<b>AGE</b>	<ul style="list-style-type: none"><li>• At least 18 years old</li></ul>
<b>IDENTIFICATION NUMBER</b>	<ul style="list-style-type: none"><li>• School will request a Portfolio Candidate Identification number.</li></ul>
<b>APPLICATION</b>	<ul style="list-style-type: none"><li>• Complete the Board “Application for Law and Ethics Examination.</li><li>• Complete the Board “Application for Determination of Licensure Eligibility (Portfolio)”</li></ul>
<b>REQUIREMENTS</b>	<ul style="list-style-type: none"><li>• Successful completion of all competency examinations specified for the Portfolio Examination</li><li>• Certification of good academic standing by the dean of the dental school attended by the candidate such that the candidate is expected to graduate from said dental school; no pending ethical issues</li><li>• Minimum number of clinical experiences</li><li>• NBDE Passing Results</li><li>• Passing the Dentistry Law and Ethics Examination</li><li>• Certification of Licensure (If licensed in another country)</li><li>• Submission of fingerprints</li></ul>

### ***Certification of good standing***

An application for determination of licensure eligibility (Portfolio) may be submitted prior to graduation, if the application is accompanied by a certification from the school that the applicant is expected to graduate. The Board will not issue a license, until receipt of a certification letter from the dean of the school attended by the applicant, certifying the date the applicant graduated on school letterhead with the school seal.

### ***Submission of Portfolio to the Board***

A candidate must arrange with the school to have his or her completed Portfolio submitted to the Board. The earliest date that a candidate may submit his/her portfolio for review by the Board will be determined by each individual school. The Portfolio will not reviewed by the Board until the “Application for Determination of Licensure Eligibility (Portfolio) has been received along with the required fee.

The Application and completed Portfolio must be submitted within 90 days of graduation.

## ***Issuance of license***

The Board will review the submitted Portfolio materials to determine that it is complete and that the candidate has met the requirements. Once approved, the candidate will be sent an "Application for Issuance of License Number and Registration of Place of Practice". A license will be issued in 7-10 days once the completed application and required fee has been received by the Board.

## ***Demonstrations of clinical experience***

Each candidate must satisfactorily complete at least the minimum number of clinical experiences in the competencies prior to submission of their portfolio to the Board. Clinical experiences identified below have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge and skill level to reliably demonstrate competency. All clinical experiences must be performed on patients under the supervision of dental school faculty and must be included in the portfolio submitted to the Board. Clinical experience may be obtained at the dental school clinic, any extramural dental facility or a mobile dental clinic approved by the Board.

## ***Portfolio competency examinations vs. clinical experiences***

A competency examination is performed without faculty intervention; however, completion of a successful competency examination may be counted as a clinical experience for the purposes of the Portfolio Examination at the discretion of the dental school at which the candidate is enrolled.

## ***Guidelines***

- Candidates perform Portfolio competency examinations independently without faculty intervention.
- Schools have the option of using the same faculty to grade each competency examination.
- Each of the schools will designate faculty as competency examiners and is responsible for administering the Board approved calibration course for said examiners.
- Each competency examination will be graded by two (2) examiners.



- If a candidate fails a Portfolio competency examination three times, the candidate cannot take the same Portfolio competency examination until remediation has been completed.
- Readiness for Portfolio competency examinations may be determined by clinical faculty.

## ***Portfolio examiners***

The Board has outlined a process for selection of dental school faculty who wish to serve as a Portfolio examiner. Each Portfolio examiner will undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods.

- At the beginning of each school year, each school submits the names, credentials and qualifications of the dental school faculty to be appointed by the Board as Portfolio examiners. Documentation of qualifications must include but is not limited to, evidence the dental school faculty examiner satisfies the dental school criteria and standards established by his/her school to conduct Portfolio competency examinations. The school faculty examiner must have documented experience in conducting examinations in an objective manner.
- In addition to the names, credentials and qualifications, the Board approved school must submit documentation the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements. Changes to the list of school faculty examiners must be reported to the Board. The school must provide the Board an annual updated list of their faculty examiners.
- The Board reserves the right to approve or disapprove dental school faculty who wish to serve as Portfolio examiners.

## ***Portfolio examiner calibration***

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

- Calibration of Portfolio examiners shall be conducted at least annually.
- Portfolio examiners will receive hands-on calibration sessions with feedback on their performance.
- Hands-on calibration sessions will include, but are not limited to, an overview of the rating process, examples of rating errors, examples of how to complete the

grading forms, several sample cases in each of the competency domains, and ongoing feedback to individual examiners.

- d) All Portfolio examiners will be trained and calibrated to use the same rating (grading) criteria.
- e) Calibration sessions will be conducted on an ongoing basis, with the expectation that examiners participating in the Portfolio Examination process will have opportunity to participate in Portfolio competency examinations conducted at schools other than their own.

## ***Scoring***

Each Portfolio competency examination will be graded by two (2) independent competency examiners in accordance with the Board's standardized rating (grading) criteria on forms prescribed by the Board. The Portfolio Examination must be signed by the school faculty Portfolio examiner for the prescribed competency.

## ***Patient safety***

If the patient's well being is put into jeopardy at any time during the examination, the examination will be terminated. The candidate fails the examination, regardless of performance on any other part of the examination.

## ***Critical errors***

A critical error is a gross error that is irreversible, may impact patient safety and well being and/or requires faculty intervention. If a candidate commits a critical error, the candidate cannot proceed with the examination.

If the candidate makes a critical error at any point during a Portfolio competency examination, a score of "0" is assigned and the Portfolio competency examination is terminated immediately.

## ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

- For Oral Diagnosis and Treatment Planning, Endodontics, and Periodontics, a rating of "2" (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

- For Direct Restoration and Indirect Restoration, a rating of “3” (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.
- For Removable Prosthodontics, a rating of “3” (rating scale 1, 2, 3, 4, 5) is considered minimum competence level performance.

## ***Scaled scores***

- Ratings for each Portfolio competency examination based on a total of rating points, rather than an average of rating points.
- Total points for each Portfolio competency examination will be converted to scaled scores to place them on a common metric.
- A scaled score of 75 is considered a passing score for each Portfolio competency examination.
- Staff will be designated by each dental school to convert total points for each Portfolio competency examination to scaled scores. This activity will be performed independent of the examiners.

## ***Compensatory model***

Within a given competency examination, a low rating in one area can be compensated by a higher score in another area.

For example, a candidate who achieves a scaled score 76 from one examiner and 74 from another examiner will be credited for a scaled score 150 based on total points.

Likewise, a candidate who achieves a scaled score of 75 from one examiner and 75 from another examiner will be credited with a scaled score 150 based on total points.

## Chapter 4 – Board policies

The following rules are in addition to any other examination rules set forth elsewhere in this guide and are adopted for the uniform conduct of the Portfolio examination.

### ***Radiographs***

Radiographs for Portfolio competency examinations must be of diagnostic quality either digital or conventional.

### ***Infection control***

Candidates are responsible for maintaining all of the standards of infection control while treating patients. This includes the appropriate sterilization and disinfection of the cubicle, instruments and handpieces, as well as, the use of barrier techniques (including glasses, mask, gloves, proper attire, etc.) as required by OSHA and the Dental Practice Act.

### ***Use of local anesthetics***

Local anesthetics must be administered according to school protocol and standards of care. The type and amount of anesthetics must be consistent with the patient's health and other factors.

### ***Use of dental dams***

Dental dams must be used during endodontic treatment and the preparation of amalgam and composite restorations. Finished restorations will be graded without the dental dam in place.

### ***Personal protective equipment***

Candidates must wear masks, gloves and eye protection during this section of the examination.

### ***Patients of record***

Candidates will provide clinical services upon patients of record who fulfill the patient selection criteria for each of the six types of Portfolio competency examinations.

### ***Identification numbers***

Candidates will request from the Board an identification number to be used for all Portfolio competency examinations prior to completing any competency examination.

### ***Patient treatment session time limits***

Candidates shall be allowed 3 hours, 30 minutes for each patient treatment session.

DRAFT


# Chapter 5 – Documentation

## ***Grading worksheets***

Each Portfolio examiner is expected to complete all sections in the rating (grading) worksheet with the following information:

<b>CANDIDATE ID#</b>	This number is the identification number that the Board assigns to each student participating in the Portfolio Examination pathway.
<b>PATIENT CHART#</b>	This number corresponds to the chart number associated with a patient who is receiving treatment at a given dental school clinic.
<b>TOOTH#</b>	This number corresponds to the tooth or teeth numbers associated with the treatment site.
<b>FINAL SCORE</b>	The total number of points for all scoring factors from two (2) examiners.
<b>FACTOR SCORE</b>	Each factor within a competency examination should receive a score, e.g., 1, 2, 3, 4, etc.
<b>COMMENTS</b>	Any noteworthy comments justifying the factor score rating.
<b>DATE</b>	The date that competency examination was administered.
<b>EXAMINER SIGNATURE</b>	The signature of the Portfolio examiners who administered a given factor (subsection) of the Portfolio competency examination.

## Example of a rating (grading) worksheet

Candidate ID #	Factor Scores	Tooth number	Patient Chart #	Final Score
 <b>DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION ORAL DIAGNOSIS/TREATMENT PLANNING COMPETENCY EXAM</b>				
Candidate ID# <b>14532</b>			Patient's Chart #: <b>9085</b>	
<b>Factor 1: Medical issues that impact dental care – Score [ <b>3</b> ]</b>  <p><b>[4]</b> – Identifies and evaluates all medical issues; Explains dental implications of systemic conditions; Identifies and assesses patient's medications.</p> <p><b>[3]</b> – Misses <u>one</u> item that would NOT cause harm.</p> <p><b>[2]</b> – Misses <u>two</u> items that would NOT cause</p> <p><b>[1]</b> – Misses <u>more than two</u> items that would</p> <p><b>[0]</b> – <b>Critical errors</b> –</p> <ul style="list-style-type: none"> <li>Misses medical or medication issues</li> </ul> <p><b>Comments:</b></p> <p>(Comments justifying the rating provided)</p> <p><b>Date:</b> <b>10/12/14</b></p> <p><b>Examiner signature:</b></p> <p><b>Mary Jones, DDS</b></p>		<b>Factor 2: Treatment modifications based on medical conditions – Score [ <b>3</b> ]</b>  <p><b>[4]</b> – Identifies all treatment modifications.</p> <p><b>[3]</b> – Misses one item that would NOT cause harm.</p> <p><b>[2]</b> – Misses <u>two</u> items that would NOT cause harm.</p> <p><b>[1]</b> – Misses <u>more than two</u> items that would NOT cause potential harm.</p> <p><b>[0]</b> – <b>Critical errors-</b></p> <ul style="list-style-type: none"> <li>Misses treatment modifications that</li> </ul> <p><b>Comments:</b></p> <p>(Comments justifying the rating provided)</p> <p><b>Date:</b> <b>10/12/14</b></p> <p><b>Examiner signature:</b></p> <p><b>Mary Jones, DDS</b></p>		

## ***Summary of competency examinations***

The Summary of Competency Examinations is a required document submitted to the Board as proof of completion of the Portfolio Competency Examination. The Summary can be completed after the rating (grading) worksheets have been compiled for a given candidate.



### **DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION SUMMARY OF COMPETENCY EXAMINATIONS**

**Candidate ID# 14532**

<b>Competency Examination</b>	<b>Scaled</b>	<b>Status</b>	<b>Date Completed</b>
<b>Oral Diagnosis and Treatment</b>	<b>152</b>	<b>P</b>	<b>12/12/12</b>
<b>Direct Restoration</b>	<b>150</b>	<b>P</b>	<b>12/13/12</b>
<b>Indirect Restoration</b>	<b>168</b>	<b>P</b>	<b>9/3/12</b>
<b>Removable Prosthodontics</b>	<b>153</b>	<b>P</b>	<b>12/15/12</b>
<b>Endodontics</b>	<b>178</b>	<b>P</b>	<b>10/9/12</b>
<b>Periodontics</b>	<b>150</b>	<b>P</b>	<b>11/20/12</b>

**Highest scaled score is 200**

**I, \_\_\_\_\_, hereby attest that the information provided in the Summary**

**Signature of Dean \_\_\_\_\_**

**Date \_\_\_\_\_**



# Chapter 6 – Oral Diagnosis and Treatment Planning

## ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Oral Diagnosis and Treatment Planning, a rating of “2” (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

## ***ODTP grading worksheet***

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

## ***Overview***

- Fifteen (15) scoring factors.
- Initiation and completion of one (1) multidisciplinary Portfolio competency examination.
- Treatment plan must involve at least three (3) of the following six disciplines:
  - > Periodontics
  - > Endodontics
  - > Operative (direct and indirect restoration)
  - > Fixed and removable prosthodontics
  - > Orthodontics
  - > Oral surgery



**DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION  
ORAL DIAGNOSIS/TREATMENT PLANNING COMPETENCY EXAM**

<b>Candidate ID#</b> _____ <b>Candidate Name:</b> _____	<b>Patient's Chart #:</b> _____
<b><u>Factor 1: Medical issues that impact dental care – Score [   ]</u></b>  [4] – Identifies and evaluates all medical issues; Explains dental implications of systemic conditions; Identifies and assesses patient's medications.  [3] – Misses <u>one</u> item that would NOT cause harm.  [2] – Misses <u>two</u> items that would NOT cause harm.  [1] – Misses <u>more than two</u> items that would NOT cause harm.  [0] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>• Misses medical or medication items that would cause potential harm.</li></ul> <b>Comments:</b>          <b>Date:</b> _____  <b>Examiner signature:</b> _____	<b><u>Factor 2: Treatment modifications based on medical conditions – Score [   ]</u></b>  [4] – Identifies all treatment modifications.  [3] – Misses <u>one</u> item that would NOT cause harm.  [2] – Misses <u>two</u> items that would NOT cause harm.  [1] – Misses <u>more than two</u> items that would NOT cause harm.  [0] – <b>Critical errors-</b> <ul style="list-style-type: none"><li>• Misses treatment modifications that would cause potential harm.</li></ul> <b>Comments:</b>          <b>Date:</b> _____  <b>Examiner signature:</b> _____
<b>ODTP</b>	

<p><b><u>Factor 3: Patient concerns/chief complaint</u> – Score [   ]</b></p> <p><b>[4]</b> – Identifies all patient concerns including chief complaint.</p> <p><b>[3]</b> – Identifies chief complaint <u>but</u> misses <u>one</u> patient concern.</p> <p><b>[2]</b> – Identifies chief complaint <u>but</u> misses <u>two</u> patient concern.</p> <p><b>[1]</b> – Identifies chief complaint <u>but</u> misses <u>more than two</u> patient concerns.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Chief complaint not identified.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b><u>Factor 4: Dental history</u> – Score [   ]</b></p> <p><b>[4]</b> – Identifies all parameters in dental history.</p> <p><b>[3]</b> – Misses <u>one</u> parameter in dental history.</p> <p><b>[2]</b> – Misses <u>two</u> parameters in dental history.</p> <p><b>[1]</b> – Misses <u>more than two</u> parameters in dental history.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Neglects to address dental history.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>
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**ODTP**

<p><b><u>Factor 5: Significant radiographic findings – Score [   ]</u></b></p> <p><b>[4]</b> – Identifies all radiographic findings.</p> <p><b>[3]</b> – Misses <u>one</u> radiographic finding that does NOT substantially alter treatment plan.</p> <p><b>[2]</b> – Misses <u>two</u> radiographic findings that do NOT substantially alter treatment plan.</p> <p><b>[1]</b> – Misses <u>more than two</u> radiographic findings that do NOT substantially alter treatment plan.</p> <p><b>[0] – Critical findings –</b></p> <ul style="list-style-type: none"> <li>• Misses radiographic findings that substantially alter treatment plan.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b><u>Factor 6: Clinical findings – Score [   ]</u></b></p> <p><b>[4]</b> – Identifies all clinical findings.</p> <p><b>[3]</b> – Misses <u>one</u> clinical findings that does NOT substantially alter treatment plan.</p> <p><b>[2]</b> – Misses <u>two</u> clinical findings that do NOT substantially alter treatment plan.</p> <p><b>[1]</b> – Misses <u>more than two</u> clinical findings that do NOT substantially alter treatment plan.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Misses clinical findings that substantially alter treatment plan.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>
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**ODTP**

<p><b>Factor 7: Risk level assessment – Score [   ]</b></p> <p><b>[4]</b> – Risk level (risk factors/indicators and protective factors) identified; Relevance of risk level identified.</p> <p><b>[3]</b> – Risk level and relevance of risk level identified but misses <u>one</u> item. (risk factors/indicators and protective factors)</p> <p><b>[2]</b> – Risk level and relevance of risk level identified but misses <u>two</u> items. (risk factors/indicators and protective factors)</p> <p><b>[1]</b> – Risk level identified but misses <u>more than two</u> items (risk factors/indicators and protective factors); Relevance of risk level NOT identified.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Risk level NOT identified.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 8: Need for additional diagnostic tests/referrals – Score [   ]</b></p> <p><b>[4]</b> – Prescribes/acquires all clinically necessary diagnostic tests and referrals with comprehensive rationale.</p> <p><b>[3]</b> – Identifies need for clinically necessary diagnostic tests and referrals with limited rationale.</p> <p><b>[2]</b> – Identifies need for additional diagnostic tests and referrals without rationale.</p> <p><b>[1]</b> – Identifies need for additional diagnostic tests and referrals without rationale <u>and</u> prescribes non-contributory tests or referrals.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Does NOT identify clinically necessary diagnostic tests or referrals.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>ODTP</b></p>
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<p><b>Factor 9: Findings from mounted diagnostic casts – Score [   ]</b></p> <p><b>[4]</b> – Casts and mounting reflect patient’s oral condition; Identifies all diagnostic findings from casts.</p> <p><b>[3]</b> – Casts and mounting reflects patient’s oral condition; Misses <u>one</u> diagnostic finding that does NOT substantially alter treatment plan.</p> <p><b>[2]</b> – Casts and mounting reflect patient’s oral condition <u>but</u> misses <u>two</u> diagnostic findings that do NOT substantially alter treatment plan.</p> <p><b>[1]</b> – Casts and mounting reflect patient’s oral condition <u>but</u> misses <u>more than two</u> diagnostic findings that do NOT substantially alter treatment plan.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Casts and mounting do NOT reflect patient’s oral condition.</li> <li>• Misses diagnostic cast findings that substantially alter treatment plan.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 10: Comprehensive problem list – Score [   ]</b></p> <p><b>[4]</b> – All problems listed.</p> <p><b>[3]</b> – <u>One</u> problem NOT identified without potential harm to patient.</p> <p><b>[2]</b> – <u>Two</u> problems NOT identified without potential harm to patient.</p> <p><b>[1]</b> – <u>Two or more</u> problems NOT identified without potential harm to patient.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Problems with potential harm to patient NOT identified.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>ODTP</b></p>
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<p><b>Factor 11: Diagnosis and interaction of problems – Score [   ]</b></p> <p><b>[4]</b> – All diseases correctly diagnosed; All interactions identified.</p> <p><b>[3]</b> – <u>One</u> missed diagnosis or interaction without potential harm to patient.</p> <p><b>[2]</b> – <u>Two</u> missed diagnoses or interactions without potential harm to patient.</p> <p><b>[1]</b> – <u>More than two</u> missed diagnoses or interactions without potential harm to patient.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>Missed diagnosis or interaction resulting in potential harm to patient.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 12: Overall treatment approach – Score [   ]</b></p> <p><b>[4]</b> – All treatment options identified within standard of care; Provides rationale which is <u>optimal</u>.</p> <p><b>[3]</b> – All treatment options identified within standard of care; Provides <u>acceptable</u> rationale.</p> <p><b>[2]</b> – All treatment options identified within standard of care <u>and</u> lacks sound rationale for treatment.</p> <p><b>[1]</b> – Incomplete treatment options <u>and</u> lacks sound rationale for treatment.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>Treatment options presented are NOT within standard of care.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>ODTP</b></p>
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<p><b><u>Factor 13: Phasing and sequencing of treatment</u> – Score [   ]</b></p> <p><b>[4]</b> – Treatment optimally phased and sequenced.</p> <p><b>[3]</b> – Treatment phased correctly but <u>one</u> procedure out of sequence with no harm to patient.</p> <p><b>[2]</b> – Treatment phased correctly but <u>two</u> procedures out of sequence with no harm to patient.</p> <p><b>[1]</b> – Treatment NOT phased correctly <u>but</u> no potential harm to patient.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Treatment NOT phased nor sequenced correctly with potential harm to patient.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b><u>Factor 14: Comprehensiveness of treatment plan</u> – Score [   ]</b></p> <p><b>[4]</b> – Treatment plan addresses all problems; All treatment procedures are indicated.</p> <p><b>[3]</b> – <u>One</u> treatment procedure that is NOT indicated but will NOT result in harm to patient <u>but</u> treatment plan address all problems.</p> <p><b>[2]</b> – <u>Two or more</u> treatment procedures that are NOT indicated but reflect problem list; but treatment plan addresses all problems.</p> <p><b>[1]</b> – <u>Two or more</u> treatment procedures that are NOT indicated and do NOT reflect problem list; Treatment plan is incomplete but does not cause harm to patient.</p> <p><b>[0] – Critical errors-</b></p> <ul style="list-style-type: none"> <li>• Treatment plan is incomplete and causes potential harm to patient.</li> <li>• Treatment procedures included that are NOT indicated resulting in harm to patient.</li> <li>• Treatment procedures are missing from treatment plan resulting in harm to patient.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>ODTP</b></p>
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**Factor 15: Treatment record –**  
**Score [    ]**

**[4]** – Summarized all data collected, diagnoses, and comprehensive rationale for treatment options; Documents presentation of risks and benefits of all treatment options.

**[3]** – Summarized all data collected, diagnoses, and treatment options; Documents presentation of risks and benefits of all treatment options and provides limited rationale.

**[2]** – Summarized all data collected, diagnoses and treatment options; Documents presentation of risks and benefits of all treatment options but provides no rationale.

**[1]** – Summarized all data collected, diagnoses and treatment options; And documents presentation of risks and benefits only for preferred option(s).

**[0] – Critical errors –**

- Does NOT summarize all data collected, diagnoses and/or treatment options.
- Does NOT document presentation of risks and benefits of all treatment options.

**Comments:**

**Date:** \_\_\_\_\_

**Examiner signature:**

\_\_\_\_\_

**ODTP**

# Chapter 7 – Direct Restoration

## ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Direct Restoration, a rating of “3” (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.

## ***Direct Restoration grading worksheet***

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

## ***Overview***

- Seven (7) scoring factors.
- Two (2) restorations:
  - > Class II amalgam or composite; maximum one slot preparation, and,
  - > Class II amalgam or composite or Class III or IV composite
- Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.
- Requires a case presentation for which the proposed treatment is appropriate for patient’s medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management. Candidate must be familiar with patient’s medical and dental history.
- Medical conditions must be managed appropriately.



**DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION  
DIRECT RESTORATION COMPETENCY EXAM**

<b>Candidate ID#</b> _____	<b>Patient's Chart #:</b> _____
<b>Candidate Name:</b> _____	<b>Tooth #:</b> _____ <b>Restoration type:</b> _____
<p><b>Factor 1: Case presentation – Score [    ]</b></p> <p><b>[5] – Obtains informed consent; Presents a comprehensive review of medical and dental history; Provides rationale for restorative procedure; Proposes initial design of preparation and restoration; Demonstrates full understanding of the procedure.</b></p> <p><b>[4] – <u>Slight</u> deviation from optimal case presentation.</b></p> <p><b>[3] – <u>Moderate</u> deviation from optimal case presentation.</b></p> <p><b>[2] – <u>Major</u> deviation from optimal case presentation.</b></p> <p><b>[1] – <u>Multiple</u> deviations from optimal case presentation.</b></p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Critical errors in assessing patient’s medical and/or dental history.</li> <li>• Unable to justify treatment.</li> <li>• Proposed treatment would cause harm to patient.</li> <li>• Proposed treatment not indicated.</li> <li>• Misses critical factors in medical and/or dental review that affect treatment of patient’s well being.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	

**DR**



**DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION  
DIRECT RESTORATION COMPETENCY EXAM**

**Factor 2: Outline and extensions –**

**[5] – Optimal outline and extensions such as:**  
Smooth flowing; Does not weaken tooth;  
Includes the lesion; Breaks proximal contact  
as appropriate; Appropriate cavosurface  
angles; Optimal treatment of fissures; No  
damage to adjacent teeth; Optimal extension  
for caries; Decalcification; Appropriate  
extension requests.

**[4] – Slight deviation(s) from optimal minimal  
impact on treatment.**

**[3] – Moderate clinically acceptable  
deviation(s) from optimal minimal impact on  
treatment.**

**[2] – Major deviations from optimal such as;**  
Irregular outline; Outline weakens the tooth;  
Does not include the lesion; Contacts not  
broken where appropriate; Proximal  
extensions excessive; Inappropriate  
cavosurface angle(s); Inappropriate treatment  
of fissures; Adjacent tooth requires major  
recontouring; Inappropriate extension  
requests.

**[1] – Multiple major deviations from optimal  
including:** Irregular outline; Outline weakens  
the tooth; Does not include the lesion;  
Contacts not broken where appropriate;  
Proximal extensions excessive; Inappropriate  
cavosurface angle(s); Inappropriate treatment  
of fissures; Adjacent tooth requires major  
recontouring; Inappropriate extension  
requests.

**Factor 2: Outline and extensions – Continued**  
**Score [    ]**

**[0] – Critical errors –**

- Critical errors in outline and extensions.
- Deviations from optimal that are irreversible and have a significant impact on treatment.
- Damage to adjacent tooth that requires restoration.

**Comments:**

**Date:** \_\_\_\_\_

**Examiner signature:** \_\_\_\_\_

**DR**

<p><b>Factor 3: Internal form – Score [   ]</b></p> <p><b>[5]</b> – Optimal internal form <u>such as</u>: Optimal pulpal and axial depth; Optimal wall relationships; Optimal axio-pulpal line angles; Optimal internal refinement; All previous restorative material removed; Optimal caries removal; Preparation is clean and free of fluids and/or debris; Appropriate liners and bases; Appropriate extension requests.</p> <p><b>[4]</b> – <u>Slight</u> deviation(s) from optimal</p> <p><b>[3]</b> – <u>Moderate</u>, clinically acceptable deviation(s) from optimal.</p> <p><b>[2]</b> – <u>Major</u> deviation from optimal <u>such as</u>: Excessive or inadequate pulpal or axial depth; Inappropriate wall relationships; Inappropriate internal line angles; Rough or uneven internal features; Previous restorative material present; Inappropriate caries removal; Fluids and/or debris present; Inappropriate handling of liners and bases; Inappropriate extension requests.</p> <p><b>[1]</b> – <u>Multiple major</u> deviations from optimal <u>including</u>: Excessive or inadequate pulpal or axial depth; Inappropriate wall relationships; Inappropriate internal line angles; Rough or uneven internal features; Previous restorative material present; Inappropriate caries removal; Fluids and/or debris present; Inappropriate handling of liners and bases; Inappropriate extension requests..</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Critical errors from optimal internal form.</li> <li>• Noncarious pulp exposure.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 4: Operative environment – Score [   ]</b></p> <p><b>[5]</b> – Soft tissue free of unnecessary damage; Proper patient comfort/pain management; Optimal isolation; Correct teeth isolation; Dam fully inverted; Clamp stable with no tissue damage; No leakage; Preparation can be accessed and visualized.</p> <p><b>[4]</b> – <u>Slight</u> deviation(s) from optimal.</p> <p><b>[3]</b> – <u>Moderate</u>, clinically acceptable deviation(s) from optimal.</p> <p><b>[2]</b> – <u>Major</u> deviation from optimal <u>such as</u>: Incorrect teeth isolated; Dam not inverted, causing leakage that may compromise the final restoration; Clamp is not stable or impinges on tissue; Preparation cannot be accessed or visualized to allow proper placement of restoration; Major tissue damage.</p> <p><b>[1]</b> – <u>Multiple</u> deviations from optimal <u>including</u>: Incorrect teeth isolated; Dam not inverted, causing leakage that may compromise the final restoration; Clamp is not stable or impinges on tissue; Preparation cannot be accessed or visualized to allow proper placement of restoration; Major tissue damage.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Critical errors from optimal in operative environment.</li> <li>• Gross soft tissue damage.</li> <li>• Gross lack of concern for patient comfort.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>DR</b></p>
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<p><b>Factor 5: Anatomical form: - Score [   ]</b></p> <p><b>[5]</b> – Optimal anatomic form <u>such as</u>: Harmonious and consistent with adjacent tooth structure; Interproximal contour and shape are proper; Interproximal contact area and position are properly restored; Contact is closed, floss passes through with resistance; Height and shape of marginal ridge is appropriate.</p> <p><b>[4]</b> – <u>Slight</u> deviation(s) from optimal.</p> <p><b>[3]</b> – <u>Moderate</u>, clinically acceptable deviation(s) from optimal.</p> <p><b>[2]</b> – <u>Major</u> deviation from optimal <u>such as</u>: Inconsistent with adjacent tooth structure; Interproximal contour and shape are inappropriate; Height and shape of marginal ridge is inappropriate.</p> <p><b>[1]</b> – <u>Multiple major</u> deviations from optimal <u>including</u>: Inconsistent with adjacent tooth structure; Interproximal contour and shape are inappropriate; Height and shape of marginal ridge is inappropriate.</p> <p><b>[0]</b> – <b>Critical errors</b> –</p> <ul style="list-style-type: none"> <li>• Critical errors that require restoration to be redone.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 6: Margins: - Score [   ]</b></p> <p><b>[5]</b> – Optimal margins with no deficiencies or excesses.</p> <p><b>[4]</b> – <u>Slight</u> deviation(s) from optimal.</p> <p><b>[3]</b> – <u>Moderate</u>, clinically acceptable deviation(s) from optimal.</p> <p><b>[2]</b> – <u>Major</u> deviation from optimal <u>such as</u>: Open margin; Subgingival and/or excess restorative material.</p> <p><b>[1]</b> – <u>Multiple major</u> deviations from optimal.</p> <p><b>[0]</b> – <b>Critical errors</b> –</p> <ul style="list-style-type: none"> <li>• Critical errors that require restoration to be redone.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>DR</b></p>
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**Factor 7: Finish and function: -**

**Score [    ]**

**[5] – Optimal finish and function such as:**  
Smooth with no pits, voids or irregularities in restoration; Occlusion is properly restored with no interferences; No damage to hard or soft tissue.

**[4] – Slight deviation(s) from optimal.**

**[3] – Moderate, clinically acceptable deviation(s) from optimal.**

**[2] – Major deviation from optimal such as:**  
Significant pits, voids or irregularities in the surfaces; Severe hyper-occlusion or hypo-occlusion; Moderate damage to hard or soft tissue.

**[1] – Multiple major deviations from optimal.**

**[0] – Critical errors –**

- Critical errors that require restoration to be redone.
- Procedure is not completed within allotted time.
- Unnecessary, gross damage to hard and soft tissue as related to finishing procedure.

**Comments:**

**Date:** \_\_\_\_\_

**Examiner signature:**

\_\_\_\_\_

**DR**

## Chapter 8 – Indirect Restoration

### ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Indirect Restoration, a rating of “3” (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.

### ***Indirect Restoration grading worksheet***

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

### ***Overview***

- Seven (7) scoring factors.
- One (1) indirect restoration which may be a combination of the following procedures:
  - > Ceramic restoration must be onlay or more extensive
  - > Partial gold restoration must be onlay or more extensive
  - > Metal ceramic restoration (PFM)
  - > Full gold restoration
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management; candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.





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INDIRECT RESTORATION COMPETENCY EXAM**

<b>Candidate ID#</b> _____  <b>Candidate Name:</b> _____ <b>Factor 1: Case presentation – Score [    ]</b>  [5] – Obtains informed consent; Presents a comprehensive medical and dental review; Provides rationale for restorative procedure; Proposes initial design of restoration; Provides method for provisionalization; Demonstrates full understanding of the procedure; Sequencing of treatment follows standards of care.  [4] – <u>Slight</u> deviation from optimal case presentation.  [3] – <u>Moderate</u> deviations from optimal case presentation.  [2] – <u>Major</u> deviation from optimal case presentation; Provides inappropriate justification for treatment; Sequencing of treatment does not follow standards of care.  [1] – <u>Multiple major</u> deviations from optimal case presentation.  [0] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>• Critical errors in assessing patient's medical and/or dental history.</li><li>• Unable to justify treatment.</li><li>• Proposed treatment would cause harm to patient.</li><li>• Proposed treatment not indicated.</li><li>• Misses critical factors in medical and dental review that affect treatment or patient well being.</li></ul> <b>Comments:</b>  <b>Date:</b> _____  <b>Examiner signature:</b> _____	<b>Patient's Chart #:</b> _____ <b>Tooth #:</b> _____/Type of Restoration _____ <b>Final Score:</b> _____ <b>Factor 2: Preparation – Score [    ]</b>  [5] – Meets all accepted criteria for optimal preparation: Occlusal/incisal reduction; Axial reduction; Finish lines; Caries removal; Pulpal protection; Soft tissue management; No damage to soft and hard tissue; Resistance and retention; Debridement.  [4] – <u>Slight</u> deviations from optimal; minimal impact on treatment.  [3] – <u>Moderate</u> , clinically acceptable deviations from optimal; minimal impact on treatment.  [2] – <u>Major</u> deviation from optimal but correctable without significantly changing the procedure.  [1] – <u>Multiple</u> major deviations from optimal preparation.  [0] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>• Critical errors that are irreversible and have a significant impact on treatment.</li><li>• Critical errors that require major modifications of the proposed treatment <u>such as</u>:<ul style="list-style-type: none"><li>❖ Onlay that must change to full crown.</li><li>❖ Overextension requiring crown lengthening.</li></ul></li></ul> <b>Comments:</b>  <b>Date:</b> _____  <b>Examiner signature:</b> _____  <div style="text-align: right;"><b>IR</b></div>
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**Factor 3: Impression – Score [    ]**

**[5] –** Achieves optimal, clinically acceptable impression in one attempt; Impression extends beyond finish line; Detail of preparation and adjacent teeth captured accurately; Free of voids in critical areas; No aspect of impression technique that would result in inaccuracy; Interocclusal record is accurate, if needed.

**[4]** – Achieves clinically acceptable impression in second attempt.

**[3]** – Achieves clinically acceptable impression more than two attempts.

**[2]** – Major deviation that requires retaking impression such as:

- Lack of recognition of unacceptable impression or interocclusal relationship.

**[1] – Multiple** major deviations from optimal in impression including:

- Lack of recognition of unacceptable impression or interocclusal relationship.

## [0] – Critical errors –

- failure to achieve a clinically acceptable impression after five (5) attempts
- Critical errors in impression procedure cause unnecessary tissue damage that require corrective treatment procedures.

**Comments:**

Date: \_\_\_\_\_

**Examiner signature:**

**Factor 4: Provisional – Score [    ]**

**[5] – Meets all acceptable criteria for optimal provisional: Occlusal form and function; Proximal contact; Axial contour; Marginal fit; External surface smooth and polished without pits, voids or debris; Optimal internal adaptation; Retention; Esthetics.**

**[4] – Slight** deviations from optimal with minimal impact on treatment.

**[3] – Moderate** deviations from accepted criteria have minimal impact on treatment.

**[2] – Major deviation from optimal that can be corrected** such as: Lack of recognition of major deviation that can be corrected.

**[1] – Multiple major deviations that have significant impact on treatment including: Lack of recognition of major deviation that can be corrected.**

**[0] - Critical errors –**

- Critical errors that are clinically unacceptable.

**Comments:**

Date: \_\_\_\_\_

**Examiner signature:**

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IR

<p><b>Factor 5: Student evaluation of laboratory work – Score [   ]</b></p> <p><b>[5]</b> – Verifies that restoration meets all accepted criteria; Verifies errors in restoration and proposes changes, if needed.</p> <p><b>[4]</b> – Lack of recognition of <u>slight</u> deviations from accepted criteria and minimal impact on treatment.</p> <p><b>[3]</b> – Lack of recognition of <u>moderate</u> deviations from accepted criteria with minimal impact on treatment.</p> <p><b>[2]</b> – Lack of recognition of a <u>major</u> deviation from optimal that can be corrected.</p> <p><b>[1]</b> – Lack of recognition of <u>multiple</u> major deviations from optimal.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Critical errors that require restoration to be redone.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 6: Pre-cementation – Score [   ]</b></p> <p><b>[5]</b> – Meets all accepted criteria for pre-cementation: Occlusal form and function; Proximal contact; Axial contours; Marginal fit; External surface smooth and polished without pits, voids, or debris; Optimal internal adaptation; Retention; Esthetics; Patient acceptance.</p> <p><b>[4]</b> – Lack of recognition of <u>slight</u> deviations from accepted criteria and minimal impact on treatment.</p> <p><b>[3]</b> – Lack of recognition of <u>moderate</u> deviations from accepted criteria with minimal impact on treatment.</p> <p><b>[2]</b> – Lack of recognition of major deviation that can be corrected.</p> <p><b>[1]</b> – Lack of recognition of <u>multiple</u> major deviations from optimal.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Lack of recognition of critical errors which <u>cannot</u> be corrected.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>IR</b></p>
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**Factor 7: Cementation and finish –  
Score [    ]**

**[5]** – Meets all accepted criteria for optimal cementation: Occlusal form and function; Proximal contact; Axial contours; Marginal fit; External surfaces smooth and polished without pits, voids, or debris; Optimal internal adaptation; Retention; Esthetics; All excess cement removed; No unnecessary tissue trauma; Appropriate postoperative instructions.

**[4]** – Slight deviations from optimal; minimal impact on treatment.

**[3]** – Moderate deviations from accepted criteria; minimal impact on treatment.

**[2]** – Major deviation from accepted that can be corrected.

**[1]** – Multiple major deviations from optimal.

**[0] – Critical errors –**

- Critical errors which require restoration to be redone.
- Procedure is not completed within allotted time.
- Unnecessary, gross damage to hard and soft tissue as related to finishing.

**Comments:**

**Date:** \_\_\_\_\_

**Examiner signature:**

\_\_\_\_\_

**IR**

# Chapter 9 – Removable Prosthodontics

## ***Minimum competence level of performance***

- The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.
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- For Removable Prosthodontics, a rating of “3” (rating scale 1, 2, 3, 4, 5) is considered minimum competence level performance.

## ***Removable Prosthodontics grading worksheet***

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

## ***Overview***

- Twelve (12) scoring factors.
- One (1) of the following prosthetic treatments from start to finish on the same patient
  - > Denture or overdenture for a single edentulous arch, or,
  - > Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch
- An immediate or interim denture.
- No patient sharing; cannot split patients between candidates.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.
- Case complexity is not a criteria.



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REMOVABLE PROSTHODONTICS COMPETENCY EXAM**

<b>Candidate ID#</b> _____	<b>Patient's Chart #:</b> _____ <b>Final Score:</b> _____
<b>Candidate Name:</b> _____	<b>Type of prosthesis:</b> _____
<b>Factor 1: Patient evaluation and diagnosis – Score [   ]</b> [5] – Evaluation and diagnosis is comprehensive and discriminating; Recognizes significant diagnostic implications of all findings.  [4] – Recognizes significant diagnostic implications but misses some findings that do NOT affect diagnosis.  [3] – Recognized significant findings <u>but</u> there are errors in findings or judgment that do NOT compromise diagnosis.  [2] – Does NOT recognize significant findings or diagnostic implications; Diagnosis is jeopardized.  [1] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>• Gross errors in evaluation or judgment.</li><li>• Gross errors in diagnosis.</li></ul>	<b>Factor 2: Treatment plan and sequencing – Score [   ]</b> [5] – Presents/formulates all treatment options and understands clinical nuances of each option; Presents comprehensive treatment plan based on clinical evidence, patient history and direct examination; Performs risk-based analysis to present appropriate treatment options and prognosis; Demonstrates critical thinking as evidenced in steps in treatment plan; No errors in planning and sequencing.  [4] – Presents/formulates most treatment options and understands rationale of each option; Treatment plan is appropriate some contributing factors NOT considered; <u>Minor</u> errors that do NOT affect planning and sequencing.  [3] – Presents/formulates appropriate treatment options with less than ideal understanding of chief complaint, diagnosis, and prognosis; <u>Moderate</u> errors that do NOT compromise planning and sequencing.  [2] – Does NOT address patient's chief complaint; Treatment plan NOT based on diagnosis; <u>Major</u> errors in evidence based, critical thinking, risk-based, and prognostic assessment; Treatment sequence inappropriate.  [1] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>• Treatment plan NOT based on diagnostic findings or prognostic information.</li><li>• Treatment plan grossly inadequate.</li><li>• Treatment sequence grossly inappropriate.</li></ul>
<b>Comments:</b>  <b>Date:</b> _____  <b>Examiner signature:</b> _____	<b>Comments:</b>  <b>Date:</b> _____  <b>Examiner signature:</b> _____

**RP**

<p><b>Factor 3: Preliminary impressions –</b> <b>Score [    ]</b></p> <p><b>[5]</b> – Perform and recognize adequate capture of anatomy; Free of distortions and voids.</p> <p><b>[4]</b> – Performs impression with <u>minor</u> errors that do NOT affect final outcome.</p> <p><b>[3]</b> – Performs impression with <u>moderate</u> errors that do NOT compromise final outcome.</p> <p><b>[2]</b> – Performs impression with <u>major</u> errors; or fails to recognize that final outcome is compromised.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Inadequate capture of anatomy or Gross distortion/voids.</li> <li>• Fails to recognize that subsequent steps are impossible.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 4: RPD design (if applicable) –</b> <b>Score [    ]</b></p> <p><b>[5]</b> – Design demonstrates understanding of biomechanical and esthetic principles; Casts are surveyed accurately; Design is drawn with detail.</p> <p><b>[4]</b> – Design demonstrates understanding of biomechanical and esthetic principles with <u>minor</u> errors; Minor errors in cast survey and design.</p> <p><b>[3]</b> – Design is functional but includes rests, clasp assembly or major connector that is NOT first choice; <u>Moderate</u> errors in survey and design; Moderate errors in understanding of RPD design principles.</p> <p><b>[2]</b> – Demonstrates lack of understanding of biomechanical or esthetic principles; <u>Major</u> errors in cast survey and design.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Design is grossly inappropriate.</li> <li>• Inaccurate survey.</li> <li>• Illegible drawing.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>RP</b></p>
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<p><b><u>Factor 5: Tooth modification (if applicable)</u></b>  <b>– Score [   ]</b></p> <p><b>[5]</b> – Parallel guiding planes; Optimal size and location of rest preparations; Conservative recontouring of abutment teeth for optimal location of clasp and to optimize occlusal plane; Survey crowns as needed.</p> <p><b>[4]</b> – <u>Minor</u> deficiencies in tooth modification; RPD fit and service unaffected.</p> <p><b>[3]</b> – <u>Moderate</u> deficiencies in tooth modifications; But NO compromise in RPD fit and service.</p> <p><b>[2]</b> – <u>Major</u> errors in tooth modifications leading to compromised RPD fit and service; Tooth modifications may require restorations.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• RPD abutment teeth are grossly over-prepared.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b>  _____</p>	<p><b><u>Factor 6: Border molding and final impression</u></b> – Score [   ]</p> <p><b>[5]</b> – Obtain optimal vestibular extension and peripheral seal; Perform and recognize adequate capture of anatomy; Impression free of distortions/voids.</p> <p><b>[4]</b> – Border molding and/or impression have <u>minor</u> errors that do NOT affect final outcome.</p> <p><b>[3]</b> – Border molding and/or impression have <u>moderate</u> deviations that do NOT compromise final outcome.</p> <p><b>[2]</b> – Border molding and/or impression have <u>major</u> errors that affect final outcome.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Border molding and/or impression do NOT adequately capture of anatomy.</li> <li>• Gross distortion/voids so that final outcome is impossible.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b>  _____</p> <p style="text-align: right;"><b>RP</b></p>
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<p><b>Factor 7: Framework try-in (if applicable) – Score [   ]</b></p> <p><b>[5]</b> – Perform and recognize functional and occlusal adjustments; Complete seating of framework is achieved; Determine sequence for establishing denture-base support.</p> <p><b>[4]</b> – <u>Minor</u> deficiencies in ability to recognize and correct minor discrepancies in framework fit; but do NOT affect RPD service.</p> <p><b>[3]</b> – <u>Moderate</u> deficiencies in ability to recognize or correct discrepancies in framework fit; but no significant compromise to RPD service.</p> <p><b>[2]</b> – <u>Major</u> errors in framework fit NOT recognized; Errors in judgment regarding sequence of correction.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• <u>Gross</u> errors in framework fit NOT recognized.</li> <li>• Unable to determine sequence of correction.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 8: Jaw relation records – Score [   ]</b></p> <p><b>[5]</b> – Smooth record bases with appropriate peripheral extensions/thickness; Smoothly contoured wax rim establishes esthetic parameters; Vertical dimension is physiologically appropriate; Accurately captures centric relation; Relates opposing casts without interference.</p> <p><b>[4]</b> – <u>Minor</u> deficiencies in jaw relation records that do NOT adversely affect prosthetic service.</p> <p><b>[3]</b> – <u>Moderate</u> discrepancies in jaw relation records that do NOT compromise prosthetic service; Records do NOT require repeating.</p> <p><b>[2]</b> – <u>Major</u> errors in jaw relation records that adversely affect prosthetic service; Records should be redone.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• <u>Gross</u> error in jaw relations records with poor understanding and judgment.</li> <li>• Records should be redone.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p> <p style="text-align: right;"><b>RP</b></p>
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<p><b>Factor 9: Trial dentures – Score [   ]</b></p> <p><b>[5] – Recognized optimal <u>esthetics</u></b> (midline, incisal length, tooth mold and shade, arrangement); <u>Occlusal</u> (MIP=CR, VDO &lt; VDR, bilateral posterior contact); <u>Speech and contour</u> aspects of trial denture; Deviations from the optimal are corrected or managed appropriately.</p> <p><b>[4] – <u>Minor</u> deficiencies in ability to recognize and correct discrepancies in</b> esthetics; Vertical dimension; Occlusion; Phonetics; and contour.</p> <p><b>[3] – <u>Moderate</u> deficiencies in ability to recognize or correct discrepancies in</b> esthetics; Vertical dimension; Occlusion; and phonetics which do NOT compromise final outcome.</p> <p><b>[2] – <u>Major</u> errors in ability to recognize or correct discrepancies in</b> esthetics; Vertical dimension; Occlusion and phonetics which adversely affect final outcome.</p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Demonstrates inability to recognize or correct gross errors which will result in failure of final outcome.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p>	<p><b>Factor 10: Insertion of removable prosthesis – Score [   ]</b></p> <p><b>[5] – Optimize definitive prosthesis, recognizing errors and correcting if necessary, including the following:</b></p> <ul style="list-style-type: none"> <li>• Tissue fit.</li> <li>• Prosthetic support, stability and retention.</li> <li>• RPD extension base tissue support.</li> <li>• Vestibular extension and bulk.</li> <li>• Occlusion; clinical remount required.</li> <li>• Phonetics.</li> <li>• Contours and polish.</li> <li>• Patient home care instructions.</li> </ul> <p><b>[4] – <u>Minor</u> discrepancies in judgment and/or performance of optimizing prosthesis fit and function; No adverse effect on prosthesis service.</b></p> <p><b>[3] – <u>Moderate</u> discrepancies in judgment and performance of optimizing prosthesis fit/function; No compromise on prosthesis service.</b></p> <p><b>[2] – <u>Major</u> errors in judgment and performance of optimizing prosthesis fit/function; prosthesis service adversely affected; May require significant correction or prosthesis.</b></p> <p><b>[1] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Gross errors in judgment and performance results in failure of prosthesis with no possibility to correct; Prosthesis must be redone.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p> <p style="text-align: right;"><b>RP</b></p>
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<p><b>Factor 11: Post insertion (1 week) –</b> <b>Score [   ]</b></p> <p><b>[5]</b> –Perform an appropriate recall sequence to evaluate and diagnose prosthesis problem and make adjustments until patient is satisfied with fit, form and function of new prosthesis; Enroll patient in maintenance program; Demonstrate familiarity with common prosthesis complications and solutions.</p> <p><b>[4]</b> – <u>Minor</u> discrepancies in ability to evaluate and solve prosthesis problems; no affect on patient comfort and function.</p> <p><b>[3]</b> – <u>Moderate</u> discrepancies in ability to evaluate and solve prosthesis problems that do NOT compromise patient comfort and function.</p> <p><b>[2]</b> – <u>Major</u> errors in ability to evaluate and solve prosthesis problems that adversely affect patient comfort and function.</p> <p><b>[1]</b> – Gross errors in ability to evaluate and solve prosthesis problems; patient confidence is compromised</p> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p>	<p><b>Factor 12: Laboratory services –</b> <b>Score [   ]</b></p> <p><b>[5]</b> – Prescription clearly communicates desired laboratory work and materials; Complies with infection control protocols between clinic and laboratory environments; Accurately evaluates laboratory work products.</p> <p><b>[4]</b> – Prescription, or management of laboratory services has <u>minor</u> errors that do NOT adversely affect prosthesis.</p> <p><b>[3]</b> – Prescription, or management of laboratory services has <u>moderate</u> discrepancies that do NOT compromise prosthesis.</p> <p><b>[2]</b> – Prescription, or management of laboratory services, has <u>major</u> errors that adversely affect prosthesis.</p> <p><b>[1]</b> –Prescription, or management of laboratory services has <u>gross</u> errors that result in prosthesis failure.</p> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p> <p style="text-align: right;"><b>RP</b></p>
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# Chapter 10 – Endodontics

## ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales. For Endodontics, a rating of “2” (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

## ***Endodontics grading worksheet***

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

## ***Overview***

- Ten (10) scoring factors.
- One (1) clinical case.
- Requires patient management; therefore, candidate must be familiar with the patient’s medical and dental history.
- Medical conditions must be managed appropriately.



**DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION  
ENDODONTICS COMPETENCY EXAM**

<b>Candidate ID#</b> _____  <b>Candidate Name:</b> _____ <b><u>Factor 1: Pretreatment clinical testing and radiographic imaging – Score [   ]</u></b>  [4] - Clinical tests and radiographic imaging completed and recorded accurately; radiographic images are of diagnostic quality.  [3] – Clinical tests and radiographic imaging completed and recorded accurately with minor discrepancies.  [2] – Some clinical tests and radiographic images are lacking <u>but</u> diagnosis can be determined.  [1] – Some clinical tests and radiographic images are lacking <u>and</u> diagnosis is questionable.  [0] – <b>Critical errors</b> - <ul style="list-style-type: none"><li>• Clinical tests and radiographic images are lacking and diagnosis CANNOT be determined.</li><li>• Radiographic images are missing or are NOT of diagnostic quality</li></ul> <b>Comments:</b>    <b>Date:</b> _____  <b>Examiner signature:</b> _____	<b>Patient's Chart #:</b> _____ <b>Tooth #:</b> _____ <b>Final Score:</b> _____ <b><u>Factor 2: Endodontic diagnosis – Score [   ]</u></b>  [4] – Establishes correct pulpal and periapical diagnosis with accurate interpretation of clinical tests and radiographic images.  [3] – Establishes correct pulpal and periapical diagnosis with accurate interpretation, <u>but</u> missing <u>one</u> clinical test and/or radiographic image.  [2] – Establishes correct pulpal and periapical diagnosis with adequate interpretation, <u>but</u> missing <u>multiple</u> clinical tests and/or radiographic images that do NOT impact diagnosis.  [1] - Establishes inaccurate pulpal or periapical diagnosis, <u>and</u> missing <u>multiple</u> clinical tests and radiographic images that impact diagnosis.  [0] – <b>Critical errors</b> – <ul style="list-style-type: none"><li>• Demonstrates lack of understanding of endodontic diagnosis.</li><li>• No clinical tests were done.</li></ul> <b>Comments:</b>    <b>Date:</b> _____  <b>Examiner signature:</b> _____
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**E**

<p><b>Factor 3: Endodontic treatment plan –</b> <b>Score [   ]</b></p> <p><b>[4]</b> – Prognosis of treatment outcomes determined; Comprehensive evaluation of medical and dental history; Selects appropriate treatments based on clinical evidence; Understands complexities of the case such that all treatment risks identified; Informed consent obtained including alternative treatments.</p> <p><b>[3]</b> – Prognosis of treatment outcomes determined <u>and</u> adequate evaluation of medical and dental history; Selects appropriate treatment(s); Significant treatment risks identified; Informed consent obtained.</p> <p><b>[2]</b> – Prognosis of treatment outcomes determined <u>and</u> minimal evaluation of <u>one</u> of the following:</p> <ul style="list-style-type: none"> <li>• Medical or dental history</li> <li>• Appropriate treatment(s) selected</li> <li>• Most treatment risks identified</li> <li>• Informed consent obtained</li> </ul> <p><b>[1]</b> – Prognosis of treatment outcomes unclear; Inadequate evaluation of medical and dental history despite appropriate treatment selected; Key treatment risks NOT identified.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Demonstrates lack of evaluation of relevant medical and dental history.</li> <li>• Inappropriate treatment planning.</li> <li>• No treatment risks identified.</li> <li>• No informed consent obtained.</li> <li>• Demonstrates inappropriate case selection.</li> <li>• Prognosis of treatment outcomes NOT determined.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p>	<p><b>Factor 4: Anesthesia and pain control –</b> <b>Score [   ]</b></p> <p><b>[4]</b> – Thorough knowledge of technique and materials used; Monitors vital signs and patient response throughout anesthesia; Anesthesia administration effective.</p> <p><b>[3]</b> – Thorough knowledge of technique; Profound anesthesia achieved; Monitors patient response throughout anesthesia.</p> <p><b>[2]</b> – Can proceed with treatment without faculty assistance; Adequate anesthesia achieved.</p> <p><b>[1]</b> – Elements of anesthesia or pain control absent <u>but</u> patient care NOT compromised.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Incorrect anesthetic technique.</li> <li>• Inadequate pain control and patient care compromised.</li> <li>• Required faculty assistance.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p> <p style="text-align: right;"><b>E</b></p>
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<p><b>Factor 5: Caries removal, removal of failing restorations, evaluation of restorability and site isolation – Score [   ]</b></p> <p><b>[4]</b> – Compete removal of visible caries; Removal of failing restoration; Establishes complete structural restorability; Achieves complete isolation with dental dam.</p> <p><b>[3]</b> – No visible caries <u>and</u> failing restorations removed; Establishes significant aspects of structural restorability and achieves effective isolation with dental dam.</p> <p><b>[2]</b> – No visible caries present; Establishes likely restorability and achieves adequate isolation with dental dam.</p> <p><b>[1]</b> – Caries removal compromised that potentially impacts procedure; Compromised coronal seal.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Gross visible caries</li> <li>• Failing restoration present</li> <li>• Non-restorable excluding medical indications</li> <li>• Ineffective isolation</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p>	<p><b>Factor 6: Access opening – Score [   ]</b></p> <p><b>[4]</b> – Optimum outline and access form with no obstructions; All canals identified; Roof and pulp horns removed.</p> <p><b>[3]</b> – Slight under-extension of outline form <u>but</u> walls smooth <u>but</u> all canals identified <u>and</u> roof and pulp horns removed.</p> <p><b>[2]</b> – Moderate under- or over-extension of outline form; Minor irregularities for wall smoothness <u>but</u> all canals identified <u>and</u> roof and pulp horns removed.</p> <p><b>[1]</b> – Crown integrity compromised by over-extension but tooth remains restorable; All canals identified <u>but</u> minor roof and pulp horns remain.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Tooth is NOT restorable after access procedure or perforation.</li> <li>• Structural compromise.</li> <li>• Canal(s) missed or unidentified.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b> _____</p>
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**E**

<p><b>Factor 7: Canal preparation technique – Score [   ]</b></p> <p><b>[4]</b> – Optimum canal length determination and preparation within 0.5-1.0 mm of radiographic apex; Maintenance of original canal position and integrity.</p> <p><b>[3]</b> – Adequate canal length determination and preparation within 1.5 mm short of radiographic apex; Mild deviations of original canal shape.</p> <p><b>[2]</b> – Acceptable canal length determination and preparation within 2.0 mm short of working length; Moderate deviations of original canal shape.</p> <p><b>[1]</b> – Canal length and preparation shorter than original working length; Canal length &gt;2.0 mm short or 1.0 mm long of radiographic apex; Severe deviations of original canal shape but treatable; Separated instrument that does NOT prevent canal preparation.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Working length determination &gt;2.0 mm short or long of radiographic apex.</li> <li>• Sodium hypochlorite accident.</li> <li>• Canal perforated or NOT treatable.</li> <li>• Separated instrument preventing canal preparation.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 8: Master cone fit – Score [   ]</b></p> <p><b>[4]</b> – Optimum cone fit and length verification within 0.5-1.0 mm of radiographic apex; Maintenance of canal position and integrity as demonstrated in cone fit.</p> <p><b>[3]</b> – Adequate cone fit and length verified within 1.5 mm short of radiographic apex; Mild deviations of original canal shape.</p> <p><b>[2]</b> – Acceptable cone fit and length verified within 2.0 mm short of radiographic apex; Moderate deviations of original canal shape; Achieves tugback before lateral obturation.</p> <p><b>[1]</b> – Cone length determination &gt;2.0 mm short or long from radiographic apex; Cone fit &gt;2.0 mm short or &gt;1.0 mm long of radiographic apex.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Master cone too small.</li> <li>• Master cone too large.</li> <li>• Master cone fit &gt;2.0 mm short or long of radiographic apex.</li> </ul> <p><b>Comments:</b></p>  <p><b>Date :</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>
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**E**



Factor 9: Obturation technique – Score [   ]	Factor 10: Completion of case – Score [   ]
<p><b>[4]</b> – Achieves dense fill within 0.5 - 1.0 mm short of radiographic apex; None or minor over-extension of sealer; No solid core material over-extended.</p> <p><b>[3]</b> – Achieves dense fill within the apical two-thirds and less than 1.5 mm short of radiographic apex; Less than 1.0 mm of sealer extruded.</p> <p><b>[2]</b> – Achieves dense fill in apical third without voids; Solid core material 1.5 - 2.0 mm short or 1.0 mm long of radiographic apex; 1.0 - 2.0 mm of sealer extruded.</p> <p><b>[1]</b> – Apical third has slight to moderate voids; Solid core material 2.0 - 3.0 mm short or 1.0 - 2.0 mm long; More than 2.0 mm of sealer extruded.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Solid core material greater than 3 mm short or greater than 2 mm long of radiographic apex. and/or</li> <li>• Significant voids throughout fill.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>[4]</b> – Optimum coronal seal placed prior to permanent restoration; Optimum evidence of documentation (e.g., radiographs, clinical notes, assessment of outcomes); Evidence of comprehensive and inclusive post-operative instructions.</p> <p><b>[3]</b> – Effective coronal seal placed prior to permanent restoration; Thorough evidence of documentation (e.g., radiographs, clinical notes, assessment of outcomes) <u>and</u> evidence of post-operative instructions.</p> <p><b>[2]</b> – Acceptable durable coronal seal placed; Acceptable documentation (e.g., radiographs, clinical notes, assessment of outcomes) <u>and</u> evidence of post-operative instructions.</p> <p><b>[1]</b> – Acceptable coronal seal placed with limited longevity; Evidence of incomplete documentation; Evidence of incomplete post-operative instructions.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Poor coronal seal.</li> <li>• Prognosis likely impacted by iatrogenic treatment factors.</li> <li>• Improper or no documentation.</li> <li>• No evidence of post-operative instructions.</li> </ul> <p><b>Comments:</b></p> <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>

**E**

# Chapter 11 – Periodontics

## ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

For Periodontics, a rating of “2” (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.

## ***Periodontics grading worksheet***

The grading worksheets on the following pages contain the grading criteria for the examiners to make ratings of the candidate for a Portfolio competency examination.

## ***Overview***

- Nine (9) scoring factors.
- One (1) case to be scored in three parts:
  - Part A. Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan
  - Part B. Calculus detection, effectiveness of calculus removal
  - Part C. Periodontal re-evaluation
- Ideally, all three parts are to be performed on the same patient.
- In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.



**DENTAL BOARD OF CALIFORNIA PORTFOLIO EXAMINATION  
PERIODONTICS COMPETENCY EXAM**

<b>Candidate ID#</b> _____ <b>Candidate Name:</b> _____	<b>Patient's Chart #:</b> _____ <b>Final Score:</b> _____
<b><u>Factor 1: Review of medical and dental history (Part A) – Score [   ]</u></b>  [4] – Demonstrates complete knowledge and understanding of implications to dental care; Provides clear presentation of case.  [3] – Demonstrates complete understanding of implications to dental care <u>but</u> presentation could be improved.  [2] – Recognized significant findings: Misses some information but minimal impact on patient care.  [1] – Recognized medical conditions <u>but</u> fails to place in context of dental care; Unaware of medications or required precautions for dental appointment; Lack of information compromises patient care.  [0] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>Lacks current information.</li><li>Endangers patient.</li><li>Does NOT include vital signs.</li><li>Leaves questions regarding medical or dental history unanswered.</li><li>Does NOT identify need for medical consult.</li></ul> <b>Comments:</b>     <b>Date:</b> _____  <b>Examiner signature:</b> _____	<b><u>Factor 2: Radiographic findings (Part A) – Score [   ]</u></b>  [4] – Identifies and interprets all radiographic findings.  [3] – Identifies and interprets significant radiographic findings.  [2] – Interprets radiographic findings with minor deviations that do NOT substantially alter treatment.  [1] – Misses significant radiographic findings.  [0] – <b>Critical errors –</b> <ul style="list-style-type: none"><li>Grossly misinterprets radiographic findings.</li><li>Fails to identify non-diagnostic radiographs.</li><li>Presents with outdated radiographs.</li></ul> <b>Comments:</b>     <b>Date:</b> _____  <b>Examiner signature:</b> _____

**P**

**Factor 3: Comprehensive periodontal data collection (Part A – Applies to one quadrant selected by examiner) – Score [   ]**

**Quadrant:** \_\_\_\_\_

**[4]** – Provides accurate assessment of all parameters in quadrant.

**[3]** – Deviations of pocket depth up to 1 mm; Correctly identifies all furcations; Correctly identifies all tooth mobility; Correctly identifies gingival recession; Correctly identifies area with no attached gingiva.

**[2]** – Not more than one deviation of 2 mm or more in pocket depth; Correctly identifies Class II or III furcation involvements; Incorrectly identifies tooth mobility by one step in no more than one tooth; Over/under-estimates gingival recession by ≤ 1 mm on any surface; Recognizes concept of clinical attachment level and differentiate from probing pocket depth.

**[1]** – More than one deviation of 2 mm or more in pocket depth; Fails to correctly identify Class II or III furcation involvement; Fails to identify areas with no attached gingiva; Overestimates Class 0 and 1 furcations; Over/under-estimates tooth mobility by two steps on any tooth; Fails to correctly identify Grade 2 or 3 mobility; Over/under-estimates gingival recession by more than 2 mm on any surface; Performs incomplete periodontal examination; Fails to recognize concept of clinical attachment level and differentiate from probing pocket depth.

**[0] – Critical errors –**

- Performs periodontal examination which has no diagnostic value.
- Provides inaccurate assessment of key parameters.

**Comments:**

**Date:** \_\_\_\_\_

**Examiner signature:**

**Factor 4: Evaluate periodontal etiology/risk factors (Part A) – Score [   ]**

**[4]** – Identifies all systemic, local etiologic and risk factors.

**[3]** – Misses one risk factor.

**[2]** – Misses two risk factors but treatment is NOT substantially impacted.

**[1]** – Misses risk factors which compromise treatment planning and patient care.

**[0] – Critical errors –**

- Fails to identify all risk factors.

**Comments:**

**Date:** \_\_\_\_\_

**Examiner signature:**

**P**

<p><b><u>Factor 5: Comprehensive periodontal diagnosis (Part A) – Score [   ]</u></b></p> <p><b>[4]</b> – Provides accurate and complete diagnosis based on comprehensive clinical examination and findings; Demonstrates comprehensive understanding of periodontal diagnosis.</p> <p><b>[3]</b> – Provides accurate and complete diagnosis based on clinical examination and findings pertinent to the case.</p> <p><b>[2]</b> – Differentiates between periodontal health, gingivitis and periodontitis; Makes acceptable diagnosis with minimal deviations from ideal but treatment is NOT impacted.</p> <p><b>[1]</b> – Fails to diagnose periodontitis; Makes diagnosis with critical deviations from optimal; Provides a diagnosis which lacks rationale.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Fails to make a diagnosis.</li> <li>• Provides diagnosis which is grossly incorrect.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b><u>Factor 6: Treatment plan (Part A) – Score [   ]</u></b></p> <p><b>[4]</b> – Provides comprehensive and clinically appropriate treatment plan including clear description of etiology, benefits of treatment, alternatives, and risk factors.</p> <p><b>[3]</b> – Provides comprehensive and clinically appropriate treatment plan including clinically appropriate alternative treatment plan (if any); Provides adequate description of risks and benefits of treatment and alternatives.</p> <p><b>[2]</b> – Provides clinically appropriate treatment plan but fails to address some factors that are unlikely to affect outcome; Does NOT provide clear description of risks and benefits of treatment and alternatives.</p> <p><b>[1]</b> – Provides treatment plan which fails to address relevant factors which are likely to affect outcome; Provides incomplete periodontal treatment plan that is below the standard of care and adversely affects outcome.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Provides clinically inappropriate treatment plan which could harm the patient.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>
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<p><b>Factor 7: Calculus detection (Part B) –</b>  <b>Score [    ]</b>  <b>Quadrant: _____</b></p> <p><b>[4]</b> – Demonstrates complete detection of all subgingival calculus present in quadrant(s).</p> <p><b>[3]</b> – Incorrectly identifies absence or presence of <u>one</u> area of clinically demonstrable subgingival calculus.</p> <p><b>[2]</b> – Incorrectly identifies absence or presence of <u>two</u> areas of clinically demonstrable subgingival calculus.</p> <p><b>[1]</b> – Misses <u>three</u> areas of clinically demonstrable subgingival calculus.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Misses or incorrectly identifies four or more areas of clinically demonstrable subgingival calculus.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>	<p><b>Factor 8: Effectiveness of calculus removal (Part B) – Score [    ]</b></p> <p><b>[4]</b> – Demonstrates complete removal of all calculus plaque and stains from tooth surfaces; Does NOT cause any tissue trauma; Does NOT cause any patient discomfort.</p> <p><b>[3]</b> – Demonstrates complete removal of all other deposits except for stains in pits and fissures; Minimizes patient discomfort.</p> <p><b>[2]</b> – Misses <u>one</u> area of clinically demonstrable subgingival calculus; Demonstrates removal of all other deposits <u>but</u> some remaining minor stains on accessible surfaces; Provides sufficient pain management for treatment.</p> <p><b>[1]</b> – Misses <u>two</u> areas of clinically demonstrable subgingival calculus; Causes major tissue trauma; Leaves moderate plaque and supragingival calculus; Inadequate pain management.</p> <p><b>[0] – Critical errors –</b></p> <ul style="list-style-type: none"> <li>• Misses three areas of clinically demonstrable subgingival calculus.</li> <li>• Leaves heavy stains, plaque, and supragingival calculus.</li> <li>• No pain management.</li> </ul> <p><b>Comments:</b></p>   <p><b>Date:</b> _____</p> <p><b>Examiner signature:</b></p> <p>_____</p>
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**[4]** – Identifies all clinical changes of periodontal condition and describes the biological basis of changes; Evaluates patient's oral hygiene, provides patient-specific oral hygiene instruction and educates patient on the significance of plaque removal and periodontal disease treatment; Evaluates and determines all of the patient's specific periodontal needs with detailed rationale for further periodontal procedures.

**[3] –** Identifies all clinical changes of periodontal condition; Evaluates and determines specific needs for periodontal care with rationale for further periodontal procedures; Accurately assesses all of patient's oral hygiene problems; Provides oral hygiene instructions that addresses all of patient's needs; Evaluates and determines all of the patient's specific periodontal needs without detailed rationale.

**[2]** – Identifies most clinical changes of periodontal condition but fails to identify minor changes; Accurately assesses most of patient's oral hygiene problems; Provides oral hygiene instructions that only address most of the patient's needs; Evaluates and determines general needs for periodontal care including recall intervals and referral, if indicated.

**[1] – Fails to identify persistent signs and symptoms of periodontal disease; Fails to present an oral hygiene plan; Makes recommendations for further periodontal treatment that is inappropriate and demonstrates lack of understanding of patient's periodontal needs.**

- Fails to recognize any clinical change in periodontal condition.
- Did NOT assess patient's oral hygiene care or needs.
- Has NOT evaluated and/or determined patient's periodontal needs.
- Fails to recognize need for referral.

**Comments:**

Date: \_\_\_\_\_

**Examiner signature:**

## Appendix A – Common rating errors

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## ***Common rating errors***

Rating errors are systematic biases which may affect the examiner's ability to provide a fair and objective evaluation of candidates. By applying the established grading criteria systematically, rating errors can be avoided. Basically, examiners should use their professional judgment in applying the grading criteria for each grading factor and rate the candidates' performance accordingly.

1. **FIRST IMPRESSIONS.** First impressions can have a lasting and troublesome effect on the evaluation process. During the first few minutes of the examination, the examiner may form a favorable or unfavorable impression of the candidate. The end result is that the examiner may distort or ignore various aspects of candidates' performance.
2. **HALO/HORN EFFECT.** Halo or horn effect is a broader example of the type of influence which occurs during first impressions. Halo refers to positive overgeneralization based on a positive aspect of performance. Horn refers negative overgeneralization based on a negative aspect of performance. Thus, if the candidate exhibits good or poor performance for one grading factor, the ratings for all factors are distorted.
3. **STEREOTYPING.** Stereotyping refers to unfair bias towards a candidate without being aware of the bias. Examiners should be aware of individual differences of candidates rather than generalizations about a group of people.
4. **SIMILARITY EFFECTS.** Similarity effects are the tendency of examiners to rate candidates more favorably if because the candidates perform tasks in the same style or use the same process as they do.
5. **CONTRAST EFFECTS.** Contrast effects are the result of evaluating the candidate relative to other candidates rather than applying the established grading criteria.
6. **CENTRAL TENDENCY.** Central tendency is the inclination to "play it safe" and rate candidates in the middle.
7. **NEGATIVE AND POSITIVE LENIENCY.** Leniency (level) error is the tendency of an examiner to rate candidates too low or too high on a consistent basis.
8. **FRAME OF REFERENCE.** Frame of reference error occurs when examiners compare candidate performance to their personal standards of care.



## **Agenda Item 4b**

### **Candidate Handbook**

# PORTFOLIO EXAMINATION CANDIDATE HANDBOOK 2013



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**Dental Board of**  
**California**  
**2005 Evergreen Street**  
**Suite 1550**  
**Sacramento, California 95815**  
**(916) 263-2300**  
**[www.dbc.ca.gov](http://www.dbc.ca.gov)**



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# Chapter 1 – Introduction

This Candidate Handbook is designed to provide information for students who elect the Portfolio Examination pathway to initial dental licensure.

The purpose of this handbook is to provide candidates with detailed information about the Portfolio Examination (“Portfolio”). The handbook includes information about patient criteria, subject matter areas assessed by the examination, and standardized rating (grading) criteria.



# Chapter 2 – Background

## ***History***

In January 2007, the Board initiated the process of re-evaluating the California Clinical Examination, and worked with the dental schools in California to explore alternative methods of assessing dental school students for initial dental licensure.

The Portfolio Examination was born out of the desire to eliminate the need to administer a stand-alone examination to those student candidates who met the requirements set by the Board. While this new type of assessment would exceed the present requirements for testing on actual patients, it is also based on achieving a required number of clinical experiences.

The plan was to require clinical experiences in oral diagnosis and treatment planning, direct restoration, indirect restoration, removable prosthodontics, endodontics and periodontics. Competency would be demonstrated through series of standardized competency examinations to be developed by committees of faculty from California dental schools. Calibration, standardization, verification and cooperation are the important components of this new and novel approach to assessing candidates for initial licensure in California.

By July 2008, the Board commissioned an analysis of assessment methods prior to determining the Portfolio Examination as a viable pathway to qualify for licensure in California. Assembly Bill 1524, sponsored by the Dental Board of California, abolished the clinical and written examination administered by the Dental Board of California and replaced that examination with a Portfolio Examination of a candidate's competence to enter the practice of dentistry.

In 2009, committees of faculty from six dental schools began work on developing patient parameters and grading criteria for the standardized evaluation system. The faculty represented all six dental schools: University of California, Los Angeles; University of California, San Francisco; Loma Linda University; University of the Pacific; University of Southern California; and Western University of Health Sciences.

## ***Premise***

The Portfolio Examination allows candidates to build a portfolio of completed clinical experiences and clinical competency examinations in six subject areas over the normal course of clinical training. Both clinical experiences and clinical competency examinations are performed on patients of record within the normal course of treatment. The primary difference between clinical experiences and clinical competency examinations is that the clinical competency examinations are performed independently without faculty intervention unless patient safety issues are imminent.

The Portfolio Examination is conducted while the applicant is enrolled in a dental school program at a California Board approved dental school. A student may elect to begin the Portfolio Examination process during the clinical training phase of their dental education, with the approval of his/her clinical faculty.

The Portfolio Examination follows a similar structure for candidate evaluation that currently exists within the schools to assess minimum competence. The faculty observes the treatment provided and evaluates candidates according to standardized criteria developed by a consensus of key faculty from all of the dental schools. Each candidate prepares and submits a portfolio of documentation that provides proof of completion of competency evaluations for specific procedures in six subject areas: oral diagnosis and treatment planning, direct restoration (amalgam/composite), indirect restoration (fixed prosthetics), removable prosthodontics, endodontics and periodontics.

If a candidate fails to pass any of the six Portfolio competency examinations after three (3) attempts, the applicant is not eligible for re-examination in that competency until he or she has successfully completed the minimum number of required remedial education hours in the failed competency. The remedial course work content may be determined by his or her school and may include didactic, laboratory or clinical patients to satisfy the Board requirement for remediation before an additional Portfolio competency examination may be taken. When a candidate applies for re-examination he or she must furnish evidence of successful completion of the remedial education requirements for re-examination to the examiner. The remediation form must be signed and presented prior to re-examination.

The Portfolio Examination is an alternative examination that each individual school may elect at any time to implement or decline to implement.

## ***Distinguishing characteristics***

There are 10 distinguishing characteristics of the Portfolio Examination:

- *First*, the Portfolio Examination is considered a performance examination that assesses candidates' skills in commonly encountered clinical situations. Consequently, the Portfolio Examination must meet legal standards (Sections 12944 of the Government Code, Section 139 of the Business and Professions Code) and psychometric standards set forth by the Standards for Educational and Psychological Testing.
- *Second*, the Portfolio Examination is a summative assessment of a candidate's competence to practice independently. Therefore, candidates perform clinical procedures without faculty intervention in the competency examinations. If a candidate commits a critical error at any time during a competency examination, the examination is terminated immediately in the interests of patient safety.

- *Third*, it includes components of clinical examinations similar to other clinical examinations, and, is administered in a manner that is similar to other clinical examinations encountered in the candidates' course of study. The multiple clinical examinations allow for an evaluation of the full continuum of competence. No additional resources are required from candidates, schools or the Board.
- *Fourth*, treatments for candidates' clinical experience and competency examinations are rendered on patients of record. This means that candidates' competence is not evaluated in an artificial or contrived situation, but on patients who require dental interventions as a normal course of treatment and their progress can be monitored beyond the scope of the clinical experiences or competency examinations.
- *Fifth*, candidates must complete a minimum number of clinical experiences as required for each of six competency domains.
- *Sixth*, readiness for the Portfolio competency examinations is determined by the clinical faculty at the institution where the candidate is enrolled.
- *Seventh*, each of the schools will designate faculty as Portfolio competency examiners and is responsible for administering a Board approved standardized calibration training course for said examiners. The schools are also responsible for the calibration of Portfolio examiners' performance to ensure consistent implementation of the examination and a standardized examination experience for all candidates.
- *Eighth*, candidates' performance is measured according to the information provided in competency evaluations conducted in the schools by clinical faculty within the predoctoral program of education.
- *Ninth*, it produces documented data for outcomes assessment of results, thereby allowing for verification of validity evidence. The data provides the foundation of periodic audits of each school conducted by the Board to ensure that each school is implementing the Portfolio Examination according to the standardized procedures.
- *Tenth*, there are policies and procedures in place to treat candidates fairly and professionally, with timely and complete communication of examination results.

## ***Development***

The Portfolio Examination has been developed by psychometric consultants for the Dental Board of California in collaboration with committees of dental faculty knowledgeable in the six subject areas. The Portfolio Examination meets the Standards for Educational and Psychological Testing (1999) set forth by the

American Educational Research Association, the American Psychological Association, and the National Council on Measurement in Education. The Standards are used as a benchmark by the measurement profession as the psychometric standards for validating all examinations, including licensing and certification examinations.

Because the Portfolio Examination is a state licensure examination, it also meet legal standards as explicated in Sections 12944 of the California Government Code and Section 139 of the California Business and Professions Code. Section 12944 relates to establishment of qualifications for licensure that do not adversely affect any class by virtue of race, creed, color, national origin/ancestry, sex, gender, gender identity, gender expression, age, medical condition, genetic information, physical disability, mental disability, or sexual orientation. Section 139 of the California Business and Professions Code states occupational licensure examination programs must be based upon occupational (job/practice) analyses and examination validation studies.

## Chapter 3 – General Information

### *Summary of requirements*

<b>AGE</b>	<ul style="list-style-type: none"><li>• At least 18 years old</li></ul>
<b>IDENTIFICATION NUMBER</b>	<ul style="list-style-type: none"><li>• School will request a Portfolio Candidate Identification number.</li></ul>
<b>APPLICATION</b>	<ul style="list-style-type: none"><li>• Complete the Board “Application for Law and Ethics Examination.</li><li>• Complete the Board “Application for Determination of Licensure Eligibility (Portfolio)”</li></ul>
<b>REQUIREMENTS</b>	<ul style="list-style-type: none"><li>• Successful completion of all competency examinations specified for the Portfolio Examination</li><li>• Certification of good academic standing by the dean of the student’s dental school attended by the applicant such that the applicant is expected to graduate from said dental school; no pending ethical issues</li><li>• Minimum number of clinical experiences</li><li>• NBDE Passing Results</li><li>• Passing the Dentistry Law and Ethics Examination</li><li>• Certification of Licensure (If licensed in another country)</li><li>• Submission of fingerprints</li></ul>

### *Application for Licensure by Portfolio*

Applicants must include the following information in the “Application for Determination of Licensure Eligibility (Portfolio).”

- a) Full legal name.
- b) United States social security number.
- c) Address of record.
- d) Mailing address, if different from address of record.
- e) Date of birth.
- f) Telephone number (home and/or cell phone.)
- g) A 2” by 2” passport style photograph of the applicant.
- h) Information regarding applicant’s education including dental education and postgraduate study.
- i) 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.
- j) 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 must 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 required by the Board.
- k) 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 must provide any additional information requested by the Board.
  - l) 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 must 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.
  - m) 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 must be provided including state or country of surrender, date of surrender, reason for surrender, and any other information requested by the Board.
  - n) Information as to whether the applicant has ever been convicted of any crime including infractions, misdemeanors and felonies unless the conviction was for an infraction with a fine of less than \$1,000. "Conviction" for purposes of this subparagraph includes a plea of no contest and any conviction that has been set aside pursuant to Section 1203.4 of the Penal Code. Therefore, applicants must disclose any convictions in which the applicant entered a plea of no contest any conviction that was subsequently set aside pursuant to Section 1203 of the Penal Code.
  - o) Whether the applicant is in default on a United State Department of Health and Human Services education loan pursuant to Sections 685 of the Code.
  - p) Any other information the Board is authorized to consider, when determining if a candidate meets all applicable requirements for examination and licensure
  - q) A certification, under the penalty of perjury, by the applicant that the information on the application is true and correct.

### ***Applicant mailing address***

All mail from the Board will be sent to the mailing address indicated on the application. If an applicant changes his or her address or wishes information be sent to another address, he or she must notify the Board, in writing, of the change. Failure to notify the Board of a change of address may prevent the applicant from receiving relevant information.

### ***Certification of good standing***

An application for determination of licensure eligibility (portfolio) may be submitted prior to graduation, if the application is accompanied by a certification from the school that the applicant is expected to graduate. The Board will not

issue a license, until receipt of a certification letter from the dean of the school attended by the applicant, certifying the date the applicant graduated on school letterhead with the school seal.

### ***Submission of Portfolio to the Board***

A candidate must arrange with the school to have his or her completed Portfolio submitted to the Board. The earliest date that a student may submit their portfolio for review by the Board will be determined by each individual school. The Portfolio will not be reviewed by the Board until the "Application for Determination of Licensure Eligibility (Portfolio)" has been received along with the required fee.

The Application and completed Portfolio must be submitted within 90 days of graduation.

### ***Issuance of license***

The Board will review the submitted Portfolio materials to determine that it is complete and that the candidate has met the requirements. Once approved, the candidate will be sent an "Application for Issuance of License Number and Registration of Place of Practice". A license will be issued in 7-10 days once the completed application and required fee has been received by the Board.

### ***Criminal background check***

For consumer protection, California law requires all applicants to undergo a criminal background check, therefore, all applicants must submit a fingerprint-processing fee to the Board of \$49.00. The amount is subject to change by the California Department of Justice (DOJ) and the Federal Bureau of Investigations (FBI). Until further notice, all applicants may submit their fingerprints by either using the LIVESCAN system or submitting their fingerprint cards. Candidates residing in California must utilize the LIVESCAN system. Candidates residing out of California may either come to California and utilize the LIVESCAN system or submit their fingerprints on standard FBI fingerprint cards.

Board regulation requires two "classifiable" sets of fingerprints on forms provided by the Board to complete the application. Fingerprints may be submitted via LIVESCAN or standard FBI fingerprint cards. Classifiable means that the prints can be "read" by the California Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). Fingerprints are more likely to be classifiable if they are taken by a large local law enforcement agency such as a police or sheriff department.

## ***Schools offering the Portfolio Examination***

Students who engage in the Portfolio Examination process will take standardized competencies at the school in which they are enrolled. A list of dental schools is presented below:

Location	School
Loma Linda	Loma Linda University School of Dentistry 11092 Anderson Street Loma Linda, California 92350
Los Angeles	University of California, Los Angeles School of Dentistry 10833 Le Conte Avenue Los Angeles, California 90024
	University of Southern California Ostrow School of Dentistry 925 West 34 <sup>th</sup> Street Los Angeles, California 90089
Pomona	Western University of Health Sciences College of Dental Medicine 309 East Second Street Pomona, California 91766
San Francisco	University of California, San Francisco School of Dentistry 707 Parnassus Avenue San Francisco, CA 94143
	University of the Pacific Arthur A. Dugoni School of Dentistry 2155 Webster Street San Francisco, California 94115



## Chapter 4 – Board policies

The following rules are in addition to any other examination rules set forth elsewhere in this guide and are adopted for the uniform conduct of the Portfolio Examination.

### ***Radiographs***

Radiographs for Portfolio competency examinations must be of diagnostic quality either digital or conventional.

### ***Infection control***

Candidates are responsible for maintaining all of the standards of infection control while treating patients. This includes the appropriate sterilization and disinfection of the cubicle, instruments and handpieces, as well as, the use of barrier techniques (including glasses, mask, gloves, proper attire, etc.) as required by OSHA and the Dental Practice Act.

### ***Use of local anesthetics***

Local anesthetics must be administered according to school protocol and standards of care. The type and amount of anesthetics must be consistent with the patient's health and other factors.

### ***Use of dental dams***

Dental dams must be used during endodontic treatment and the preparation of amalgam and composite restorations. Finished restorations will be graded without the dental dam in place.

### ***Personal protective equipment***

Candidates must wear masks, gloves and eye protection during this section of the examination.

### ***Patients of record***

Candidates will provide clinical services upon patients of record who fulfill the patient selection criteria for each of the six types of Portfolio competency examinations.

### ***Identification numbers***

Candidates will request from the Board an identification number to be used for all Portfolio competency examinations prior to completing any competency examination.

### ***Patient treatment session time limits***

Candidates shall be allowed 3 hours, 30 minutes for each patient treatment session.

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## Chapter 5 – Overview

### Definitions

<b>SCHOOL</b>	A dental school in California approved by the Board
<b>CASE</b>	A dental procedure which satisfies the required clinical experiences
<b>INDEPENDENT PERFORMANCE</b>	Candidate is actually involved in the delivery of dental treatment by him or herself; not just observing treatment or being guided by faculty clinician
<b>CLINICAL EXPERIENCES</b>	Refers to procedures that the candidate must complete prior to submission of his or her Portfolio Examination application. The minimum number of clinical experiences is described for each of the six competency domains.
<b>PORTFOLIO DOCUMENTATION</b>	Refers to the cumulative documentation of clinical competency, submitted to the Board after completion of all requirements for licensure.
<b>EXAMINER</b>	Refers to dental school faculty Portfolio examiner, is a faculty member chosen by the school, registered with the Board, and is trained and calibrated to conduct and grade the Board competency examinations.
<b>CRITICAL ERROR</b>	<p>A <u>critical error</u> is a gross error that is irreversible, and/or may impact patient safety and wellbeing and thus prevents the candidate from completing the procedure as a competency examination.</p> <p>If the candidate makes a critical error at any point during a Board competency examination, a score of “0” is assigned and the competency examination is terminated immediately.</p>
<b>PATIENT SAFETY</b>	If the patient’s well being is put into jeopardy in any way at any time during the examination, the examination will be terminated. The candidate fails the competency examination, regardless of performance on any other part of the examination.

### Demonstrations of clinical experience

Each candidate must complete at least the minimum number of clinical experiences in the competencies prior to submission of their Portfolio to the Board. Clinical experiences identified below have been determined as a minimum number in order to provide a candidate with sufficient understanding, knowledge and skill level to reliably demonstrate competency. All clinical experiences must be performed on patients under the supervision of dental school faculty and must be included in the Portfolio submitted to the Board.

Clinical experience may be obtained at the dental school clinic, an extramural dental facility or a mobile dental clinic approved by the Board.

## ***Required elements***

The Portfolio Examination must contain documentation of the minimum clinical experiences and document of clinical competency examination as follows:

- Documentation that provides proof of satisfactory completion of a final assessment in the competency examinations prescribed by the Board. For purpose of this section satisfactory proof means the portfolio has been approved by the designated dental school faculty.
- Satisfactory evidence the candidate has completed the clinical experiences prescribed by the Board. For purpose of this section satisfactory evidence means documentation of completion of the prescribed clinical experiences in the competencies prescribed by the Board.
- A letter from the dean or his/her designee stating the candidate will graduate with no pending ethical issues from the dental education process.

## ***Competency examinations vs. clinical experiences***

A competency examination is performed without faculty intervention; however, completion of a successful competency examination may be counted as a clinical experience for the purposes of the Portfolio Examination at the discretion of the dental school at which the candidate is enrolled.

## ***Guidelines***

- Candidates perform Portfolio competency examinations independently without faculty intervention.
- Schools have the option of using the same faculty to grade each competency examination.
- Each of the schools will designate faculty as competency examiners and is responsible for administering the Board approved calibration course for said examiners.
- Each competency examination will be graded by two (2) examiners.
- If a candidate fails a Portfolio competency examination three (3) times, the candidate cannot take the same Portfolio competency examination until remediation has been completed.

- Readiness for Portfolio competency examinations is determined by clinical faculty.

## ***Portfolio examiners***

The Board has outlined a process for selection of dental school faculty who wish to serve as a Portfolio examiner. Each Portfolio examiner will undergo calibration training in the Board's standardized evaluation system through didactic and experiential methods.

- a) At the beginning of each school year, each school submits the names, credentials and qualifications of the dental school faculty to be appointed by the Board as Portfolio examiners. Documentation of qualifications must include but is not limited to, evidence the dental school faculty examiner satisfies the dental school criteria and standards established by his/her school to conduct Portfolio competency examinations. The school faculty examiner must have documented experience in conducting examinations in an objective manner.
- b) In addition to the names, credentials and qualifications, the Board approved school must submit documentation the appointed dental school faculty examiners have been trained and calibrated in compliance with the Board's requirements. Changes to the list of school faculty examiners must be reported to the Board. The school must provide the Board an annual updated list of their faculty examiners.
- c) The Board reserves the right to approve or disapprove dental school faculty who wish to serve as Portfolio examiners.

## ***Scoring***

Each Portfolio competency examination will be graded by two (2) independent competency examiners in accordance with the Board's standardized rating (grading) criteria on forms prescribed by the Board. The Portfolio Examination must be signed by the school faculty Portfolio competency examiners for the prescribed competency.

## ***Patient safety***

If the patient's well-being is put into jeopardy at any time during the examination, the examination will be terminated. The candidate fails the examination, regardless of performance on any other part of the examination.

## ***Critical errors***

A critical error is a gross error that is irreversible, and/or may impact patient safety and wellbeing and/or requires faculty intervention. If a candidate commits a critical error, the candidate cannot proceed with the examination.

If the candidate makes a critical error at any point during a Portfolio competency examination, a score of “0” is assigned and the Portfolio competency examination is terminated immediately.

### ***Minimum competence level of performance***

The minimum competence ratings for Portfolio competency examinations are identified in the description of the rating scales.

Within a given competency examination, a low rating in one area can be offset by a higher rating in another area.

- For Oral Diagnosis and Treatment Planning, Endodontics, and Periodontics, a rating of “2” (rating scale 0, 1, 2, 3, 4) is considered minimum competence level performance.
- For Direct Restoration and Indirect Restoration, a rating of “3” (rating scale 0, 1, 2, 3, 4, 5) is considered minimum competence level performance.
- For Removable Prosthodontics, a rating of “3” (rating scale 1, 2, 3, 4, 5) is considered minimum competence level performance.

### ***Scaled scores***

- Ratings for each Portfolio competency examination based on a total of rating points, rather than an average of rating points.
- Total points for each Portfolio competency examination will be converted to scaled scores to place them on a common metric.
- A scaled score of 75 is considered a passing score for each Portfolio competency examination.

### ***Compensatory model***

Within a given competency examination, a low rating in one area can be compensated by a higher score in another area.

For example, a candidate who achieves a scaled score 76 from one examiner and 74 from another examiner will be credited for a scaled score 150 based on total points.

Likewise, a candidate who achieves a scaled score of 75 from one examiner and 75 from another examiner will be credited with a scaled score 150 based on total points.

# Chapter 6 – Oral Diagnosis and Treatment Planning

## ***Purpose***

The competency examination for oral diagnosis and treatment planning (ODTP) is designed to assess the candidate's ability to identify and evaluate patient data and clinical findings; formulate diagnoses; and plan treatment interventions from a multidisciplinary perspective.

## ***Clinical experiences***

The documentation of oral diagnosis and treatment planning clinical experiences will include a minimum of 20 patient cases.

Clinical experiences for ODTP include:

- Comprehensive oral evaluations,
- Limited (problem-focused) oral evaluations, and
- Periodic oral evaluation

Each examination, ODTP clinical experience requires medical and dental history, identified problem(s), diagnoses, treatment plans, and informed consent

## ***Overview***

- Fifteen (15) scoring factors.
- Initiation and completion of one (1) multidisciplinary Portfolio competency examination.
- Treatment plan must involve at least three (3) of the following six disciplines:
  - > Periodontics
  - > Endodontics
  - > Operative (direct and indirect restoration)
  - > Fixed and removable prosthodontics
  - > Orthodontics
  - > Oral surgery

## ***Patient parameters***

- Maximum of ASA II.
- Missing or will be missing two or more teeth, NOT including third molars.
- At least moderate periodontitis (probing depths of 5 mm or more).

## **Scoring**

Scoring points for oral diagnosis and treatment planning are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

## ***Elements of the ODTP Portfolio***

The oral diagnosis and treatment planning portfolio may include, but is not limited to the following:

- a) Medical history for dental treatment provided to patients. The medical history must include: an evaluation of past illnesses and conditions, hospitalizations and operations, allergies, family history, social history, current illnesses and medications, and their effect on dental condition.
- b) Dental history for dental treatment provided to clinical patients. The dental history must include: age of previous prostheses, existing restorations, prior history of orthodontic/periodontic treatment, and oral hygiene habits/adjuncts.
- c) Documentation of a comprehensive examination for dental treatment provided to patients includes:
  - (1) Interpretation of radiographic series
  - (2) Performance of caries risk assessment
  - (3) Determination of periodontal condition
  - (4) Performance of a head and neck examination, including oral cancer screening
  - (5) Screening for temporomandibular disorders
  - (6) Assessment of vital signs
  - (7) Performance of a clinical examination of dentition
  - (8) Performance of an occlusal examination
- d) Documentation the candidate evaluated data to identify problems. The documentation of the data evaluation includes:
  - (1) Chief complaint
  - (2) Medical problem
  - (3) Stomatognathic problems
  - (4) Psychosocial problems



e) Documentation the candidate worked-up the problems and developed a tentative treatment plan. The documentation of the work-up and tentative treatment plan includes:

- (1) Problem definition, e.g., severity/chronicity and classification
- (2) Determination if additional diagnostic tests are needed
- (3) Development of a differential diagnosis
- (4) Recognition of need for referral(s)
- (5) Pathophysiology of the problem
- (6) Short term needs
- (7) Long term needs
- (8) Determination interaction of problems
- (9) Development of treatment options
- (10) Determination of prognosis
- (11) Patient information regarding informed consent

f) Documentation the candidate developed a final treatment plan. The documentation includes:

- (1) Rationale for treatment
- (2) Problems to be addressed, or any condition that puts the patient at risk in the long term
- (3) Determination of sequencing with the following framework:
  - Systemic: medical issues of concern, medications and their effects, effect of diseases on oral condition, precautions, treatment modifications
  - Urgent: Acute pain/infection management, urgent esthetic issues, further exploration/additional information, oral medicine consultation, pathology
  - Preparatory: Preventive interventions, orthodontic, periodontal (Phase I, II), endodontic treatment, caries control, other temporization
  - Restorative: operative, fixed, removable prostheses, occlusal splints, implants
  - Elective: esthetic (veneers, etc.) any procedure that is not clinically necessary, replacement of sound restoration for esthetic purposes, bleaching
  - Maintenance: periodontic recall, radiographic interval, periodic oral examination, caries risk management

## ODTP scoring criteria

### FACTOR 1: MEDICAL ISSUES THAT IMPACT DENTAL CARE

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies and evaluates all medical issues</li> <li>Explains dental implications of systemic conditions</li> <li>Identifies and assesses patient medications</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> item that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> items that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> items that would cause potential harm</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Misses medical or medication items that would cause potential harm</li> </ul>

### FACTOR 2: TREATMENT MODIFICATIONS BASED ON MEDICAL CONDITIONS

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all treatment modifications</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>one</u> item that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>two</u> items that would NOT cause harm</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>more than two</u> items that would cause potential harm</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Misses treatment modifications that would cause potential harm</li> </ul>

### FACTOR 3: PATIENT CONCERNS/CHIEF COMPLAINT

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all patient concerns including chief complaint</li> </ul>	<ul style="list-style-type: none"> <li>Identifies chief complaint <u>but</u> misses <u>one</u> patient concern</li> </ul>	<ul style="list-style-type: none"> <li>Identifies chief complaint <u>but</u> misses <u>two</u> patient concerns</li> </ul>	<ul style="list-style-type: none"> <li>Identifies chief complaint <u>but</u> misses <u>more than two</u> patient concerns</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Chief complaint NOT identified</li> </ul>

#### FACTOR 4: DENTAL HISTORY

4	3	2	1	0
<ul style="list-style-type: none"><li>Identifies all parameters in dental history</li></ul>	<ul style="list-style-type: none"><li>Misses <u>one</u> parameter in dental history</li></ul>	<ul style="list-style-type: none"><li>Misses <u>two</u> parameters in dental history</li></ul>	<ul style="list-style-type: none"><li>Misses <u>more than two</u> parameters in dental history</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Neglects to address dental history</li></ul>

#### FACTOR 5: SIGNIFICANT RADIOGRAPHIC FINDINGS

4	3	2	1	0
<ul style="list-style-type: none"><li>Identifies all radiographic findings</li></ul>	<ul style="list-style-type: none"><li>Misses <u>one</u> radiographic finding that does NOT substantially alter treatment plan</li></ul>	<ul style="list-style-type: none"><li>Misses <u>two</u> radiographic findings that do NOT substantially alter treatment plan</li></ul>	<ul style="list-style-type: none"><li>Misses <u>more than two</u> radiographic findings that do NOT substantially alter treatment plan</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Misses radiographic findings that substantially alters treatment plan</li></ul>

#### FACTOR 6: CLINICAL FINDINGS

4	3	2	1	0
<ul style="list-style-type: none"><li>Identifies all clinical findings</li></ul>	<ul style="list-style-type: none"><li>Misses <u>one</u> clinical finding that does NOT substantially alter treatment plan</li></ul>	<ul style="list-style-type: none"><li>Misses <u>two</u> clinical findings that do NOT substantially alter treatment plan</li></ul>	<ul style="list-style-type: none"><li>Misses <u>more than two</u> clinical findings that do NOT substantially alter treatment plan</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Misses clinical findings that substantially alter treatment plan</li></ul>

## FACTOR 7: RISK LEVEL ASSESSMENT

4	3	2	1	0
<ul style="list-style-type: none"> <li>Risk level (risk factors/indicators and protective factors) identified</li> <li>Relevance of risk level identified</li> </ul>	<ul style="list-style-type: none"> <li>Risk level and relevance of risk level identified <u>but</u> misses <u>one</u> item (risk factors/indicators and protective factors)</li> </ul>	<ul style="list-style-type: none"> <li>Risk level and relevance of risk level identified <u>but</u> misses <u>two</u> items (risk factors/indicators and protective factors)</li> </ul>	<ul style="list-style-type: none"> <li>Risk level identified <u>but</u> misses <u>more than two</u> items (risk factors/indicators and protective factors)</li> <li>Relevance of risk level NOT identified</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Risk level NOT identified</li> </ul>

## FACTOR 8: NEED FOR ADDITIONAL DIAGNOSTIC TESTS/REFERRALS

4	3	2	1	0
<ul style="list-style-type: none"> <li>Prescribes/acquires all clinically necessary diagnostic test and referrals with comprehensive rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies need for clinically necessary diagnostic tests and referrals with limited rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies need for additional diagnostic tests and referrals without rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies need for additional diagnostic tests and referrals without rationale <u>and</u> prescribes non-contributory test or referrals</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Does NOT identify clinically necessary diagnostic tests or referrals</li> </ul>

## FACTOR 9: FINDINGS FROM MOUNTED DIAGNOSTIC CASTS

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Casts and mounting reflect patient's oral condition</li> <li>• Identifies all diagnostic findings from casts</li> </ul>	<ul style="list-style-type: none"> <li>• Casts and mounting reflect patient's oral condition</li> <li>• Misses <u>one</u> diagnostic finding that does NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>• Casts and mounting reflect patient's oral condition <u>but</u> misses <u>two</u> diagnostic findings that do NOT substantially alter treatment plan</li> </ul>	<ul style="list-style-type: none"> <li>• Casts and mounting reflect patient's oral condition <u>but</u> misses <u>more than two</u> diagnostic findings that do NOT substantially alter treatment plan</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Casts and mounting do NOT reflect patient's oral condition</li> <li>• Misses diagnostic cast findings that substantially alter treatment plan</li> </ul>

## FACTOR 10: COMPREHENSIVE PROBLEM LIST

4	3	2	1	0
<ul style="list-style-type: none"> <li>• All problems listed</li> </ul>	<ul style="list-style-type: none"> <li>• <u>One</u> problem NOT identified without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Two</u> problems NOT identified without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Two or more</u> problems NOT identified without potential harm to patient</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Problems with potential for harm to patient NOT identified</li> </ul>

## FACTOR 11: DIAGNOSIS AND INTERACTION OF PROBLEMS

4	3	2	1	0
<ul style="list-style-type: none"> <li>• All diseases correctly diagnosed</li> <li>• All interactions identified</li> </ul>	<ul style="list-style-type: none"> <li>• <u>One</u> missed diagnosis or interaction without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Two</u> missed diagnoses or interactions without potential harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>• <u>More than two</u> missed diagnoses or interactions without potential harm to patient</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Missed diagnosis or interaction resulting in potential harm to patient</li> </ul>

## FACTOR 12: OVERALL TREATMENT APPROACH

4	3	2	1	0
<ul style="list-style-type: none"> <li>All treatment options identified within standard of care; provides rationale which is <u>optimal</u></li> </ul>	<ul style="list-style-type: none"> <li>All treatment options identified within standard of care; provides <u>acceptable</u> rationale</li> </ul>	<ul style="list-style-type: none"> <li>All treatment options identified within standard of care <u>and</u> lacks sound rationale for treatment</li> </ul>	<ul style="list-style-type: none"> <li>Incomplete treatment options <u>and</u> lacks sound rationale for treatment</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Treatment options presented are NOT within standard of care</li> </ul>

## FACTOR 13: PHASING AND SEQUENCING OF TREATMENT

4	3	2	1	0
<ul style="list-style-type: none"> <li>Treatment optimally phased and sequenced</li> </ul>	<ul style="list-style-type: none"> <li>Treatment phased correctly but <u>one</u> procedure out of sequence with no harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>Treatment phased correctly but <u>two</u> procedures out of sequence with no harm to patient</li> </ul>	<ul style="list-style-type: none"> <li>Treatment NOT phased correctly <u>but</u> no potential harm to patient</li> </ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"> <li>Treatment NOT phased nor sequenced with potential harm to patient</li> </ul>

## FACTOR 14: COMPREHENSIVENESS OF TREATMENT PLAN

4	3	2	1	0
<ul style="list-style-type: none"> <li>Treatment plan addresses all problems</li> <li>All treatment procedures are indicated</li> </ul>	<ul style="list-style-type: none"> <li><u>One</u> treatment procedure that is NOT indicated but will NOT result in harm to patient <u>but</u> treatment plan addresses all problems</li> </ul>	<ul style="list-style-type: none"> <li><u>Two or more</u> treatment procedures that are NOT indicated but reflect problem list <u>but</u> treatment plan addresses all problems</li> </ul>	<ul style="list-style-type: none"> <li><u>Two or more</u> treatment procedures that are NOT indicated and do NOT reflect problem list</li> <li>Treatment plan is incomplete but does NOT cause harm to patient</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Treatment plan is incomplete and causes potential harm to patient</li> <li>Treatment procedures included that are NOT indicated resulting in harm to patient</li> <li>Treatment procedures are missing from treatment plan resulting in harm to patient</li> </ul>

## FACTOR 15: TREATMENT RECORD

4	3	2	1	0
<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and comprehensive rationale for treatment options</li> <li>Documents presentation of risks and benefits of all treatment options</li> </ul>	<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options <u>and</u> provides limited rationale</li> </ul>	<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and treatment options, documents presentation of risks and benefits of all treatment options <u>but</u> provides no rationale</li> </ul>	<ul style="list-style-type: none"> <li>Summarizes all data collected, diagnoses, and treatment options, <u>and</u> documents presentation of risks and benefits only for preferred option</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Does NOT summarize all data collected, diagnoses and/or treatment options</li> <li>Does NOT document presentation of risks and benefits of all treatment options</li> </ul>

# Chapter 7 - Direct Restoration

## **Purpose**

The competency examinations for direct restoration are designed to assess the candidate's independent ability to restore teeth with interproximal primary carious lesions to optimal form, function and esthetics.

## **Clinical experiences**

The documentation of direct restorative clinical experiences includes 60 restorations.

The restorations completed in the clinical experiences may include any restoration on a permanent or primary tooth using standard restorative materials including:

- Amalgams,
- Composites,
- Crown buildups,
- Direct pulp caps, and,
- Temporizations.

## **Overview**

- Seven (7) scoring factors.
- Two (2) restorations:
  - > Class II amalgam or composite; maximum one slot preparation, and,
  - > Class II amalgam or composite or Class III or IV composite
- Restoration can be performed on an interproximal lesion on one interproximal surface in an anterior tooth that does not connect with a second interproximal lesion which can be restored separately.
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.

## **Patient parameters**

Class II – Any permanent posterior tooth

Treatment needs to be performed in the sequence described in the treatment plan

- More than one test procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments.



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

Class III/IV – Any permanent anterior tooth

- Treatment needs to be performed in the sequence described in the treatment plan.
- Caries as shown on the required radiographic image of an unrestored proximal surface must extend to or beyond the dento-enamel junction.
- Carious lesions must involve the interproximal contact area.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the dentition adjacent to the proposed restoration must be either natural tooth structure or a permanent restoration; provisional restorations or removable partial dentures are not acceptable adjacent surfaces.
- Tooth must be asymptomatic with no pulpal or periapical pathology; cannot be endodontically treated or in need of endodontic treatment.
- Approach must be appropriate for the tooth.
- Tooth with bonded veneer is not acceptable.

## Scoring

Scoring points for direct restorations are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- A score of 3 is acceptable; minimum competence
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

## ***Elements of the Direct Restoration Portfolio***

The Direct Restoration portfolio may include, but is not limited to the following:

- a) Documentation of the candidate's competency to perform a class II direct restoration on a tooth containing primary carious lesions to optimal form, function and esthetics using amalgam or composite restorative materials.

The case selection must be based on minimum direct restoration criteria for any permanent posterior tooth. The treatment performed should follow the sequence of the treatment plan(s). More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs.

The tooth involved in the restoration must have caries which penetrate the dento-enamel junction and must be in occlusion. Proximal caries must be in contact with at least one adjacent tooth, a natural tooth surface or a permanent restoration; provisional restorations or removal partial dentures are not acceptable adjacent surfaces. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment.

- b) Documentation of the candidate's competency to perform a class III/IV direct restoration on a tooth containing primary carious lesions to optimal forms, function and esthetics using composite restorative material. The case selected must be on any permanent anterior tooth and treatment needs to be performed in the sequence described in the treatment plan.

More than one procedure can be performed on a single tooth; teeth with multiple lesions may be restored at separate appointments. Each procedure may be considered a case. The tooth being restored must have caries that are evident on either of the two required radiographs. The tooth involved in the restoration must have caries which penetrate the dento-enamel junction.

The tooth to be restored must have an adjacent tooth to be able to restore a proximal contact. Proximal surface of the dentition adjacent to the proposed restoration must be natural tooth structure or a permanent restoration, provisional restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth involved in the restoration must be asymptomatic with no pulpal or periapical pathosis and cannot be endodontically treated or in need of endodontic treatment. The lesion is not acceptable if it is in contact with circumferential decalcification. The approach must be appropriate for the tooth. Teeth with bonded veneers are not acceptable.

## ***Direct Restoration scoring criteria***

### **FACTOR 1: CASE PRESENTATION**

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Obtains informed consent</li> <li>• Presents a comprehensive review of medical and dental history</li> <li>• Provides rationale for restorative procedure</li> <li>• Proposes initial design of preparation and restoration</li> <li>• Demonstrates full understanding of the procedure</li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate deviation from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors in assessing patient's medical and/or dental history</li> <li>• Unable to justify treatment</li> <li>• Proposed treatment would cause harm to patient</li> <li>• Proposed treatment not indicated</li> <li>• Misses critical factors in medical and/or dental review that affect treatment or patient well being</li> </ul>

## FACTOR 2: OUTLINE AND EXTENSIONS

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Optimal outline and extensions <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Smooth, flowing</li> <li>&gt; Does not weaken tooth</li> <li>&gt; Includes the lesion</li> <li>&gt; Breaks proximal contacts as appropriate</li> <li>&gt; Appropriate cavosurface angles</li> <li>&gt; Optimal treatment of fissures</li> <li>&gt; No damage to adjacent teeth</li> <li>&gt; Optimal extension for caries/</li> <li>&gt; decalcification</li> <li>&gt; Appropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation(s) from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate, clinically acceptable deviation(s) from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Irregular outline</li> <li>&gt; Outline weakens the tooth</li> <li>&gt; Does not include the lesion</li> <li>&gt; Contacts not broken where appropriate</li> <li>&gt; Proximal extensions excessive</li> <li>&gt; Inappropriate cavosurface angle(s)</li> <li>&gt; Inappropriate treatment of fissures</li> <li>&gt; Adjacent tooth requires major recontouring</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Irregular outline</li> <li>&gt; Outline weakens the tooth</li> <li>&gt; Does not include the lesion</li> <li>&gt; Contacts not broken where appropriate</li> <li>&gt; Proximal extensions excessive</li> <li>&gt; Inappropriate cavosurface angle(s)</li> <li>&gt; Inappropriate treatment of fissures</li> <li>&gt; Adjacent tooth requires major recontouring</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors in outline and extensions</li> <li>• Deviations from optimal that are irreversible and have a significant impact on treatment</li> <li>• Damage to adjacent tooth that requires restoration</li> </ul>

### FACTOR 3: INTERNAL FORM

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal internal form <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Optimal pulpal and axial depth</li> <li>&gt; Optimal wall relationships</li> <li>&gt; Optimal axio-pulpal line angles</li> <li>&gt; Optimal internal refinement</li> <li>&gt; All previous restorative material removed</li> <li>&gt; Optimal caries removal</li> <li>&gt; Preparation is clean and free of fluids and/or debris</li> <li>&gt; Appropriate liners and bases</li> <li>&gt; Appropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Moderate, clinically acceptable deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Excessive or inadequate pulpal or axial depth</li> <li>&gt; Inappropriate wall relationships</li> <li>&gt; Inappropriate internal line angles</li> <li>&gt; Rough or uneven internal features</li> <li>&gt; Previous restorative material present</li> <li>&gt; Inappropriate caries removal</li> <li>&gt; Fluids and/or debris present</li> <li>&gt; Inappropriate handling of liners and bases</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u>, major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Excessive or inadequate pulpal or axial depth</li> <li>&gt; Inappropriate wall relationships</li> <li>&gt; Inappropriate internal line angles</li> <li>&gt; Rough or uneven internal features</li> <li>&gt; Previous restorative material present</li> <li>&gt; Inappropriate caries removal</li> <li>&gt; Fluids and/or debris present</li> <li>&gt; Inappropriate handling of liners and bases</li> <li>&gt; Inappropriate extension requests</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Critical errors from optimal internal form</li> <li>Noncarious pulp exposure</li> </ul>

#### FACTOR 4: OPERATIVE ENVIRONMENT

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Soft tissue free of unnecessary damage</li> <li>• Proper patient comfort/pain management</li> <li>• Optimal isolation</li> <li>• Correct teeth isolated</li> <li>• Dam fully inverted</li> <li>• Clamp stable with no tissue damage</li> <li>• No leakage</li> <li>• Preparation can be accessed and visualized</li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate, clinically acceptable deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Incorrect teeth isolated</li> <li>&gt; Dam not inverted, causing leakage that may compromise the final restoration</li> <li>&gt; Clamp is not stable or impinges on tissue</li> <li>&gt; Preparation cannot be accessed or visualized to allow proper placement of restoration</li> <li>&gt; Major tissue damage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Incorrect teeth isolated</li> <li>&gt; Dam not inverted, causing leakage that may compromise the final restoration</li> <li>&gt; Clamp is not stable or impinges on tissue</li> <li>&gt; Preparation cannot be accessed or visualized to allow proper placement of restoration</li> <li>&gt; Major tissue damage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors from optimal in operative environment</li> <li>• Gross soft tissue damage</li> <li>• Gross lack of concern for patient comfort</li> </ul>

## FACTOR 5: ANATOMICAL FORM

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal anatomic form <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Harmonious and consistent with adjacent tooth structure</li> <li>&gt; Interproximal contour and shape are proper</li> <li>&gt; Interproximal contact area and position are properly restored</li> <li>&gt; Contact is closed</li> <li>&gt; Height and shape of marginal ridge is appropriate</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	<p>Moderate, clinically acceptable deviation(s) from optimal</p>	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Inconsistent with adjacent tooth structure</li> <li>&gt; Interproximal contour and shape are inappropriate</li> <li>&gt; Height and shape of marginal ridge is inappropriate</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Inconsistent with adjacent tooth structure</li> <li>&gt; Interproximal contour and shape are inappropriate</li> <li>&gt; Height and shape of marginal ridge is inappropriate</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that require restoration to be redone</li> </ul>

## FACTOR 6: MARGINS

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Optimal margins</li> <li>No deficiencies or excesses</li> </ul>	<ul style="list-style-type: none"> <li>Slight deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Moderate, clinically acceptable deviation(s) from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Open margin, submarginal, and/or excess restorative material</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that require restoration to be redone</li> </ul>

## FACTOR 7: FINISH AND FUNCTION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Optimal finish and function <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Smooth with no pits, voids or irregularities in restoration</li> <li>&gt; Occlusion is properly restored with no interferences</li> <li>&gt; No damage to hard or soft tissue</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviation(s) from optimal</li> </ul>	<p>Moderate, clinically acceptable deviation(s) from optimal</p>	<ul style="list-style-type: none"> <li>• Major deviation from optimal <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Significant pits, voids or irregularities in the surfaces</li> <li>&gt; Severe hyper-occlusion or hypo-occlusion</li> <li>&gt; Moderate damage to hard or soft tissue</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <u>Multiple</u> major deviations from optimal</li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors that require restoration to be redone</li> <li>• Procedure is not completed within allotted time</li> <li>• Unnecessary, gross damage to hard and soft tissue as related to finishing procedure</li> </ul>



# Chapter 8 - Indirect Restoration

## **Purpose**

The competency examinations for indirect restoration are designed to assess the candidate's independent ability to restore teeth requiring an indirect restoration to optimal form, function and esthetics with a full or partial coverage ceramic, metal or metal-ceramic indirect restoration.

## **Clinical experiences**

The documentation of indirect restorative clinical experiences will include a minimum of 14 restorations.

The restorations completed in the clinical experiences may be a combination of the following procedures:

- > Inlays,
- > Onlays,
- > Crowns,
- > Abutments,
- > Pontics,
- > Veneers,
- > Cast posts,
- > Overdenture copings, or
- > Dental implant restorations.

## **Overview**

- Seven (7) scoring factors.
- One (1) indirect restoration which may be a combination of the following procedures:
  - > Ceramic restoration must be onlay or more extensive
  - > Partial gold restoration must be onlay or more extensive
  - > Metal ceramic restoration (PFM)
  - > Full gold restoration
- Requires a case presentation for which the proposed treatment is appropriate for patient's medical and dental history, is in appropriate treatment sequence, and treatment consent is obtained.
- Requires patient management; candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

## ***Patient parameters***

- Treatment needs to be performed in the sequence described in the treatment plan
- Tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment.
- Tooth must be in occlusal contact with a natural tooth or a permanent restoration. Occlusion with a full or partial denture is not acceptable.
- The restoration must include at least one cusp.
- Must have an adjacent tooth to be able to restore a proximal contact; proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration; temporary restorations or removable partial dentures are not acceptable adjacent surfaces.
- The candidate may not have performed any portion of the crown preparation in advance.
- Direct restorative materials which are placed to contribute to the retention and resistance form of the final restoration (buildups) may be completed ahead of time, if needed.
- Restoration must be completed on the same tooth and same patient by the same candidate.
- Validated lab or fabrication error will allow a second delivery attempt starting from a new impression or modification of the existing crown.

## ***Scoring***

Scoring points for indirect restoration are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; multiple major deviations that are correctable
- A score of 2 is unacceptable; one major deviation that is correctable
- A score of 3 is acceptable; minimum competence
- A score of 4 is adequate; less than optimal
- A score of 5 is optimal

## ***Elements of the Indirect Restoration Portfolio***

The Indirect Restoration portfolio may include, but is not limited to the following:

- a) Documentation of the candidate's competency to complete a ceramic onlay or more extensive indirect restorations. The treatment needs to be performed in the sequence in the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis and cannot be in need of endodontic treatment. The tooth selected for restoration, must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a

proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of the onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.

- b) Documentation of the candidate's competency to complete a partial gold restoration must be an onlay or more extensive indirect restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.
- c) Documentation of the candidate's competency to perform a full gold restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restoration must be either an enamel surface or a permanent restoration. Temporary restorations or removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient by the same candidate.
- d) Documentation of the candidate's competency to perform a metal-ceramic restoration. The treatment must be performed in the sequence of the treatment plan. The tooth must be asymptomatic with no pulpal or periapical pathosis; cannot be in need of endodontic treatment. The tooth selected for restoration must have opposing occlusion that is stable. The tooth selected for restoration must have an adjacent tooth to be able to restore a proximal contact. The proximal surface of the tooth adjacent to the planned restorations must be either an enamel surface or a permanent restoration. Temporary restorations or

removable partial dentures are not acceptable adjacent surfaces. The tooth selected must require an indirect restoration at least the size of an onlay or greater. The tooth selected cannot replace existing or temporary crowns. Buildups may be completed ahead of time, if needed. Teeth with cast post are not allowed. The restoration must be completed on the same tooth and same patient.

- e) A facial veneer is not acceptable documentation of the candidate's competency to perform indirect restorations.

DRAFT

## ***Indirect Restoration scoring criteria***

### **FACTOR 1: CASE PRESENTATION**

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>• Obtains informed consent</li> <li>• Presents a comprehensive medical and dental review</li> <li>• Provides rationale for restorative procedure</li> <li>• Proposes initial design of restoration</li> <li>• Provides method for provisionalization</li> <li>• Demonstrates full understanding of the procedure</li> <li>• Sequencing of treatment follows standards of care</li> </ul>	<ul style="list-style-type: none"> <li>• Slight deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Moderate deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Major deviation from optimal case presentation</li> <li>• Provides inappropriate justification for treatment</li> <li>• Sequencing of treatment does not follow standards of care</li> </ul>	<ul style="list-style-type: none"> <li>• Multiple major deviations from optimal case presentation</li> </ul>	<ul style="list-style-type: none"> <li>• Critical errors in assessing patient's medical and/or dental history</li> <li>• Unable to justify treatment</li> <li>• Proposed treatment would cause harm to patient</li> <li>• Proposed treatment not indicated</li> <li>• Misses critical factors in medical and dental review that affect treatment or patient well being</li> </ul>

## FACTOR 2: PREPARATION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Meets all accepted criteria for optimal preparation:               <ol style="list-style-type: none"> <li>Occlusal /incisal reduction</li> <li>Axial reduction</li> <li>Finish lines</li> <li>Caries removal</li> <li>Pulpal protection</li> <li>Soft tissue management</li> <li>No damage to soft and hard tissues</li> <li>Resistance and retention</li> <li>Debridement</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviations from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Moderate, clinically acceptable deviations from optimal; minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal but correctable without significantly changing the procedure</li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal preparation</li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that are irreversible and have a significant impact on treatment</li> <li>Critical errors that require major modifications of the proposed treatment <u>such as</u>:               <ol style="list-style-type: none"> <li>Onlay that must change to full crown</li> <li>Overextension requiring crown lengthening</li> </ol> </li> </ul>

### FACTOR 3: IMPRESSION

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Achieves optimal, clinically acceptable impression achieved in one attempt               <ul style="list-style-type: none"> <li>a) Impression extends beyond finish lines</li> <li>b) Detail of preparation and adjacent teeth captured accurately</li> <li>c) Free of voids in critical areas</li> <li>d) No aspect of impression technique that would result in inaccuracy</li> <li>e) Interocclusal record is accurate, if needed</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Achieves clinically acceptable impression in second attempt</li> </ul>	<ul style="list-style-type: none"> <li>Achieves clinically acceptable impression more than two attempts</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation that require retaking impression <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of unacceptable impression or interocclusal relationship</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations from optimal in impression <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of unacceptable impression or interocclusal relationship</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>failure to achieve a clinically acceptable impression after five (5) attempts</li> <li>Critical errors in impression procedure cause unnecessary tissue damage that require corrective treatment procedures</li> </ul>

#### FACTOR 4: PROVISIONAL

5	4	3	2	1	0
<ul style="list-style-type: none"> <li>Meets all accepted criteria for optimal provisional:               <ol style="list-style-type: none"> <li>Occlusal form and function</li> <li>Proximal contact</li> <li>Axial contours</li> <li>Marginal fit</li> <li>External surfaces smooth and polished without pits, voids, or debris</li> <li>Optimal internal adaptation</li> <li>Retention</li> <li>Esthetics</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>Slight deviations from optimal have minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Moderate deviations from accepted criteria have minimal impact on treatment</li> </ul>	<ul style="list-style-type: none"> <li>Major deviation from optimal that can be corrected <u>such as</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of major deviation that can be corrected</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Multiple</u> major deviations that have significant impact on treatment <u>including</u>:               <ul style="list-style-type: none"> <li>&gt; Lack of recognition of major deviation that can be corrected</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Critical errors that are clinically unacceptable</li> </ul>





## **Agenda Item 5**

### **Legislative Process Overview**

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 [www.dbc.ca.gov](http://www.dbc.ca.gov)



## MEMORANDUM

<b>DATE</b>	May 16, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 5:</b> Legislative Process Overview

Ms. Donna Kantner, Legislative Analyst for the Dental Hygiene Committee of California will give an overview of the legislative process.

## **OVERVIEW OF LEGISLATIVE PROCESS**

The process of government by which bills are considered and laws enacted is commonly referred to as the Legislative Process. The California State Legislature is made up of two houses: the Senate and the Assembly. There are 40 Senators and 80 Assembly Members representing the people of the State of California. The Legislature has a legislative calendar containing important dates of activities during its two-year session.

### **Idea**

All legislation begins as an idea or concept. Ideas and concepts can come from a variety of sources. The process begins when a Senator or Assembly Member decides to author a bill.

### **The Author**

A Legislator sends the idea for the bill to the Legislative Counsel where it is drafted into the actual bill. The draft of the bill is returned to the Legislator for introduction. If the author is a Senator, the bill is introduced in the Senate. If the author is an Assembly Member, the bill is introduced in the Assembly.

### **First Reading/Introduction**

A bill is introduced or read the first time when the bill number, the name of the author, and the descriptive title of the bill is read on the floor of the house. The bill is then sent to the Office of State Printing. No bill may be acted upon until 30 days has passed from the date of its introduction.

### **Committee Hearings**

The bill then goes to the Rules Committee of the house of origin where it is assigned to the appropriate policy committee for its first hearing. Bills are assigned to policy committees according to subject area of the bill. For example, a Senate bill dealing with health care facilities would first be assigned to the Senate Health and Human Services Committee for policy review. Bills that require the expenditure of funds must also be heard in the fiscal committees: Senate Appropriations or Assembly Appropriations. Each house has a number of policy committees and a fiscal committee. Each committee is made up of a specified number of Senators or Assembly Members.

During the committee hearing the author presents the bill to the committee and testimony can be heard in support of or opposition to the bill. The committee then votes by passing the bill, passing the bill as amended, or defeating the bill. Bills can be amended several times. Letters of support or opposition are important and should be mailed to the author and committee members before the bill is scheduled to be heard in committee. It takes a majority vote of the full committee membership for a bill to be passed by the committee.

Each house maintains a schedule of legislative committee hearings. Prior to a bill's hearing, a bill analysis is prepared that explains current law, what the bill is intended to do, and some background information. Typically the analysis also lists organizations that support or oppose the bill.

## **Second and Third Reading**

Bills passed by committees are read a second time on the floor in the house of origin and then assigned to third reading. Bill analyses are also prepared prior to third reading. When a bill is read the third time it is explained by the author, discussed by the Members and voted on by a roll call vote. Bills that require an appropriation or that take effect immediately, generally require 27 votes in the Senate and 54 votes in the Assembly to be passed. Other bills generally require 21 votes in the Senate and 41 votes in the Assembly. If a bill is defeated, the Member may seek reconsideration and another vote.

## **Repeat Process in other House**

Once the bill has been approved by the house of origin it proceeds to the other house where the procedure is repeated.

## **Resolution of Differences**

If a bill is amended in the second house, it must go back to the house of origin for concurrence, which is agreement on the amendments. If agreement cannot be reached, the bill is referred to a two house conference committee to resolve differences. Three members of the committee are from the Senate and three are from the Assembly. If a compromise is reached, the bill is returned to both houses for a vote.

## **Governor**

If both houses approve a bill, it then goes to the Governor. The Governor has three choices. The Governor can sign the bill into law, allow it to become law without his or her signature, or veto it. A governor's veto can be overridden by a two thirds vote in both houses. Most bills go into effect on the first day of January of the next year. Urgency measures take effect immediately after they are signed or allowed to become law without signature.

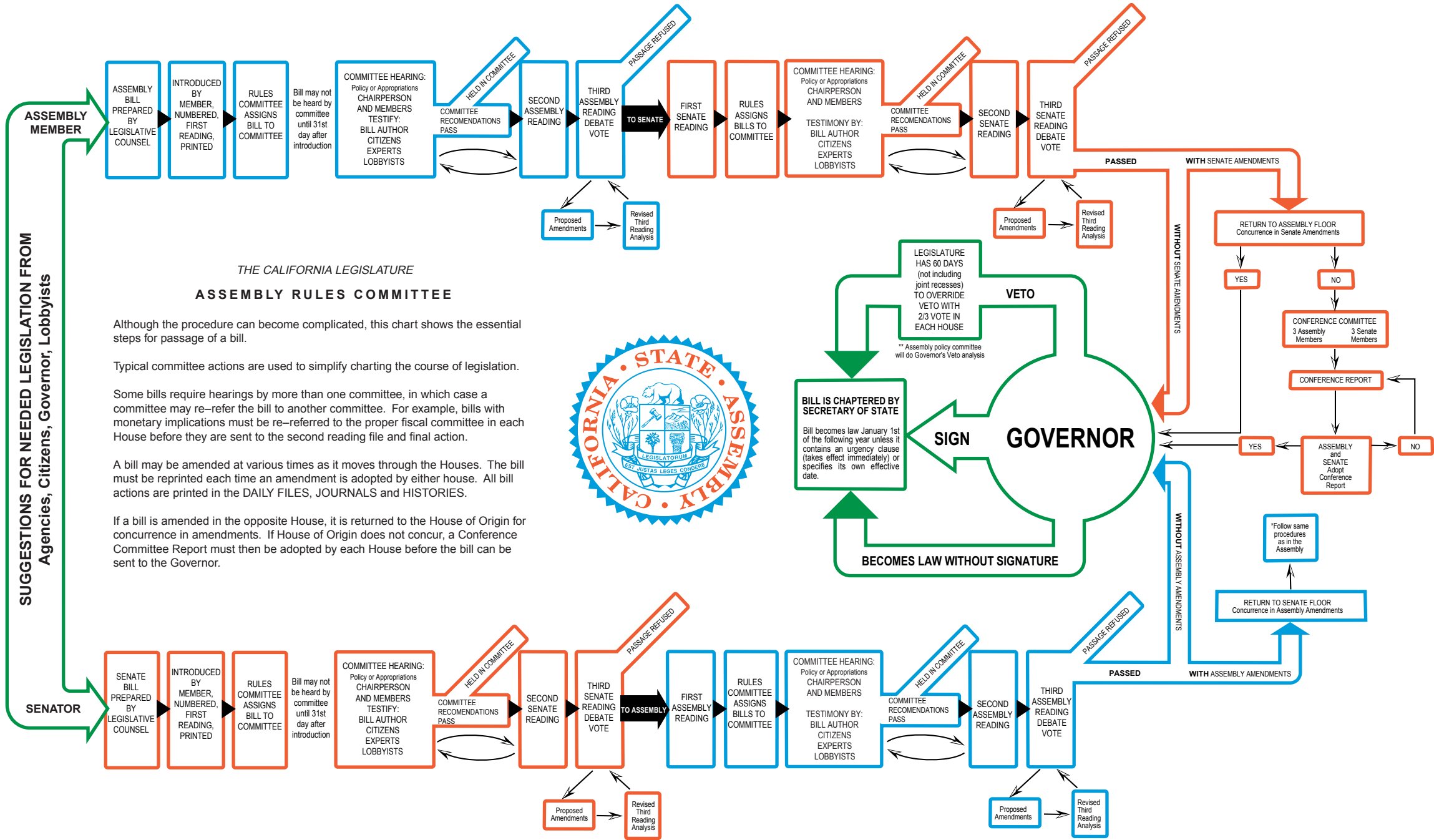
## **California Law**

Bills that are passed by the Legislature and approved by the Governor are assigned a chapter number by the Secretary of State. These Chaptered Bills (also referred to as Statutes of the year they were enacted) then become part of the California Codes. The California Codes are a comprehensive collection of laws grouped by subject matter.

The California Constitution sets forth the fundamental laws by which the State of California is governed. All amendments to the Constitution come about as a result of constitutional amendments presented to the people for their approval.

# THE LIFE CYCLE OF LEGISLATION

*From Idea into Law*





## **Agenda Item 5**

### **Discussion and Possible Action on Legislation**



## MEMORANDUM

<b>DATE</b>	May 2, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 5:</b> Discussion and Possible Action on Legislation

### **Background:**

Board staff is currently tracking a number of bills. Four (4) pertain to military licensing, and seven (7) are related to the Implementation of the Patient Protection and Affordable Care Act otherwise known as Obama Care. These bills are listed for informational purposes only. No discussion or action will be taken.

<b>MILITARY LICENSING</b>			
Bill	Author	Title	Summary
AB 186	Maienschein	Professions and Vocations: Military Spouses: Licenses	Requires a board within the Department of Consumer Affairs to issue a temporary license to an applicant who qualifies for, and requests, expedited licensure if that person is married or in a domestic partnership or legal union with a member of the Armed Forces assigned to a duty station in the state, if he or she meets specified requirements. Authorizes an investigation to see if the person is legally licensed in another jurisdiction, a criminal background check, along with a signed affidavit.
AB 258	Chavez	State Agencies: Veterans	Requires every state agency that requests on any written form or written publication, or through its Internet Web site, whether a person is a veteran, to request that information in a specified manner.
AB 851	Logue	Dentistry: Licensure and Certification Requirements	Requires the Dental Board to accept education, training, and practical experience completed by an applicant in military service toward the qualifications and requirements to receive a license or certificate. Requires certain schools seeking accreditation or approval to have procedures in place to

			evaluate an applicant's military education training and practical experience toward the completion of certain educational programs.
SB 532	DeLeon	Professions and Vocations: Military Spouses	Makes a technical, nonsubstantive change to existing law that requires a board to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation, married to, or in domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in the state.

There are several bills related to the implementation of the **Patient Protection and Affordable Care Act**, often referred to as Obama Care. These bills are listed for informational purposes only. No discussion or action will be taken. A link has been provided under each bill to access additional information.

- ABX1 1(Perez) Medi-Cal Eligibility: Expansion  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320141AB1&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141AB1&search_keywords)
- ABX1 2 (Pan) Health Care Coverage  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320141AB2&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141AB2&search_keywords)
- AB 18 (Pan) Individual Health Coverage  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB18&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB18&search_keywords)
- AB 50 (Pan) Health Care Coverage: Medi-Cal Eligibility  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB50&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB50&search_keywords)
- AB 771 (Jones) Public Health: Wellness Programs  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140AB771&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB771&search_keywords)
- SBX1 1(Hernandez) Med-Cal Eligibility  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320141SB1&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141SB1&search_keywords)
- SBX1 2(Hernandez) Health Care Coverage)  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320141SB2&search\\_keywords](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320141SB2&search_keywords)

The following bills will be presented to the Board for review and consideration:

- AB 291 (Nestande) California Sunset Review Commission
- AB 318 (Logue) Dental Care: telehealth
- AB 496 (Gordon) Medicine: sexual orientation: gender identity
- AB 512 (Rendon) Healing Arts: licensure exemption
- AB 809 (Logue) Healing Arts: telehealth
- AB 827 (Hagman) Department of Consumer Affairs
- AB 836 (Skinner) Dentists: continuing education



- AB 1174 (Bocanegra) Oral Health: virtual dental homes
- AB 1231 (Perez) Regional Centers: telehealth and teledentistry
  
- SB 456 (Padilla) Health Care Coverage
- SB 562 (Galgiani) Dentists: mobile or portable dental units
- SB 690 (Price) Licenses
- SB 809 (DeSaulnier) Controlled Substances: reporting
- SB 821 (B, P & E D) Healing Arts

The Board may take one of the following actions regarding each bill:

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

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 291

**AUTHOR:** Nestande

**SPONSOR:**

**VERSION:** Introduced 02/11/2013

**INTRODUCED:** 02/11/2013

**BILL STATUS:** 02/11/2013 – Introduced.

**BILL LOCATION:** Assembly

**SUBJECT:** California Sunset Review  
Committee

**RELATED  
BILLS:**

**SUMMARY**

Existing law establishes the Joint Sunset Review Committee, a legislative committee comprised of 10 Members of the Legislature, to identify and eliminate waste, duplication, and inefficiency in government agencies and to conduct a comprehensive analysis of every "eligible agency" for which a date for repeal has been established, to determine if the agency is still necessary and cost effective.

Existing law requires each eligible agency scheduled for repeal to submit a report to the committee containing specified information. Existing law requires the committee to take public testimony and evaluate the eligible agency prior to the date the agency is scheduled to be repealed, and requires that an eligible agency be eliminated unless the Legislature enacts a law to extend, consolidate, or reorganize the agency.

Existing law also requires the committee to review eligible agencies and evaluate and determine whether each has demonstrated a public need for its continued existence and to submit a report to the Legislature detailing whether an agency should be terminated, continued, or whether its functions should be modified.

This bill would:

- ❖ Abolish the Joint Sunset Review Committee on January 1 or an unspecified year and establish the California Sunset Review Commission within the executive branch to assess the continuing need for any agency, as defined, to exist. The commission would consist of 10 members, with 8 members appointed by the Governor and 2 Members of the Legislature each appointed by the Senate Committee on Rules and the Speaker of the Assembly, subject to specified terms. The commission would be under the direction of a director appointed by the commission members. The bill would require the commission to meet

regularly and to work with each agency subject to review to evaluate the need for the agency to exist, identify required statutory, regulatory, or management changes, and develop legislative proposals to enact those changes.

- ❖ The bill would require the commission to prepare a report, containing legislative recommendations based on its agency review, to be submitted to the Legislature and would also require the commission to meet certain cost-savings standards within 5 years.
- ❖ This bill would require an agency to submit a specified self-evaluation report to the commission prior to its review. The bill would require the Legislative Analyst's Office to provide the commission with an estimate of the staffing needed to perform the commission's work.

### **ANALYSIS**

This bill abolishes the Joint Sunset Review Committee and establishes the California Sunset Review Commission within the executive branch to assess the continuing need for any agency to exist. This bill will have minor, if any impact to the Dental Board.

### **REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

### **STAFF RECOMMENDATION**

Watch.

### **BOARD POSITION**

SUPPORT: \_\_\_\_ OPPOSE: \_\_\_\_ NEUTRAL: \_\_\_\_ WATCH: \_\_\_\_

**ASSEMBLY BILL**

**No. 291**

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**Introduced by Assembly Member Nestande**

February 11, 2013

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An act to amend and repeal Sections 9147.7, 9148.50, 9148.51, and 9148.52 of, to amend, repeal, and add Section 9148.8 of, and to add Article 7.6 (commencing with Section 9147.9) to Chapter 1.5 of Part 1 of Division 2 of Title 2 of, the Government Code, relating to state government.

LEGISLATIVE COUNSEL’S DIGEST

AB 291, as introduced, Nestande. California Sunset Review Commission.

Existing law establishes the Joint Sunset Review Committee, a legislative committee comprised of 10 Members of the Legislature, to identify and eliminate waste, duplication, and inefficiency in government agencies and to conduct a comprehensive analysis of every “eligible agency” for which a date for repeal has been established, to determine if the agency is still necessary and cost effective. Existing law requires each eligible agency scheduled for repeal to submit a report to the committee containing specified information. Existing law requires the committee to take public testimony and evaluate the eligible agency prior to the date the agency is scheduled to be repealed, and requires that an eligible agency be eliminated unless the Legislature enacts a law to extend, consolidate, or reorganize the agency. Existing law also requires the committee to review eligible agencies and evaluate and determine whether each has demonstrated a public need for its continued existence and to submit a report to the Legislature detailing whether an

agency should be terminated, continued, or whether its functions should be modified.

This bill would abolish the Joint Sunset Review Committee on January 1 or an unspecified year. The bill would, commencing on that same January 1, establish the California Sunset Review Commission within the executive branch to assess the continuing need for any agency, as defined, to exist. The commission would consist of 10 members, with 8 members appointed by the Governor and 2 Members of the Legislature each appointed by the Senate Committee on Rules and the Speaker of the Assembly, subject to specified terms. The commission would be under the direction of a director appointed by the commission members. The bill would require the commission to meet regularly and to work with each agency subject to review to evaluate the need for the agency to exist, identify required statutory, regulatory, or management changes, and develop legislative proposals to enact those changes. The bill would require the commission to prepare a report, containing legislative recommendations based on its agency review, to be submitted to the Legislature and would also require the commission to meet certain cost-savings standards within 5 years.

This bill would require an agency to submit a specified self-evaluation report to the commission prior to its review. The bill would require the Legislative Analyst's Office to provide the commission with an estimate of the staffing needed to perform the commission's work.

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

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

- 1 SECTION 1. Section 9147.7 of the Government Code is
- 2 amended to read:
- 3 9147.7. (a) For the purpose of this section, "eligible agency"
- 4 means any agency, authority, board, bureau, commission,
- 5 conservancy, council, department, division, or office of state
- 6 government, however denominated, excluding an agency that is
- 7 constitutionally created or an agency related to postsecondary
- 8 education, for which a date for repeal has been established by
- 9 statute on or after January 1, 2011.
- 10 (b) The Joint Sunset Review Committee is hereby created to
- 11 identify and eliminate waste, duplication, and inefficiency in
- 12 government agencies. The purpose of the committee is to conduct

1 a comprehensive analysis over 15 years, and on a periodic basis  
2 thereafter, of every eligible agency to determine if the agency is  
3 still necessary and cost effective.

4 (c) Each eligible agency scheduled for repeal shall submit to  
5 the committee, on or before December 1 prior to the year it is set  
6 to be repealed, a complete agency report covering the entire period  
7 since last reviewed, including, but not limited to, the following:

8 (1) The purpose and necessity of the agency.

9 (2) A description of the agency budget, priorities, and job  
10 descriptions of employees of the agency.

11 (3) Any programs and projects under the direction of the agency.

12 (4) Measures of the success or failures of the agency and  
13 justifications for the metrics used to evaluate successes and failures.

14 (5) Any recommendations of the agency for changes or  
15 reorganization in order to better fulfill its purpose.

16 (d) The committee shall take public testimony and evaluate the  
17 eligible agency prior to the date the agency is scheduled to be  
18 repealed. An eligible agency shall be eliminated unless the  
19 Legislature enacts a law to extend, consolidate, or reorganize the  
20 eligible agency. No eligible agency shall be extended in perpetuity  
21 unless specifically exempted from the provisions of this section.  
22 The committee may recommend that the Legislature extend the  
23 statutory sunset date for no more than one year to allow the  
24 committee more time to evaluate the eligible agency.

25 (e) The committee shall be comprised of 10 members of the  
26 Legislature. The Senate Committee on Rules shall appoint five  
27 members of the Senate to the committee, not more than three of  
28 whom shall be members of the same political party. The Speaker  
29 of the Assembly shall appoint five members of the Assembly to  
30 the committee, not more than three of whom shall be members of  
31 the same political party. Members shall be appointed within 15  
32 days after the commencement of the regular session. Each member  
33 of the committee who is appointed by the Senate Committee on  
34 Rules or the Speaker of the Assembly shall serve during that  
35 committee member's term of office or until that committee member  
36 no longer is a Member of the Senate or the Assembly, whichever  
37 is applicable. A vacancy on the committee shall be filled in the  
38 same manner as the original appointment. Three Assembly  
39 Members and three Senators who are members of the committee  
40 shall constitute a quorum for the conduct of committee business.

1 Members of the committee shall receive no compensation for their  
2 work with the committee.

3 (f) The committee shall meet not later than 30 days after the  
4 first day of the regular session to choose a chairperson and to  
5 establish the schedule for eligible agency review provided for in  
6 the statutes governing the eligible agencies. The chairperson of  
7 the committee shall alternate every two years between a Member  
8 of the Senate and a Member of the Assembly, and the vice  
9 chairperson of the committee shall be a member of the opposite  
10 house as the chairperson.

11 (g) This section shall not be construed to change the existing  
12 jurisdiction of the budget or policy committees of the Legislature.

13 (h) *This section shall remain in effect only until January 1, 20\_\_,*  
14 *and as of that date is repealed, unless a later enacted statute, that*  
15 *is enacted before January 1, 20\_\_, deletes or extends that date.*

16 SEC. 2. Article 7.6 (commencing with Section 9147.9) is added  
17 to Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government  
18 Code, to read:

19  
20 Article 7.6. California Sunset Review Commission  
21

22 9147.9. This article may be cited as the California Sunset  
23 Review Commission Act.

24 9147.11. For the purpose of this section, the following  
25 definitions shall apply:

26 (a) "Agency" means any agency, authority, board, bureau,  
27 commission, conservancy, council, department, division, or office  
28 of state government, however denominated, excluding an agency  
29 that is constitutionally created or an agency related to  
30 postsecondary education.

31 (b) "Commission" means the California Sunset Review  
32 Commission.

33 (c) "Act" means the California Sunset Review Commission Act.

34 9147.13. The California Sunset Review Commission is hereby  
35 created within the executive branch of state government. The  
36 commission shall be located in Sacramento.

37 9147.15. (a) The commission shall consist of 10 members.

38 (1) The Governor shall appoint 8 members to serve a term of  
39 four years.

1 (2) The Senate Committee on Rules shall appoint one Member  
2 of the Senate to serve a term of two years or until that Member is  
3 no longer a Member of the Senate, whichever is applicable.

4 (3) The Speaker of the Assembly shall appoint one Member of  
5 the Assembly to serve a term of two years or until that Member is  
6 no longer a Member of the Assembly, whichever is applicable.

7 (b) The commission shall appoint a chairperson from its  
8 members appointed pursuant to paragraph (1).

9 (c) The Members of the Legislature appointed to the commission  
10 shall serve at the pleasure of the appointing power and shall  
11 participate in the activities of the commission to the extent that  
12 the participation is not incompatible with their respective positions  
13 as Members of the Legislature.

14 (d) A vacancy on the commission shall be filled in the same  
15 manner as the original appointment.

16 (e) (1) The members of the commission shall serve without  
17 compensation, except that each member appointed by the Governor  
18 shall receive fifty dollars (\$50) for each day's attendance at a  
19 meeting of the commission.

20 (2) Each member shall be allowed actual expenses incurred in  
21 the discharge of his or her duties, including travel expenses.

22 9147.17. (a) The commission shall be under the direction of  
23 a director appointed by the commission members.

24 (b) The director shall employ sufficient staff to carry out the  
25 commission's responsibilities.

26 (c) The Legislative Analyst's Office shall estimate the staffing  
27 needed to manage the workload of the commission.

28 9147.19. (a) The commission shall serve in an advisory  
29 capacity and shall meet regularly to assess and review the  
30 continuing need for an agency to exist.

31 (b) Prior to the commission's review of an agency, the  
32 commission staff shall work with each agency to evaluate the need  
33 for the agency to exist, identify required statutory, regulatory, or  
34 management changes, and develop recommendation for legislative  
35 proposals to enact those changes. The commission shall also  
36 consult with interest groups, affected agencies, and other interested  
37 parties in reviewing an agency.

38 (c) In carrying out its duties pursuant to this section, the  
39 commission shall evaluate an agency pursuant to the following  
40 criteria, as applicable:



- 1 (1) The efficiency and effectiveness of the agency's operations.
- 2 (2) Whether the agency has been successful in achieving its
- 3 mission, goals, and objectives.
- 4 (3) Whether the agency performs duties that are not statutorily
- 5 authorized and, if so, identify the authority for those activities and
- 6 whether those activities are needed.
- 7 (4) Whether the agency has any authority related to fees,
- 8 inspections, enforcement, and penalties.
- 9 (5) Whether the agency's functions and operations could be less
- 10 burdensome or restrictive while still serving the public.
- 11 (6) Whether the functions of the agency could be effectively
- 12 consolidated or merged with another agency to promote efficiency
- 13 in government.
- 14 (7) Whether the agency's programs and jurisdiction duplicate
- 15 those of other state agencies.
- 16 (8) Whether the agency promptly and effectively addresses
- 17 complaints.
- 18 (9) Whether the agency utilizes public participation for
- 19 rulemaking and decisions and, if so, whether it is done in an
- 20 effective manner.
- 21 (10) Whether the agency complied with federal and state
- 22 requirements regarding equal employment, privacy rights, and
- 23 purchasing guidelines for underutilized businesses.
- 24 (11) Whether the agency effectively enforces rules regarding
- 25 the potential conflicts of interest of its employees.
- 26 (12) Whether abolishing the agency would cause federal
- 27 government intervention or loss of federal funds.
- 28 (13) Whether the agency's statutory reporting requirements
- 29 effectively fulfill a useful purpose; and whether there are reporting
- 30 requirements of this agency that are duplicative of other agencies
- 31 or can effectively be combined or consolidated into another agency
- 32 that has similar requirements.
- 33 (d) The commission shall take public testimony from agency
- 34 staff, interest groups, and affected parties relating to whether an
- 35 agency should continue in existence.
- 36 (e) (1) The commission shall prepare a staff report to be
- 37 submitted to the Legislature. The report shall include, but not be
- 38 limited to, specific recommendations to the Legislature to enact
- 39 legislation to do the following:

1 (A) Repeal unnecessary, outdated, or unnecessary statutes,  
2 regulations, and programs.

3 (B) Develop reorganization plans that abolish and streamline  
4 existing agencies, if needed.

5 (2) A report to the Legislature pursuant to this section shall be  
6 submitted in compliance with Section 9795.

7 (3) This subdivision shall become inoperative on January 1,  
8 2018, pursuant to Section 10231.5

9 9147.21. Prior to review by the commission, an agency shall  
10 submit a self-evaluation report to the commission. The report shall  
11 include, but not be limited to, the criteria described in subdivision  
12 (c) of Section 9147.19.

13 9147.23. In order to ensure accountability, the commission  
14 shall demonstrate a 5-to-1 cost savings within the first five years  
15 of sunset review hearings, and every five years thereafter. For  
16 every dollar it costs to run the commission, five dollars (\$5) shall  
17 be saved in streamlining the government process and eliminating  
18 unnecessary agencies.

19 9147.25. This article shall become operative on January 1,  
20 20\_\_.

21 SEC. 3. Section 9148.8 of the Government Code is amended  
22 to read:

23 9148.8. (a) The appropriate policy committee of the Legislature  
24 may evaluate a plan prepared pursuant to Section 9148.4 or 9148.6.  
25 The chairperson of a policy committee may alternatively require  
26 that the Joint Sunset Review Committee evaluate and provide  
27 recommendations on any plan prepared pursuant to Section 9148.4  
28 or 9148.6, or any other legislative issue or proposal to create a new  
29 state board.

30 (b) The Joint Sunset Review Committee shall provide to the  
31 respective policy and fiscal committees of the Legislature any  
32 evaluation and recommendations prepared pursuant to this section.

33 (c) If an appropriate policy committee does not evaluate a plan  
34 prepared pursuant to Section 9148.6, then the Joint Sunset Review  
35 Committee shall evaluate the plan and provide recommendations  
36 to the Legislature.

37 (d) *This section shall remain in effect only until January 1, 20\_\_,*  
38 *and as of that date is repealed, unless a later enacted statute, that*  
39 *is enacted before January 1, 20\_\_, deletes or extends that date.*

1 SEC. 4. Section 9148.8 is added to the Government Code, to  
2 read:

3 9148.8. (a) The appropriate policy committee of the Legislature  
4 may evaluate a plan prepared pursuant to Section 9148.4 or 9148.6.  
5 The chairperson of a policy committee may alternatively require  
6 that the California Sunset Review Commission evaluate and  
7 provide recommendations on any plan prepared pursuant to Section  
8 9148.4 or 9148.6, or any other legislative issue or proposal to  
9 create a new state board.

10 (b) The California Sunset Review Commission shall provide to  
11 the respective policy and fiscal committees of the Legislature any  
12 evaluation and recommendations prepared pursuant to this section.

13 (c) If an appropriate policy committee does not evaluate a plan  
14 prepared pursuant to Section 9148.6, then the California Sunset  
15 Review Commission shall evaluate the plan and provide  
16 recommendations to the Legislature.

17 This section shall become operative on January 1, 20\_\_.

18 SEC. 5. Section 9148.50 of the Government Code is amended  
19 to read:

20 9148.50. The Legislature finds and declares all of the following:

21 (a) California's multilevel, complex governmental structure  
22 today contains more than 400 categories of administrative or  
23 regulatory boards, commissions, committees, councils, associations,  
24 and authorities.

25 (b) These administrative or regulatory boards, commissions,  
26 committees, councils, associations, and authorities have been  
27 established without any method of periodically reviewing their  
28 necessity, effectiveness, or utility.

29 (c) As a result, the Legislature and residents of California cannot  
30 be assured that existing or proposed administrative or regulatory  
31 boards, commissions, committees, councils, associations, and  
32 authorities adequately protect the public health, safety, and welfare.

33 (d) *This section shall remain in effect only until January 1, 20\_\_,*  
34 *and as of that date is repealed, unless a later enacted statute, that*  
35 *is enacted before January 1, 20\_\_, deletes or extends that date.*

36 SEC. 6. Section 9148.51 of the Government Code is amended  
37 to read:

38 9148.51. (a) It is the intent of the Legislature that all existing  
39 and proposed eligible agencies, as defined in subdivision (a) of  
40 Section 9147.7, be subject to review to evaluate and determine

1 whether each has demonstrated a public need for its continued  
2 existence in accordance with enumerated factors and standards as  
3 set forth in Article 7.5 (commencing with Section 9147.7).

4 (b) If any state board becomes inoperative or is repealed in  
5 accordance with the act that added this section, any provision of  
6 existing law that provides for the appointment of board members  
7 and specifies the qualifications and tenure of board members shall  
8 not be implemented and shall have no force or effect while that  
9 state board is inoperative or repealed.

10 (c) Any provision of law authorizing the appointment of an  
11 executive officer by a state board subject to the review described  
12 in Article 7.5 (commencing with Section 9147.7), or prescribing  
13 his or her duties, shall not be implemented and shall have no force  
14 or effect while the applicable state board is inoperative or repealed.

15 *(d) This section shall remain in effect only until January 1, 20\_\_,*  
16 *and as of that date is repealed, unless a later enacted statute, that*  
17 *is enacted before January 1, 20\_\_, deletes or extends that date.*

18 SEC. 7. Section 9148.52 of the Government Code is amended  
19 to read:

20 9148.52. (a) The Joint Sunset Review Committee established  
21 pursuant to Section 9147.7 shall review all eligible agencies.

22 (b) The committee shall evaluate and make determinations  
23 pursuant to Article 7.5 (commencing with Section 9147.7).

24 (c) Pursuant to an evaluation made as specified in this section,  
25 the committee shall make a report which shall be available to the  
26 public and the Legislature on whether an agency should be  
27 terminated, or continued, or whether its functions should be revised  
28 or consolidated with those of another agency, and include any  
29 other recommendations as necessary to improve the effectiveness  
30 and efficiency of the agency. If the committee deems it advisable,  
31 the report may include proposed legislative proposals that would  
32 carry out its recommendations.

33 *(d) This section shall remain in effect only until January 1, 20\_\_,*  
34 *and as of that date is repealed, unless a later enacted statute, that*  
35 *is enacted before January 1, 20\_\_, deletes or extends that date.*

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 318

**AUTHOR:** Assembly Member Logue

**SPONSOR:**

**VERSION:** 3/19/13 – Amended in  
Assembly

**INTRODUCED:** 02/12/2013

**BILL STATUS:** 4/9/13 In committee: Set, first  
hearing. Hearing canceled at  
the request of the author

**BILL LOCATION:** Assembly

**SUBJECT:** Medi-cal: teledentistry

**RELATED  
BILLS:**

AB 415 (Logue,  
Chapter 547,  
Statutes of 2011)

**SUMMARY**

The Dental Practice Act (Act) provides for the licensure and regulation by the Dental Board of California of those engaged in the practice of dentistry.

This bill would add Section 14132.726 to the Welfare and Institutions Code, relating to Medi-Cal.

**ANALYSIS**

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

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

Medi-Cal. The bill would also require, on or before January 1, 2017, the department to report to the Legislature the number and type of services provided, and the payments made related to the application of teledentistry, as specified.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**STAFF RECOMMENDATION**

Watch

**BOARD POSITION**

SUPPORT: \_\_\_\_ OPPOSE: \_\_\_\_ NEUTRAL: \_\_\_\_ WATCH: \_\_\_\_

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

## ASSEMBLY BILL

No. 318

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### Introduced by Assembly Member Logue

February 12, 2013

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An act to add Section 14132.726 to the Welfare and Institutions Code, relating to ~~dental care~~ Medi-Cal.

#### LEGISLATIVE COUNSEL'S DIGEST

AB 318, as amended, Logue. ~~Dental care; telehealth. Medi-Cal; teledentistry.~~

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

*This bill would enact similar provisions relating to the use of teledentistry, as defined, under the Medi-Cal program. The bill would provide that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for “teledentistry by store and forward.” The bill would define that term to mean an asynchronous transmission of dental information to be*

*reviewed at a later time by a licensed dentist at a distant site, where the dentist at the distant site reviews the dental information without the patient being present in real time, as defined and as specified. The bill would also provide that dentist participation in services provided at an intermittent clinic, as defined, through the use of telehealth, as defined, shall be considered a billable encounter under Medi-Cal. The bill would also require, on or before January 1, 2017, the department to report to the Legislature the number and type of services provided, and the payments made related to the application of teledentistry, as specified.*

~~Existing law, the Dental Practice Act, provides for the licensure and regulation by the Dental Board of California of those engaged in the practice of dentistry. Existing law provides that a person practices dentistry if the person, among other things, manages or conducts as manager, proprietor, conductor, lessor, or otherwise, in any place where dental operations are performed.~~

~~This bill would declare the intent of the Legislature to enact legislation that would promote the advancement of telehealth in dental care.~~

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

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

- 1     *SECTION 1. Section 14132.726 is added to the Welfare and*
- 2     *Institutions Code, to read:*
- 3     *14132.726. (a) To the extent that federal financial participation*
- 4     *is available, face-to-face contact between a health care provider*
- 5     *and a patient shall not be required under the Medi-Cal program*
- 6     *for teledentistry by store and forward. Services appropriately*
- 7     *provided through the store and forward process are subject to*
- 8     *billing and reimbursement policies developed by the department.*
- 9     *(b) A patient receiving teledentistry by store and forward shall*
- 10    *be notified of the right to receive interactive communication with*
- 11    *the distant dentist, and shall receive an interactive communication*
- 12    *with the distant dentist, upon request. If requested, communication*
- 13    *with the distant dentist may occur either at the time of the*
- 14    *consultation, or within 30 days of the patient's notification of the*
- 15    *results of the consultation.*
- 16    *(c) Dentist participation in services provided at an intermittent*
- 17    *clinic, as defined in Section 1206 of the Health and Safety Code,*
- 18    *through the use of telehealth, as defined in Section 2290.5 of the*



1 *Business and Professions Code, shall be considered a billable*  
2 *encounter under Medi-Cal.*

3 *(d) Notwithstanding Chapter 3.5 (commencing with Section*  
4 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*  
5 *the department may implement, interpret, and make specific this*  
6 *section by means of all-county letters, provider bulletins, and*  
7 *similar instructions.*

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

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

13 *(1) "Asynchronous store and forward" means the transmission*  
14 *of a patient's dental information from an originating site to the*  
15 *health care provider at a distant site without the presence of the*  
16 *patient.*

17 *(2) "Distant site" means a site where a health care provider*  
18 *who provides health care services is located while providing these*  
19 *services via a telecommunications system.*

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

23 *(4) "Originating site" means a site where a patient is located*  
24 *at the time health care services are provided via a*  
25 *telecommunications system or where the asynchronous store and*  
26 *forward service originates.*

27 *(5) "Synchronous interaction" means a real-time interaction*  
28 *between a patient and a health care provider located at a distant*  
29 *site.*

30 *(6) "Teledentistry" means the mode of delivering dental health*  
31 *care services and public dental health via information and*  
32 *communication technologies to facilitate the diagnosis,*  
33 *consultation, treatment, education, care management, and*  
34 *self-management of a patient's dental health care while the patient*  
35 *is at the originating site and the dental health care provider is at*  
36 *a distant site. Teledentistry includes synchronous interactions and*  
37 *asynchronous store and forward transfers.*

38 *(7) "Teledentistry by store and forward" means an*  
39 *asynchronous transmission of dental information to be reviewed*  
40 *at a later time by a licensed dentist at a distant site, where the*

- 1 *dentist at the distant site reviews the dental information without*
- 2 *the patient being present in real time.*
- 3 ~~SECTION 1. It is the intent of the Legislature to enact~~
- 4 ~~legislation to promote the advancement of telehealth in dental care.~~

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 496

**AUTHOR:** Gordon

**SPONSOR:** Equality California

**VERSION:** 4/10/2013, amended

**INTRODUCED:** 2/22/2013

**BILL STATUS:** Assembly Appropriations  
Committee

**BILL LOCATION:** Assembly

**SUBJECT:** Medicine: Sexual Orientation,  
Gender Identity, and Gender  
Expression

**RELATED  
BILLS:**

**SUMMARY**

This bill reestablishes and expands the Task Force on Culturally and Linguistically Competent Physicians and Dentists to consider the needs of lesbian, gay, bisexual and transgender groups (LGBT) and report findings to the legislature by January 1, 2016.

Specifically this bill would;

- Reestablish the task force to consist of the Deputy Director of the Office of Health Equity or his or her designee and the Director of the Department of Consumer Affairs or his or her designee to serve as co-chairs; the Executive Director of the Medical Board of California or his or her designees; the Executive Officer of the Dental Board of California or his or her designee; one member appointed by the Senate; and one member appointed by the Assembly. This bill would also allow additional members to be appointed by the Director of DCA, in consultation with the Office of Health Equality;
- Require the Task Force to hold hearings and convene meetings to obtain input from persons belonging to LGBT groups in communities that have large populations of LGBT groups;
- Specify the duties of the Task Force to be the same as before: to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to meet linguistic competence; to identify key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices; and to assess the need for voluntary certification standards and examinations for cultural competency;

- Require the Board and the Medical Board of California to pay for the administrative costs associated with the implementation of the Task Force, the hearings, and the final report to the legislature;
- Amend the Cultural and Linguistic Competency of Physicians Act of 2003 operated by the local medical societies of the California Medical Association and monitored by the Medical Board of California;
- This bill would define “cultural and linguistic competency” to include understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care.

## **ANALYSIS**

Although DCA, the Board, and the Medical Board already convened and participated in the Task Force on Culturally and Linguistically Competent Physicians and Dentists, LGBT issues were not addressed at the Task Force, the hearings, or in the final report to the Legislature.

The Board’s Executive Officer or his or her designee would be required to participate in the reauthorized Task Force and the Board would be partially responsible for the costs associated with the Task Force, hearings, and the report to the Legislature. These costs are expected to amount to \$55,000 (50/50 split with the Medical Board of California).

## **REGISTERED SUPPORT/OPPOSITION (As of 4/15/13)**

Support:

- Equality California (sponsor)
- AIDS Legal Referral Panel
- API Equality - Northern California
- Asian & Pacific Islander American Health Forum
- Asian American Center for Advancing Justice
- Asian Americans for Civil Rights and Equality
- Asian Law Caucus
- Black AIDS Institute
- California Communities United Institute
- California Immigrant Policy Center
- California Pan-Ethnic Health Network
- Gay Asian Pacific Alliance
- LMA: Health Professionals Advancing LGBT Equity
- Greenlining Institute

- L.A. Gay and Lesbian Center
- Latino Equality Alliance
- National Asian Pacific American Women's Forum
- National Association of Social Workers, California Chapter
- National Center for Lesbian Rights
- Our Family Coalition
- Planned Parenthood Affiliates of California
- San Diego LGBT Community Center
- San Francisco HIV Health Services Planning Council
- Trevor Project
- 61 private individuals

Opposition:

None on file.

### **STAFF RECOMMENDATION**

Watch until determined whether or not Board can absorb costs associated with this bill.

### **BOARD POSITION**

**SUPPORT:** \_\_\_\_ **OPPOSE:** \_\_\_\_ **NEUTRAL:** \_\_\_\_ **WATCH:** \_\_\_\_

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 2, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

## ASSEMBLY BILL

**No. 496**

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**Introduced by Assembly Member Gordon**

February 20, 2013

---

An act to amend Sections 852, 2198, and 2198.1 of the Business and Professions Code, relating to medicine.

### LEGISLATIVE COUNSEL'S DIGEST

AB 496, as amended, Gordon. Medicine: sexual orientation, gender identity, and gender expression.

Existing law creates the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the Director of Health Care Services and the Director of Consumer Affairs to serve as cochairs of the task force. *Existing law requires that the task force consist of, among other people, the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California.* Existing law *additionally* requires the Director of Consumer Affairs, in consultation with the Director of Health Care Services, to appoint as task force members, among other people, California licensed physicians and dentists ~~that~~ *who* provide health services to members of language and ethnic minority groups and representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups. Existing law required the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2003.

This bill would replace the Director of Health Care Services with the Deputy Director of the Office of Health Equity, *or his or her designee*, as cochair of the task force. The bill would also instead require the appointment of members to be made in consultation with the Office of Health Equity. *The bill would authorize a designee of the Director of Consumer Affairs to serve as cochair of the task force and would authorize designees of the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California to serve as task force members.* The bill would require the licensed task force members and advocate task force members to ~~provide~~ *be providers* of health services to, or ~~advocate~~ *advocates* on behalf of, members of language and ethnic minority groups as well as lesbian, gay, bisexual, and transgender groups. The bill would require the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016.

Existing law, the Cultural and Linguistic Competency of Physicians Act of 2003, establishes the cultural and linguistic physician competency program which is operated by local medical societies of the California Medical Association and is monitored by the Medical Board of California. That voluntary program consists of educational classes for all interested physicians and is designed to teach foreign language and cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California. Existing law also defines “cultural and linguistic competency” for the purposes of those provisions as meaning cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care, and awareness of how the attitudes, values, and beliefs of health care providers and patients influence and impact professional and patient relations.

This bill would additionally require the program to address lesbian, gay, bisexual, and transgender groups of interest to local medical societies. The bill would require the training programs to be formulated in collaboration with California-based lesbian, gay, bisexual, and transgender medical societies. The bill would also redefine the term “cultural and linguistic competency” as understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care,

and awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations. The bill would also make related technical, nonsubstantive changes.

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

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

1 SECTION 1. Section 852 of the Business and Professions Code  
2 is amended to read:

3 852. (a) The Task Force on Culturally and Linguistically  
4 Competent Physicians and Dentists is hereby created and shall  
5 consist of the following members:

6 (1) The Deputy Director of the Office of Health Equity, *or his*  
7 *or her designee*, and the Director of Consumer Affairs, *or his or*  
8 *her designee*, who shall serve as cochairs of the task force.

9 (2) The Executive Director of the Medical Board of California,  
10 *or his or her designee*.

11 (3) The Executive Director of the Dental Board of California,  
12 *or his or her designee*.

13 (4) One member appointed by the Senate Committee on Rules.

14 (5) One member appointed by the Speaker of the Assembly.

15 (b) Additional task force members shall be appointed by the  
16 Director of Consumer Affairs, in consultation with the Office of  
17 Health Equity, as follows:

18 (1) Representatives of organizations that advocate on behalf of  
19 California licensed physicians and dentists.

20 (2) California licensed physicians and dentists ~~that~~ *who* provide  
21 health services to members of language and ethnic minority groups,  
22 as well as lesbian, gay, bisexual, and transgender groups.

23 (3) Representatives of organizations that advocate on behalf of,  
24 or provide health services to, members of language and ethnic  
25 minority groups, as well as lesbian, gay, bisexual, and transgender  
26 groups.

27 (4) Representatives of entities that offer continuing education  
28 for physicians and dentists.

29 (5) Representatives of California's medical and dental schools.

30 (6) Individuals with experience in developing, implementing,  
31 monitoring, and evaluating cultural and linguistic programs.



1 (c) The duties of the task force shall include the following:

2 (1) Developing recommendations for a continuing education  
3 program that includes language proficiency standards of foreign  
4 language to be acquired to meet linguistic competency.

5 (2) Identifying the key cultural elements necessary to meet  
6 cultural competency by physicians, dentists, and their offices.

7 (3) Assessing the need for voluntary certification standards and  
8 examinations for cultural and linguistic competency.

9 (d) The task force shall hold hearings and convene meetings to  
10 obtain input from persons belonging to language and ethnic  
11 minority groups, as well as lesbian, gay, bisexual, and transgender  
12 groups, to determine their needs and preferences for having  
13 culturally competent medical providers. These hearings and  
14 meetings shall be convened in communities that have large  
15 populations of language and ethnic minority groups, as well as  
16 lesbian, gay, bisexual, and transgender groups.

17 (e) The task force shall report its findings to the Legislature and  
18 appropriate licensing boards on or before January 1, 2016.

19 (f) The Medical Board of California and the Dental Board of  
20 California shall pay the state administrative costs of implementing  
21 this section.

22 (g) Nothing in this section shall be construed to require  
23 mandatory continuing education of physicians and dentists.

24 SEC. 2. Section 2198 of the Business and Professions Code is  
25 amended to read:

26 2198. (a) This article shall be known and may be cited as the  
27 Cultural and Linguistic Competency of Physicians Act of 2003.  
28 The cultural and linguistic physician competency program is hereby  
29 established and shall be operated by local medical societies of the  
30 California Medical Association and shall be monitored by the  
31 Medical Board of California.

32 (b) This program shall be a voluntary program for all interested  
33 physicians. As a primary objective, the program shall consist of  
34 educational classes which shall be designed to teach physicians  
35 the following:

36 (1) A foreign language at the level of proficiency that initially  
37 improves their ability to communicate with non-English speaking  
38 patients.

1 (2) A foreign language at the level of proficiency that eventually  
2 enables direct communication with the non-English speaking  
3 patients.

4 (3) Cultural beliefs and practices that may impact patient health  
5 care practices and allow physicians to incorporate this knowledge  
6 in the diagnosis and treatment of patients who are not from the  
7 predominate culture in California.

8 (c) The program shall operate through local medical societies  
9 and shall be developed to address the ethnic language minority  
10 groups, as well as lesbian, gay, bisexual, and transgender groups,  
11 of interest to local medical societies.

12 (d) In dealing with Spanish language and cultural practices of  
13 Mexican immigrant communities, the cultural and linguistic  
14 training program shall be developed with direct input from  
15 physician groups in Mexico who serve the same immigrant  
16 population in Mexico. A similar approach may be used for any of  
17 the languages and cultures that are taught by the program or  
18 appropriate ethnic medical societies may be consulted for the  
19 development of these programs.

20 (e) Training programs shall be based and developed on the  
21 established knowledge of providers already serving target  
22 populations and shall be formulated in collaboration with the  
23 California Medical Association, the Medical Board of California,  
24 and other California-based ethnic medical societies, as well as  
25 lesbian, gay, bisexual, and transgender medical societies.

26 (f) Programs shall include standards that identify the degree of  
27 competency for participants who successfully complete  
28 independent parts of the course of instruction.

29 (g) Programs shall seek accreditation by the Accreditation  
30 Council for Continuing Medical Education.

31 (h) The Medical Board of California shall convene a workgroup  
32 including, but not limited to, representatives of affected patient  
33 populations, medical societies engaged in program delivery, and  
34 community clinics to perform the following functions:

35 (1) Evaluation of the progress made in the achievement of the  
36 intent of this article.

37 (2) Determination of the means by which achievement of the  
38 intent of this article can be enhanced.

39 (3) Evaluation of the reasonableness and the consistency of the  
40 standards developed by those entities delivering the program.

(4) Determination and recommendation of the credit to be given to participants who successfully complete the identified programs. Factors to be considered in this determination shall include, at a minimum, compliance with requirements for continuing medical education and eligibility for increased rates of reimbursement under Medi-Cal, the Healthy Families Program, and health maintenance organization contracts.

(i) Funding shall be provided by fees charged to physicians who elect to take these educational classes and any other funds that local medical societies may secure for this purpose.

(j) A survey for language minority patients shall be developed and distributed by local medical societies, to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided under this section. Local medical societies shall also develop an evaluation survey for physicians to assess the quality of educational or training programs on cultural and linguistic competency. This information shall be shared with the workgroup established by the Medical Board of California.

SEC. 3. Section 2198.1 of the Business and Professions Code is amended to read:

2198.1. For purposes of this article, “cultural and linguistic competency” means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including, but not limited to, the following:

(a) Direct communication in the patient-client primary language.

(b) Understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care.

(c) Awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 512

**AUTHOR:** Rendon

**SPONSOR:**

**VERSION:** Introduced 02/20/2013

**INTRODUCED:** 02/20/2013

**BILL STATUS:** 02/20/2013 – Introduced.

**BILL LOCATION:** Senate

**SUBJECT:** Healing Arts: Licensure  
Exemption

**RELATED  
BILLS:** AB 2699 (Bass,  
Chapter 270,  
Statutes of 2010)

**SUMMARY**

Existing law provides for the licensure and regulation of various healing arts practitioners by the Department of Consumer Affairs (Department). Existing law, Business and Professions Code Section 901, provides an exemption for a health care practitioner, licensed or certified in another state, from the licensing and regulatory requirements of the applicable California healing arts board. To be exempted from California licensure requirements, a health care practitioner must provide services at a sponsored healthcare event to uninsured or underinsured people on a short-term, voluntary basis. Section 901 requires the out-of-state health care practitioner to seek authorization from the applicable healing arts board in California and provides the regulatory framework for the approval of an out-of-state health care practitioner and a sponsoring entity to seek approval from the applicable healing arts boards. Each individual healing arts board was responsible for promulgating regulations to specify the requirements for the approval of an out-of-state practitioner and a sponsoring entity. Existing law specifies that the Section 901 would be repealed on January 1, 2014 unless a later enacted statute deletes or extends the repeal date.

This bill would extend the repeal date of Section 901 until January 1, 2018.

**ANALYSIS**

The Dental Board of California (Board) promulgated regulations to implement the provisions contained in Section 901 to provide for out-of-state licensed dentists (DDS) to seek authorization to participate in sponsored free health care events. The Board's regulation specifies the requirements and procedures to authorize out-of-state dentists (DDS), who possess valid, current, and active licenses, to participate in sponsored free health care events for uninsured or underinsured people on a short-term voluntary basis in the State of California. These regulations became effective on December 7, 2012.

This bill would allow the Board to continue authorizing out-of-state licensed dentists (DDS) to participate in sponsored free health care events until January 1, 2018.

**REGISTERED SUPPORT/OPPOSITION**

Support

The County of Los Angeles

Opposition

The California Nurses Association

**STAFF RECOMMENDATION**

Watch

**BOARD POSITION**

SUPPORT: \_\_\_\_ OPPOSE: \_\_\_\_ NEUTRAL: \_\_\_\_ WATCH: \_\_\_\_

**ASSEMBLY BILL**

**No. 512**

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**Introduced by Assembly Member Rendon**

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as introduced, Rendon. Healing arts: licensure exemption.

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

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

board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.

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

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

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

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

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

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

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

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

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

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

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

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

1 (A) Obtains authorization from the board to participate in the  
2 sponsored event after submitting to the board a copy of his or her  
3 valid license or certificate from each state in which he or she holds  
4 licensure or certification and a photographic identification issued  
5 by one of the states in which he or she holds licensure or  
6 certification. The board shall notify the sponsoring entity, within  
7 20 calendar days of receiving a request for authorization, whether  
8 that request is approved or denied, provided that, if the board  
9 receives a request for authorization less than 20 days prior to the  
10 date of the sponsored event, the board shall make reasonable efforts  
11 to notify the sponsoring entity whether that request is approved or  
12 denied prior to the date of that sponsored event.

13 (B) Satisfies the following requirements:

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

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

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

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

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

31 (A) To uninsured or underinsured persons.

32 (B) On a short-term voluntary basis, not to exceed a  
33 10-calendar-day period per sponsored event.

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

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

38 (c) The board may deny a health care practitioner authorization  
39 to practice without a license if the health care practitioner fails to



1 comply with this section or for any act that would be grounds for  
2 denial of an application for licensure.

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

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

10 (A) The name of the sponsoring entity.

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

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

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

20 (E) Any additional information required by the board.

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

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

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

36 (g) The sponsoring entity shall maintain a list of health care  
37 practitioners associated with the provision of health care services  
38 under this section. The sponsoring entity shall maintain a copy of  
39 each health care practitioner's current license or certification and  
40 shall require each health care practitioner to attest in writing that

1 his or her license or certificate is not suspended or revoked pursuant  
2 to disciplinary proceedings in any jurisdiction. The sponsoring  
3 entity shall maintain these records for a period of at least five years  
4 following the provision of health care services under this section  
5 and shall, upon request, furnish those records to the board or any  
6 county health department.

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

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

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

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

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

39 (k) The provisions of this section are severable. If any provision  
40 of this section or its application is held invalid, that invalidity shall

- 1 not affect other provisions or applications that can be given effect
- 2 without the invalid provision or application.
- 3 (l) This section shall remain in effect only until January 1, ~~2014~~,
- 4 2018, and as of that date is repealed, unless a later enacted statute,
- 5 that is enacted before January 1, ~~2014~~, 2018, deletes or extends
- 6 that date.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
MAY 16 - May 17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 809

**AUTHOR:** Logue

**SPONSOR:**

**VERSION:** Amended 04/29/2013

**INTRODUCED:** 02/21/2013

**BILL STATUS:** 04/30/2013 – Re-referred to  
Com. -on B., P. & C.P.

**BILL LOCATION:** Assembly

**SUBJECT:** Healing Arts: Telehealth

**RELATED  
BILLS:**

**SUMMARY**

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

**ANALYSIS**

This bill would allow the verbal consent for the use of telehealth to apply in the present instance and for any subsequent use of telehealth. This bill would declare that it is to take effect immediately as an urgency statute. This bill does not appear to have an impact on the Dental Board.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**STAFF RECOMMENDATION**

Watch.

**BOARD POSITION:**

**SUPPORT:**\_\_\_\_\_ **OPPOSE:**\_\_\_\_\_ **NEUTRAL:**\_\_\_\_\_ **WATCH:**\_\_\_\_\_

AMENDED IN ASSEMBLY APRIL 29, 2013

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

## ASSEMBLY BILL

**No. 809**

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### Introduced by Assembly Member Logue

February 21, 2013

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An act to amend ~~Sections 1626.2, Section 2290.5, 4980.01, 4982, 4989.54, 4992.3, 4996, and 4999.90~~ of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

#### LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

~~This bill would instead require the health care provider at the originating site to provide the patient with a waiver for the course of treatment involving telehealth services to obtain informed consent for the agreed upon course of treatment. The bill would require the signed waiver to be contained in the patient's medical record. The bill would make additional conforming changes: allow the verbal consent for the use of telehealth to apply in the present instance and for any subsequent use of telehealth.~~

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

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: no.  
State-mandated local program: no.

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

- 1     ~~SECTION 1. Section 1626.2 of the Business and Professions~~  
2     ~~Code is amended to read:~~  
3     ~~1626.2. A dentist licensed under this chapter is a licentiate for~~  
4     ~~purposes of paragraph (2) of subdivision (a) of Section 805, and~~  
5     ~~this is a health care practitioner subject to the provisions of Section~~  
6     ~~2290.5.~~  
7     ~~SEC. 2.~~  
8     ~~SECTION 1.~~ Section 2290.5 of the Business and Professions  
9     Code is amended to read:  
10    2290.5. (a) For purposes of this division, the following  
11    definitions shall apply:  
12    (1) “Asynchronous store and forward” means the transmission  
13    of a patient’s medical information from an originating site to the  
14    health care provider at a distant site without the presence of the  
15    patient.  
16    (2) “Distant site” means a site where a health care provider who  
17    provides health care services is located while providing these  
18    services via a telecommunications system.  
19    (3) “Health care provider” means a person who is licensed under  
20    this division.  
21    (4) “Originating site” means a site where a patient is located at  
22    the time health care services are provided via a telecommunications  
23    system or where the asynchronous store and forward service  
24    originates.  
25    (5) “Synchronous interaction” means a real-time interaction  
26    between a patient and a health care provider located at a distant  
27    site.  
28    (6) “Telehealth” means the mode of delivering health care  
29    services and public health via information and communication  
30    technologies to facilitate the diagnosis, consultation, treatment,  
31    education, care management, and self-management of a patient’s  
32    health care while the patient is at the originating site and the health  
33    care provider is at a distant site. Telehealth facilitates patient  
34    self-management and caregiver support for patients and includes

1 synchronous interactions and asynchronous store and forward  
2 transfers.

3 (b) Prior to the delivery of health care via telehealth, the health  
4 care provider *initiating the use of telehealth* at the originating site  
5 shall ~~provide the patient with a waiver for the course of treatment~~  
6 ~~involving telehealth services to obtain informed consent for the~~  
7 ~~agreed-upon course of treatment~~ *verbally inform the patient about*  
8 *the use of telehealth and request the patient's verbal consent, which*  
9 *may apply in the present instance and for any subsequent use of*  
10 *telehealth*. The ~~signed waiver~~ *verbal consent* shall be ~~contained~~  
11 *documented* in the patient's medical record.

12 (c) Nothing in this section shall preclude a patient from receiving  
13 in-person health care delivery services during a course of treatment  
14 after agreeing to receive services via telehealth.

15 (d) The failure of a health care provider to comply with this  
16 section shall constitute unprofessional conduct. Section 2314 shall  
17 not apply to this section.

18 (e) This section shall not be construed to alter the scope of  
19 practice of any health care provider or authorize the delivery of  
20 health care services in a setting, or in a manner, not otherwise  
21 authorized by law.

22 (f) All laws regarding the confidentiality of health care  
23 information and a patient's rights to his or her medical information  
24 shall apply to telehealth interactions.

25 (g) This section shall not apply to a patient under the jurisdiction  
26 of the Department of Corrections and Rehabilitation or any other  
27 correctional facility.

28 (h) (1) Notwithstanding any other provision of law and for  
29 purposes of this section, the governing body of the hospital whose  
30 patients are receiving the telehealth services may grant privileges  
31 to, and verify and approve credentials for, providers of telehealth  
32 services based on its medical staff recommendations that rely on  
33 information provided by the distant-site hospital or telehealth  
34 entity, as described in Sections 482.12, 482.22, and 485.616 of  
35 Title 42 of the Code of Federal Regulations.

36 (2) By enacting this subdivision, it is the intent of the Legislature  
37 to authorize a hospital to grant privileges to, and verify and approve  
38 credentials for, providers of telehealth services as described in  
39 paragraph (1).

(3) For the purposes of this subdivision, “telehealth” shall include “telemedicine” as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 3. ~~Section 4980.01 of the Business and Professions Code is amended to read:~~

~~4980.01. (a) Nothing in this chapter shall be construed to constrict, limit, or withdraw the Medical Practice Act, the Social Work Licensing Law, the Nursing Practice Act, the Licensed Professional Clinical Counselor Act, or the Psychology Licensing Act.~~

~~(b) This chapter shall not apply to any priest, rabbi, or minister of the gospel of any religious denomination when performing counseling services as part of his or her pastoral or professional duties, or to any person who is admitted to practice law in the state, or who is licensed to practice medicine, when providing counseling services as part of his or her professional practice.~~

~~(c) (1) This chapter shall not apply to an employee working in any of the following settings if his or her work is performed solely under the supervision of the employer:~~

~~(A) A governmental entity.~~

~~(B) A school, college, or university.~~

~~(C) An institution that is both nonprofit and charitable.~~

~~(2) This chapter shall not apply to a volunteer working in any of the settings described in paragraph (1) if his or her work is performed solely under the supervision of the entity, school, or institution.~~

~~(d) A marriage and family therapist licensed under this chapter is a licensee for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5.~~

~~(e) Notwithstanding subdivisions (b) and (c), all persons registered as interns or licensed under this chapter shall not be exempt from this chapter or the jurisdiction of the board.~~

SEC. 4. ~~Section 4982 of the Business and Professions Code is amended to read:~~

~~4982. The board may deny a license or registration or may suspend or revoke the license or registration of a licensee or registrant if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:~~



1     ~~(a) The conviction of a crime substantially related to the~~  
2     ~~qualifications, functions, or duties of a licensee or registrant under~~  
3     ~~this chapter. The record of conviction shall be conclusive evidence~~  
4     ~~only of the fact that the conviction occurred. The board may inquire~~  
5     ~~into the circumstances surrounding the commission of the crime~~  
6     ~~in order to fix the degree of discipline or to determine if the~~  
7     ~~conviction is substantially related to the qualifications, functions,~~  
8     ~~or duties of a licensee or registrant under this chapter. A plea or~~  
9     ~~verdict of guilty or a conviction following a plea of nolo contendere~~  
10    ~~made to a charge substantially related to the qualifications,~~  
11    ~~functions, or duties of a licensee or registrant under this chapter~~  
12    ~~shall be deemed to be a conviction within the meaning of this~~  
13    ~~section. The board may order any license or registration suspended~~  
14    ~~or revoked, or may decline to issue a license or registration when~~  
15    ~~the time for appeal has elapsed, or the judgment of conviction has~~  
16    ~~been affirmed on appeal, or, when an order granting probation is~~  
17    ~~made suspending the imposition of sentence, irrespective of a~~  
18    ~~subsequent order under Section 1203.4 of the Penal Code allowing~~  
19    ~~the person to withdraw a plea of guilty and enter a plea of not~~  
20    ~~guilty, or setting aside the verdict of guilty, or dismissing the~~  
21    ~~accusation, information, or indictment.~~

22    ~~(b) Securing a license or registration by fraud, deceit, or~~  
23    ~~misrepresentation on any application for licensure or registration~~  
24    ~~submitted to the board, whether engaged in by an applicant for a~~  
25    ~~license or registration, or by a licensee in support of any application~~  
26    ~~for licensure or registration.~~

27    ~~(c) Administering to himself or herself any controlled substance~~  
28    ~~or using of any of the dangerous drugs specified in Section 4022,~~  
29    ~~or of any alcoholic beverage to the extent, or in a manner, as to be~~  
30    ~~dangerous or injurious to the person applying for a registration or~~  
31    ~~license or holding a registration or license under this chapter, or~~  
32    ~~to any other person, or to the public, or, to the extent that the use~~  
33    ~~impairs the ability of the person applying for or holding a~~  
34    ~~registration or license to conduct with safety to the public the~~  
35    ~~practice authorized by the registration or license. The board shall~~  
36    ~~deny an application for a registration or license or revoke the~~  
37    ~~license or registration of any person, other than one who is licensed~~  
38    ~~as a physician and surgeon, who uses or offers to use drugs in the~~  
39    ~~course of performing marriage and family therapy services.~~

- 1     ~~(d) Gross negligence or incompetence in the performance of~~  
2     ~~marriage and family therapy.~~
- 3     ~~(e) Violating, attempting to violate, or conspiring to violate any~~  
4     ~~of the provisions of this chapter or any regulation adopted by the~~  
5     ~~board.~~
- 6     ~~(f) Misrepresentation as to the type or status of a license or~~  
7     ~~registration held by the person, or otherwise misrepresenting or~~  
8     ~~permitting misrepresentation of his or her education, professional~~  
9     ~~qualifications, or professional affiliations to any person or entity.~~
- 10    ~~(g) Impersonation of another by any licensee, registrant, or~~  
11    ~~applicant for a license or registration, or, in the case of a licensee,~~  
12    ~~allowing any other person to use his or her license or registration.~~
- 13    ~~(h) Aiding or abetting, or employing, directly or indirectly, any~~  
14    ~~unlicensed or unregistered person to engage in conduct for which~~  
15    ~~a license or registration is required under this chapter.~~
- 16    ~~(i) Intentionally or recklessly causing physical or emotional~~  
17    ~~harm to any client.~~
- 18    ~~(j) The commission of any dishonest, corrupt, or fraudulent act~~  
19    ~~substantially related to the qualifications, functions, or duties of a~~  
20    ~~licensee or registrant.~~
- 21    ~~(k) Engaging in sexual relations with a client, or a former client~~  
22    ~~within two years following termination of therapy, soliciting sexual~~  
23    ~~relations with a client, or committing an act of sexual abuse, or~~  
24    ~~sexual misconduct with a client, or committing an act punishable~~  
25    ~~as a sexually related crime, if that act or solicitation is substantially~~  
26    ~~related to the qualifications, functions, or duties of a marriage and~~  
27    ~~family therapist.~~
- 28    ~~(l) Performing, or holding oneself out as being able to perform,~~  
29    ~~or offering to perform, or permitting any trainee or registered intern~~  
30    ~~under supervision to perform, any professional services beyond~~  
31    ~~the scope of the license authorized by this chapter.~~
- 32    ~~(m) Failure to maintain confidentiality, except as otherwise~~  
33    ~~required or permitted by law, of all information that has been~~  
34    ~~received from a client in confidence during the course of treatment~~  
35    ~~and all information about the client that is obtained from tests or~~  
36    ~~other means.~~
- 37    ~~(n) Prior to the commencement of treatment, failing to disclose~~  
38    ~~to the client or prospective client the fee to be charged for the~~  
39    ~~professional services, or the basis upon which that fee will be~~  
40    ~~computed.~~

1     ~~(o) Paying, accepting, or soliciting any consideration;~~  
2     ~~compensation, or remuneration, whether monetary or otherwise;~~  
3     ~~for the referral of professional clients. All consideration;~~  
4     ~~compensation, or remuneration shall be in relation to professional~~  
5     ~~counseling services actually provided by the licensee. Nothing in~~  
6     ~~this subdivision shall prevent collaboration among two or more~~  
7     ~~licensees in a case or cases. However, no fee shall be charged for~~  
8     ~~that collaboration, except when disclosure of the fee has been made~~  
9     ~~in compliance with subdivision (n).~~

10    ~~(p) Advertising in a manner that is false, fraudulent, misleading,~~  
11    ~~or deceptive, as defined in Section 651.~~

12    ~~(q) Reproduction or description in public, or in any publication~~  
13    ~~subject to general public distribution, of any psychological test or~~  
14    ~~other assessment device, the value of which depends in whole or~~  
15    ~~in part on the naivete of the subject, in ways that might invalidate~~  
16    ~~the test or device.~~

17    ~~(r) Any conduct in the supervision of any registered intern,~~  
18    ~~associate clinical social worker, or trainee by any licensee that~~  
19    ~~violates this chapter or any rules or regulations adopted by the~~  
20    ~~board.~~

21    ~~(s) Performing or holding oneself out as being able to perform~~  
22    ~~professional services beyond the scope of one's competence, as~~  
23    ~~established by one's education, training, or experience. This~~  
24    ~~subdivision shall not be construed to expand the scope of the~~  
25    ~~license authorized by this chapter.~~

26    ~~(t) Permitting a trainee or registered intern under one's~~  
27    ~~supervision or control to perform, or permitting the trainee or~~  
28    ~~registered intern to hold himself or herself out as competent to~~  
29    ~~perform, professional services beyond the trainee's or registered~~  
30    ~~intern's level of education, training, or experience.~~

31    ~~(u) The violation of any statute or regulation governing the~~  
32    ~~gaining and supervision of experience required by this chapter.~~

33    ~~(v) Failure to keep records consistent with sound clinical~~  
34    ~~judgment, the standards of the profession, and the nature of the~~  
35    ~~services being rendered.~~

36    ~~(w) Failure to comply with the child abuse reporting~~  
37    ~~requirements of Section 11166 of the Penal Code.~~

38    ~~(x) Failure to comply with the elder and dependent adult abuse~~  
39    ~~reporting requirements of Section 15630 of the Welfare and~~  
40    ~~Institutions Code.~~

~~(y) Willful violation of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.~~

~~(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.~~

~~(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.~~

~~(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.~~

~~SEC. 5. Section 4989.54 of the Business and Professions Code is amended to read:~~

~~4989.54. The board may deny a license or may suspend or revoke the license of a licensee if he or she has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:~~

~~(a) Conviction of a crime substantially related to the qualifications, functions, and duties of an educational psychologist.~~

~~(1) The record of conviction shall be conclusive evidence only of the fact that the conviction occurred.~~

~~(2) The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee under this chapter.~~

~~(3) A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee under this chapter shall be deemed to be a conviction within the meaning of this section.~~

1     ~~(4) The board may order a license suspended or revoked, or~~  
2     ~~may decline to issue a license when the time for appeal has elapsed,~~  
3     ~~or the judgment of conviction has been affirmed on appeal, or~~  
4     ~~when an order granting probation is made suspending the~~  
5     ~~imposition of sentence, irrespective of a subsequent order under~~  
6     ~~Section 1203.4 of the Penal Code allowing the person to withdraw~~  
7     ~~a plea of guilty and enter a plea of not guilty or setting aside the~~  
8     ~~verdict of guilty or dismissing the accusation, information, or~~  
9     ~~indictment.~~

10    ~~(b) Securing a license by fraud, deceit, or misrepresentation on~~  
11    ~~an application for licensure submitted to the board, whether~~  
12    ~~engaged in by an applicant for a license or by a licensee in support~~  
13    ~~of an application for licensure.~~

14    ~~(c) Administering to himself or herself a controlled substance~~  
15    ~~or using any of the dangerous drugs specified in Section 4022 or~~  
16    ~~an alcoholic beverage to the extent, or in a manner, as to be~~  
17    ~~dangerous or injurious to himself or herself or to any other person~~  
18    ~~or to the public or to the extent that the use impairs his or her ability~~  
19    ~~to safely perform the functions authorized by the license. The board~~  
20    ~~shall deny an application for a license or revoke the license of any~~  
21    ~~person, other than one who is licensed as a physician and surgeon,~~  
22    ~~who uses or offers to use drugs in the course of performing~~  
23    ~~educational psychology.~~

24    ~~(d) Advertising in a manner that is false, fraudulent, misleading,~~  
25    ~~or deceptive, as defined in Section 651.~~

26    ~~(e) Violating, attempting to violate, or conspiring to violate any~~  
27    ~~of the provisions of this chapter or any regulation adopted by the~~  
28    ~~board.~~

29    ~~(f) Commission of any dishonest, corrupt, or fraudulent act~~  
30    ~~substantially related to the qualifications, functions, or duties of a~~  
31    ~~licensee.~~

32    ~~(g) Denial of licensure, revocation, suspension, restriction, or~~  
33    ~~any other disciplinary action imposed by another state or territory~~  
34    ~~or possession of the United States or by any other governmental~~  
35    ~~agency, on a license, certificate, or registration to practice~~  
36    ~~educational psychology or any other healing art. A certified copy~~  
37    ~~of the disciplinary action, decision, or judgment shall be conclusive~~  
38    ~~evidence of that action.~~

39    ~~(h) Revocation, suspension, or restriction by the board of a~~  
40    ~~license, certificate, or registration to practice as an educational~~

1 psychologist, a clinical social worker, professional clinical  
2 counselor, or marriage and family therapist.

3 (i) Failure to keep records consistent with sound clinical  
4 judgment, the standards of the profession, and the nature of the  
5 services being rendered.

6 (j) Gross negligence or incompetence in the practice of  
7 educational psychology.

8 (k) Misrepresentation as to the type or status of a license held  
9 by the licensee or otherwise misrepresenting or permitting  
10 misrepresentation of his or her education, professional  
11 qualifications, or professional affiliations to any person or entity.

12 (l) Intentionally or recklessly causing physical or emotional  
13 harm to any client.

14 (m) Engaging in sexual relations with a client or a former client  
15 within two years following termination of professional services;  
16 soliciting sexual relations with a client, or committing an act of  
17 sexual abuse or sexual misconduct with a client or committing an  
18 act punishable as a sexually related crime, if that act or solicitation  
19 is substantially related to the qualifications, functions, or duties of  
20 a licensed educational psychologist.

21 (n) Prior to the commencement of treatment, failing to disclose  
22 to the client or prospective client the fee to be charged for the  
23 professional services or the basis upon which that fee will be  
24 computed.

25 (o) Paying, accepting, or soliciting any consideration,  
26 compensation, or remuneration, whether monetary or otherwise,  
27 for the referral of professional clients.

28 (p) Failing to maintain confidentiality, except as otherwise  
29 required or permitted by law, of all information that has been  
30 received from a client in confidence during the course of treatment  
31 and all information about the client that is obtained from tests or  
32 other means.

33 (q) Performing, holding himself or herself out as being able to  
34 perform, or offering to perform any professional services beyond  
35 the scope of the license authorized by this chapter or beyond his  
36 or her field or fields of competence as established by his or her  
37 education, training, or experience.

38 (r) Reproducing or describing in public, or in any publication  
39 subject to general public distribution, any psychological test or  
40 other assessment device the value of which depends in whole or

1 in-part on the naivete of the subject in ways that might invalidate  
2 the test or device. An educational psychologist shall limit access  
3 to the test or device to persons with professional interests who can  
4 be expected to safeguard its use.

5 (s) ~~Aiding or abetting an unlicensed person to engage in conduct~~  
6 ~~requiring a license under this chapter.~~

7 (t) ~~When employed by another person or agency, encouraging,~~  
8 ~~either orally or in writing, the employer's or agency's clientele to~~  
9 ~~utilize his or her private practice for further counseling without~~  
10 ~~the approval of the employing agency or administration.~~

11 (u) ~~Failing to comply with the child abuse reporting~~  
12 ~~requirements of Section 11166 of the Penal Code.~~

13 (v) ~~Failing to comply with the elder and adult dependent abuse~~  
14 ~~reporting requirements of Section 15630 of the Welfare and~~  
15 ~~Institutions Code.~~

16 (w) ~~Willful violation of Chapter 1 (commencing with Section~~  
17 ~~123100) of Part 1 of Division 106 of the Health and Safety Code.~~

18 (x) (1) ~~Engaging in an act described in Section 261, 286, 288a,~~  
19 ~~or 289 of the Penal Code with a minor or an act described in~~  
20 ~~Section 288 or 288.5 of the Penal Code regardless of whether the~~  
21 ~~act occurred prior to or after the time the registration or license~~  
22 ~~was issued by the board. An act described in this subdivision~~  
23 ~~occurring prior to the effective date of this subdivision shall~~  
24 ~~constitute unprofessional conduct and shall subject the licensee to~~  
25 ~~refusal, suspension, or revocation of a license under this section.~~

26 (2) ~~The Legislature hereby finds and declares that protection of~~  
27 ~~the public, and in particular minors, from sexual misconduct by a~~  
28 ~~licensee is a compelling governmental interest, and that the ability~~  
29 ~~to suspend or revoke a license for sexual conduct with a minor~~  
30 ~~occurring prior to the effective date of this section is equally~~  
31 ~~important to protecting the public as is the ability to refuse a license~~  
32 ~~for sexual conduct with a minor occurring prior to the effective~~  
33 ~~date of this section.~~

34 (y) ~~Engaging in any conduct that subverts or attempts to subvert~~  
35 ~~any licensing examination or the administration of the examination~~  
36 ~~as described in Section 123.~~

37 (z) ~~Impersonation of another by any licensee or applicant for a~~  
38 ~~license, or, in the case of a licensee, allowing any other person to~~  
39 ~~use his or her license.~~

1     (aa) ~~Permitting a person under his or her supervision or control~~  
2     ~~to perform, or permitting that person to hold himself or herself out~~  
3     ~~as competent to perform, professional services beyond the level~~  
4     ~~of education, training, or experience of that person.~~

5     SEC. 6. ~~Section 4992.3 of the Business and Professions Code~~  
6     ~~is amended to read:~~

7     ~~4992.3. The board may deny a license or a registration, or may~~  
8     ~~suspend or revoke the license or registration of a licensee or~~  
9     ~~registrant if he or she has been guilty of unprofessional conduct.~~  
10    ~~Unprofessional conduct includes, but is not limited to, the~~  
11    ~~following:~~

12    ~~(a) The conviction of a crime substantially related to the~~  
13    ~~qualifications, functions, or duties of a licensee or registrant under~~  
14    ~~this chapter. The record of conviction shall be conclusive evidence~~  
15    ~~only of the fact that the conviction occurred. The board may inquire~~  
16    ~~into the circumstances surrounding the commission of the crime~~  
17    ~~in order to fix the degree of discipline or to determine if the~~  
18    ~~conviction is substantially related to the qualifications, functions,~~  
19    ~~or duties of a licensee or registrant under this chapter. A plea or~~  
20    ~~verdict of guilty or a conviction following a plea of nolo contendere~~  
21    ~~made to a charge substantially related to the qualifications,~~  
22    ~~functions, or duties of a licensee or registrant under this chapter~~  
23    ~~is a conviction within the meaning of this section. The board may~~  
24    ~~order any license or registration suspended or revoked, or may~~  
25    ~~decline to issue a license or registration when the time for appeal~~  
26    ~~has elapsed, or the judgment of conviction has been affirmed on~~  
27    ~~appeal, or, when an order granting probation is made suspending~~  
28    ~~the imposition of sentence, irrespective of a subsequent order under~~  
29    ~~Section 1203.4 of the Penal Code allowing the person to withdraw~~  
30    ~~a plea of guilty and enter a plea of not guilty, or setting aside the~~  
31    ~~verdict of guilty, or dismissing the accusation, information, or~~  
32    ~~indictment.~~

33    ~~(b) Securing a license or registration by fraud, deceit, or~~  
34    ~~misrepresentation on any application for licensure or registration~~  
35    ~~submitted to the board, whether engaged in by an applicant for a~~  
36    ~~license or registration, or by a licensee in support of any application~~  
37    ~~for licensure or registration.~~

38    ~~(c) Administering to himself or herself any controlled substance~~  
39    ~~or using any of the dangerous drugs specified in Section 4022 or~~  
40    ~~any alcoholic beverage to the extent, or in a manner, as to be~~



1 dangerous or injurious to the person applying for a registration or  
2 license or holding a registration or license under this chapter, or  
3 to any other person, or to the public, or, to the extent that the use  
4 impairs the ability of the person applying for or holding a  
5 registration or license to conduct with safety to the public the  
6 practice authorized by the registration or license. The board shall  
7 deny an application for a registration or license or revoke the  
8 license or registration of any person who uses or offers to use drugs  
9 in the course of performing clinical social work. This provision  
10 does not apply to any person also licensed as a physician and  
11 surgeon under Chapter 5 (commencing with Section 2000) or the  
12 Osteopathic Act who lawfully prescribes drugs to a patient under  
13 his or her care.

14 (d) ~~Incompetence in the performance of clinical social work.~~

15 (e) ~~An act or omission that falls sufficiently below the standard~~  
16 ~~of conduct of the profession as to constitute an act of gross~~  
17 ~~negligence.~~

18 (f) ~~Violating, attempting to violate, or conspiring to violate this~~  
19 ~~chapter or any regulation adopted by the board.~~

20 (g) ~~Misrepresentation as to the type or status of a license or~~  
21 ~~registration held by the person, or otherwise misrepresenting or~~  
22 ~~permitting misrepresentation of his or her education, professional~~  
23 ~~qualifications, or professional affiliations to any person or entity.~~  
24 ~~For purposes of this subdivision, this misrepresentation includes,~~  
25 ~~but is not limited to, misrepresentation of the person's~~  
26 ~~qualifications as an adoption service provider pursuant to Section~~  
27 ~~8502 of the Family Code.~~

28 (h) ~~Impersonation of another by any licensee, registrant, or~~  
29 ~~applicant for a license or registration, or, in the case of a licensee,~~  
30 ~~allowing any other person to use his or her license or registration.~~

31 (i) ~~Aiding or abetting any unlicensed or unregistered person to~~  
32 ~~engage in conduct for which a license or registration is required~~  
33 ~~under this chapter.~~

34 (j) ~~Intentionally or recklessly causing physical or emotional~~  
35 ~~harm to any client.~~

36 (k) ~~The commission of any dishonest, corrupt, or fraudulent act~~  
37 ~~substantially related to the qualifications, functions, or duties of a~~  
38 ~~licensee or registrant.~~

39 (l) ~~Engaging in sexual relations with a client or with a former~~  
40 ~~client within two years from the termination date of therapy with~~

1 the client, soliciting sexual relations with a client, or committing  
2 an act of sexual abuse, or sexual misconduct with a client, or  
3 committing an act punishable as a sexually related crime, if that  
4 act or solicitation is substantially related to the qualifications,  
5 functions, or duties of a clinical social worker.

6 (m) Performing, or holding one's self out as being able to  
7 perform, or offering to perform or permitting, any registered  
8 associate clinical social worker or intern under supervision to  
9 perform any professional services beyond the scope of one's  
10 competence, as established by one's education, training, or  
11 experience. This subdivision shall not be construed to expand the  
12 scope of the license authorized by this chapter.

13 (n) Failure to maintain confidentiality, except as otherwise  
14 required or permitted by law, of all information that has been  
15 received from a client in confidence during the course of treatment  
16 and all information about the client that is obtained from tests or  
17 other means.

18 (o) Prior to the commencement of treatment, failing to disclose  
19 to the client or prospective client the fee to be charged for the  
20 professional services, or the basis upon which that fee will be  
21 computed.

22 (p) Paying, accepting, or soliciting any consideration,  
23 compensation, or remuneration, whether monetary or otherwise,  
24 for the referral of professional clients. All consideration,  
25 compensation, or remuneration shall be in relation to professional  
26 counseling services actually provided by the licensee. Nothing in  
27 this subdivision shall prevent collaboration among two or more  
28 licensees in a case or cases. However, no fee shall be charged for  
29 that collaboration, except when disclosure of the fee has been made  
30 in compliance with subdivision (o).

31 (q) Advertising in a manner that is false, fraudulent, misleading,  
32 or deceptive, as defined in Section 651.

33 (r) Reproduction or description in public, or in any publication  
34 subject to general public distribution, of any psychological test or  
35 other assessment device, the value of which depends in whole or  
36 in part on the naivete of the subject, in ways that might invalidate  
37 the test or device. A licensee shall limit access to that test or device  
38 to persons with professional interest who are expected to safeguard  
39 its use.

1     ~~(s) Any conduct in the supervision of any registered associate~~  
2     ~~clinical social worker, intern, or trainee by any licensee that violates~~  
3     ~~this chapter or any rules or regulations adopted by the board.~~

4     ~~(t) Failure to keep records consistent with sound clinical~~  
5     ~~judgment, the standards of the profession, and the nature of the~~  
6     ~~services being rendered.~~

7     ~~(u) Failure to comply with the child abuse reporting~~  
8     ~~requirements of Section 11166 of the Penal Code.~~

9     ~~(v) Failure to comply with the elder and dependent adult abuse~~  
10    ~~reporting requirements of Section 15630 of the Welfare and~~  
11    ~~Institutions Code.~~

12    ~~(w) Willful violation of Chapter 1 (commencing with Section~~  
13    ~~123100) of Part 1 of Division 106 of the Health and Safety Code.~~

14    ~~(x) (1) Engaging in an act described in Section 261, 286, 288a,~~  
15    ~~or 289 of the Penal Code with a minor or an act described in~~  
16    ~~Section 288 or 288.5 of the Penal Code regardless of whether the~~  
17    ~~act occurred prior to or after the time the registration or license~~  
18    ~~was issued by the board. An act described in this subdivision~~  
19    ~~occurring prior to the effective date of this subdivision shall~~  
20    ~~constitute unprofessional conduct and shall subject the licensee to~~  
21    ~~refusal, suspension, or revocation of a license under this section.~~

22    ~~(2) The Legislature hereby finds and declares that protection of~~  
23    ~~the public, and in particular minors, from sexual misconduct by a~~  
24    ~~licensee is a compelling governmental interest, and that the ability~~  
25    ~~to suspend or revoke a license for sexual conduct with a minor~~  
26    ~~occurring prior to the effective date of this section is equally~~  
27    ~~important to protecting the public as is the ability to refuse a license~~  
28    ~~for sexual conduct with a minor occurring prior to the effective~~  
29    ~~date of this section.~~

30    ~~(y) Engaging in any conduct that subverts or attempts to subvert~~  
31    ~~any licensing examination or the administration of the examination~~  
32    ~~as described in Section 123.~~

33    ~~SEC. 7. Section 4996 of the Business and Professions Code is~~  
34    ~~amended to read:~~

35    ~~4996. (a) Only individuals who have received a license under~~  
36    ~~this article may style themselves as "Licensed Clinical Social~~  
37    ~~Workers." Every individual who styles himself or herself or who~~  
38    ~~holds himself or herself out to be a licensed clinical social worker,~~  
39    ~~or who uses any words or symbols indicating or tending to indicate~~  
40    ~~that he or she is a licensed clinical social worker, without holding~~

1 his or her license in good standing under this article, is guilty of a  
2 misdemeanor.

3 (b) ~~It is unlawful for any person to engage in the practice of~~  
4 ~~clinical social work unless at the time of so doing that person holds~~  
5 ~~a valid, unexpired, and unrevoked license under this article.~~

6 (e) ~~A clinical social worker licensed under this chapter is a~~  
7 ~~licentiate for purposes of paragraph (2) of subdivision (a) of Section~~  
8 ~~805, and thus is a health care practitioner subject to the provisions~~  
9 ~~of Section 2290.5.~~

10 SEC. 8. ~~Section 4999.90 of the Business and Professions Code~~  
11 ~~is amended to read:~~

12 ~~4999.90. The board may refuse to issue any registration or~~  
13 ~~license, or may suspend or revoke the registration or license of~~  
14 ~~any intern or licensed professional clinical counselor, if the~~  
15 ~~applicant, licensee, or registrant has been guilty of unprofessional~~  
16 ~~conduct. Unprofessional conduct includes, but is not limited to,~~  
17 ~~the following:~~

18 (a) ~~The conviction of a crime substantially related to the~~  
19 ~~qualifications, functions, or duties of a licensee or registrant under~~  
20 ~~this chapter. The record of conviction shall be conclusive evidence~~  
21 ~~only of the fact that the conviction occurred. The board may inquire~~  
22 ~~into the circumstances surrounding the commission of the crime~~  
23 ~~in order to fix the degree of discipline or to determine if the~~  
24 ~~conviction is substantially related to the qualifications, functions,~~  
25 ~~or duties of a licensee or registrant under this chapter. A plea or~~  
26 ~~verdict of guilty or a conviction following a plea of nolo contendere~~  
27 ~~made to a charge substantially related to the qualifications,~~  
28 ~~functions, or duties of a licensee or registrant under this chapter~~  
29 ~~shall be deemed to be a conviction within the meaning of this~~  
30 ~~section. The board may order any license or registration suspended~~  
31 ~~or revoked, or may decline to issue a license or registration when~~  
32 ~~the time for appeal has elapsed, or the judgment of conviction has~~  
33 ~~been affirmed on appeal, or, when an order granting probation is~~  
34 ~~made suspending the imposition of sentence, irrespective of a~~  
35 ~~subsequent order under Section 1203.4 of the Penal Code allowing~~  
36 ~~the person to withdraw a plea of guilty and enter a plea of not~~  
37 ~~guilty, or setting aside the verdict of guilty, or dismissing the~~  
38 ~~accusation, information, or indictment.~~

39 (b) ~~Securing a license or registration by fraud, deceit, or~~  
40 ~~misrepresentation on any application for licensure or registration~~

1 submitted to the board, whether engaged in by an applicant for a  
2 license or registration, or by a licensee in support of any application  
3 for licensure or registration.

4 (e) ~~Administering to himself or herself any controlled substance~~  
5 ~~or using any of the dangerous drugs specified in Section 4022, or~~  
6 ~~any alcoholic beverage to the extent, or in a manner, as to be~~  
7 ~~dangerous or injurious to the person applying for a registration or~~  
8 ~~license or holding a registration or license under this chapter, or~~  
9 ~~to any other person, or to the public, or, to the extent that the use~~  
10 ~~impairs the ability of the person applying for or holding a~~  
11 ~~registration or license to conduct with safety to the public the~~  
12 ~~practice authorized by the registration or license. The board shall~~  
13 ~~deny an application for a registration or license or revoke the~~  
14 ~~license or registration of any person, other than one who is licensed~~  
15 ~~as a physician and surgeon, who uses or offers to use drugs in the~~  
16 ~~course of performing licensed professional clinical counseling~~  
17 ~~services.~~

18 (d) ~~Gross negligence or incompetence in the performance of~~  
19 ~~licensed professional clinical counseling services.~~

20 (e) ~~Violating, attempting to violate, or conspiring to violate any~~  
21 ~~of the provisions of this chapter or any regulation adopted by the~~  
22 ~~board.~~

23 (f) ~~Misrepresentation as to the type or status of a license or~~  
24 ~~registration held by the person, or otherwise misrepresenting or~~  
25 ~~permitting misrepresentation of his or her education, professional~~  
26 ~~qualifications, or professional affiliations to any person or entity.~~

27 (g) ~~Impersonation of another by any licensee, registrant, or~~  
28 ~~applicant for a license or registration, or, in the case of a licensee~~  
29 ~~or registrant, allowing any other person to use his or her license~~  
30 ~~or registration.~~

31 (h) ~~Aiding or abetting, or employing, directly or indirectly, any~~  
32 ~~unlicensed or unregistered person to engage in conduct for which~~  
33 ~~a license or registration is required under this chapter.~~

34 (i) ~~Intentionally or recklessly causing physical or emotional~~  
35 ~~harm to any client.~~

36 (j) ~~The commission of any dishonest, corrupt, or fraudulent act~~  
37 ~~substantially related to the qualifications, functions, or duties of a~~  
38 ~~licensee or registrant.~~

39 (k) ~~Engaging in sexual relations with a client, or a former client~~  
40 ~~within two years following termination of therapy, soliciting sexual~~

1 relations with a client, or committing an act of sexual abuse, or  
2 sexual misconduct with a client, or committing an act punishable  
3 as a sexually related crime, if that act or solicitation is substantially  
4 related to the qualifications, functions, or duties of a licensed  
5 professional clinical counselor.

6 (l) Performing, or holding oneself out as being able to perform,  
7 or offering to perform, or permitting any trainee, applicant, or  
8 registrant under supervision to perform, any professional services  
9 beyond the scope of the license authorized by this chapter.

10 (m) Failure to maintain confidentiality, except as otherwise  
11 required or permitted by law, of all information that has been  
12 received from a client in confidence during the course of treatment  
13 and all information about the client which is obtained from tests  
14 or other means.

15 (n) Prior to the commencement of treatment, failing to disclose  
16 to the client or prospective client the fee to be charged for the  
17 professional services, or the basis upon which that fee will be  
18 computed.

19 (o) Paying, accepting, or soliciting any consideration,  
20 compensation, or remuneration, whether monetary or otherwise,  
21 for the referral of professional clients. All consideration,  
22 compensation, or remuneration shall be in relation to professional  
23 clinical counseling services actually provided by the licensee.  
24 Nothing in this subdivision shall prevent collaboration among two  
25 or more licensees in a case or cases. However, no fee shall be  
26 charged for that collaboration, except when disclosure of the fee  
27 has been made in compliance with subdivision (n).

28 (p) Advertising in a manner that is false, fraudulent, misleading,  
29 or deceptive, as defined in Section 651.

30 (q) Reproduction or description in public, or in any publication  
31 subject to general public distribution, of any psychological test or  
32 other assessment device, the value of which depends in whole or  
33 in part on the naivete of the subject, in ways that might invalidate  
34 the test or device.

35 (r) Any conduct in the supervision of a registered intern,  
36 associate clinical social worker, or clinical counselor trainee by  
37 any licensee that violates this chapter or any rules or regulations  
38 adopted by the board.

39 (s) Performing or holding oneself out as being able to perform  
40 professional services beyond the scope of one's competence, as

1 established by one's education, training, or experience. This  
2 subdivision shall not be construed to expand the scope of the  
3 license authorized by this chapter.

4 (t) ~~Permitting a clinical counselor trainee or intern under one's~~  
5 ~~supervision or control to perform, or permitting the clinical~~  
6 ~~counselor trainee or intern to hold himself or herself out as~~  
7 ~~competent to perform, professional services beyond the clinical~~  
8 ~~counselor trainee's or intern's level of education, training, or~~  
9 ~~experience.~~

10 (u) ~~The violation of any statute or regulation of the standards~~  
11 ~~of the profession, and the nature of the services being rendered,~~  
12 ~~governing the gaining and supervision of experience required by~~  
13 ~~this chapter.~~

14 (v) ~~Failure to keep records consistent with sound clinical~~  
15 ~~judgment, the standards of the profession, and the nature of the~~  
16 ~~services being rendered.~~

17 (w) ~~Failure to comply with the child abuse reporting~~  
18 ~~requirements of Section 11166 of the Penal Code.~~

19 (x) ~~Failing to comply with the elder and dependent adult abuse~~  
20 ~~reporting requirements of Section 15630 of the Welfare and~~  
21 ~~Institutions Code.~~

22 (y) ~~Repeated acts of negligence.~~

23 (z) (1) ~~Engaging in an act described in Section 261, 286, 288a,~~  
24 ~~or 289 of the Penal Code with a minor or an act described in~~  
25 ~~Section 288 or 288.5 of the Penal Code regardless of whether the~~  
26 ~~act occurred prior to or after the time the registration or license~~  
27 ~~was issued by the board. An act described in this subdivision~~  
28 ~~occurring prior to the effective date of this subdivision shall~~  
29 ~~constitute unprofessional conduct and shall subject the licensee to~~  
30 ~~refusal, suspension, or revocation of a license under this section.~~

31 (2) ~~The Legislature hereby finds and declares that protection of~~  
32 ~~the public, and in particular minors, from sexual misconduct by a~~  
33 ~~licensee is a compelling governmental interest, and that the ability~~  
34 ~~to suspend or revoke a license for sexual conduct with a minor~~  
35 ~~occurring prior to the effective date of this section is equally~~  
36 ~~important to protecting the public as is the ability to refuse a license~~  
37 ~~for sexual conduct with a minor occurring prior to the effective~~  
38 ~~date of this section.~~

1     ~~(aa) Engaging in any conduct that subverts or attempts to subvert~~  
2     ~~any licensing examination or the administration of an examination~~  
3     ~~as described in Section 123.~~

4     ~~(ab) Revocation, suspension, or restriction by the board of a~~  
5     ~~license, certificate, or registration to practice as a professional~~  
6     ~~clinical counselor, clinical social worker, educational psychologist,~~  
7     ~~or marriage and family therapist.~~

8     ~~(ac) Willful violation of Chapter 1 (commencing with Section~~  
9     ~~123100) of Part 1 of Division 106 of the Health and Safety Code.~~

10    ~~SEC. 9.~~

11    ~~SEC. 2.~~ This act is an urgency statute necessary for the  
12    immediate preservation of the public peace, health, or safety within  
13    the meaning of Article IV of the Constitution and shall go into  
14    immediate effect. The facts constituting the necessity are:

15    In order to protect the health and safety of the public due to a  
16    lack of access to health care providers in rural and urban medically  
17    underserved areas of California, the increasing strain on existing  
18    providers expected to occur with the implementation of the federal  
19    Patient Protection and Affordable Care Act, and the assistance that  
20    further implementation of telehealth can provide to help relieve  
21    these burdens, it is necessary for this act to take effect immediately.



**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 827

**AUTHOR:** Hagman

**SPONSOR:**

**VERSION:** Introduced 02/21/2013

**INTRODUCED:** 02/21/2013

**BILL STATUS:** 02/21/2013 – Introduced.

**BILL LOCATION:** Assembly

**SUBJECT:** Department of Consumer  
Affairs

**RELATED  
BILLS:**

**SUMMARY**

Makes technical, nonsubstantive changes to provisions of the Dental Board and the Medical Board with respect to setting standards, conducting examinations, passing candidates, and revoking licenses under the Law governing the Department of Consumer Affairs.

**ANALYSIS**

This bill makes only technical, nonsubstantive changes and will have minor, if any impact to the Dental Board.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**STAFF RECOMMENDATION**

Watch.

**BOARD POSITION**

**SUPPORT:** \_\_\_\_ **OPPOSE:** \_\_\_\_ **NEUTRAL:** \_\_\_\_ **WATCH:** \_\_\_\_

**ASSEMBLY BILL**

**No. 827**

---

**Introduced by Assembly Member Hagman**

February 21, 2013

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An act to amend Section 109 of the Business and Professions Code, relating to consumer affairs.

LEGISLATIVE COUNSEL'S DIGEST

AB 827, as introduced, Hagman. Department of Consumer Affairs.

Existing law establishes the Department of Consumer Affairs, within the state government, comprised of boards and bureaus, including, but not limited to, the Dental Board of California and the Medical Board of California. Except as otherwise provided, the decisions of any of the boards comprising the department, with respect to setting standards, conducting examinations, passing candidates, and revoking licenses, are not subject to review by the Director of Consumer Affairs, but are final within the limits provided by the code provisions which are applicable to the particular board.

This bill would make technical, nonsubstantive changes to those provisions.

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

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

- 1     SECTION 1. Section 109 of the Business and Professions Code
- 2     is amended to read:
- 3     109. (a) The decisions of any of the boards comprising the
- 4     department, with respect to setting standards, conducting

1 examinations, passing candidates, and revoking licenses, are not  
2 subject to review by the director, but are final within the limits  
3 provided by this code ~~which~~ *that* are applicable to the particular  
4 board, except as provided in this section.

5 (b) The director may initiate an investigation of any allegations  
6 of misconduct in the preparation, administration, or scoring of an  
7 examination ~~which~~ *that* is administered by a board, or in the review  
8 of qualifications ~~which~~ *that* are a part of the licensing process of  
9 any board. A request for investigation shall be made by the director  
10 to the Division of Investigation through the chief of the division  
11 or to any law enforcement agency in the jurisdiction where the  
12 alleged misconduct occurred.

13 (c) The director may intervene in any matter of ~~any~~ *a* board  
14 where an investigation by the Division of Investigation discloses  
15 probable cause to believe that the conduct or activity of a board,  
16 or its members or employees constitutes a violation of criminal  
17 law.

18 The term “intervene,” as used in paragraph (c) of this section  
19 may include, but is not limited to, an application for a restraining  
20 order or injunctive relief as specified in Section 123.5, or a referral  
21 or request for criminal prosecution. For purposes of this section,  
22 the director shall be deemed to have standing under Section 123.5  
23 and shall seek representation of the Attorney General, or other  
24 appropriate counsel in the event of a conflict in pursuing that  
25 action.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 836

**AUTHOR:** Skinner

**SPONSOR:** California Dental Association

**VERSION:** 4/9/13 – Amended Assembly

**INTRODUCED:** 02/21/2013

**BILL STATUS:** 02/21/2013 – Introduced.

**BILL LOCATION:** Assembly

**SUBJECT:** Dentists: Continuing Education

**RELATED  
BILLS:**

**SUMMARY**

The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California (Board). The Board is authorized to require licensees to complete continuing education hours as a condition of license renewal. Business and Professions Code Section 1716.1(a) authorizes the Board to, by regulation, reduce the renewal fee for a licensee who has practiced dentistry for twenty (20) years or more in California, has reached the age of retirement under the federal Social Security Act, and customarily provides his or her services free of charge to any person, organization, or agency.

This bill would prohibit the Board from requiring those licensees who qualify under the provisions of Section 1716.1(a) to complete more than 60% of the hours of continuing education that is required of other dentists.

**ANALYSIS**

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

This bill would prohibit the board from requiring a retired dentist who provides only uncompensated care more than 60% of the hours of continuing education that is required of other licensed dentists. The bill would require the board to report on the outcome of that provision, pursuant to, and at the time of, its regular sunset review process.

The Dental Board of California will need to promulgate regulations to implement the provisions contained in Section 1645 to provide for reduction of the required continuing education units for retired dentists (DDS) who customarily provide services free of charge.

The Dental Board of California will be required to report the outcome of this provision as part of the regular sunset review process as provided in Section 1601.1 which is January 1, 2016.

**REGISTERED SUPPORT/OPPOSITION**

Support

California Dental Association

California Society of Pediatric Dentistry

Opposition

None

**STAFF RECOMMENDATION**

Neutral

**BOARD POSITION**

SUPPORT: \_\_\_\_ OPPOSE: \_\_\_\_ NEUTRAL: \_\_\_\_ WATCH: \_\_\_\_

AMENDED IN ASSEMBLY APRIL 9, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 836**

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**Introduced by Assembly Member Skinner**

February 21, 2013

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

LEGISLATIVE COUNSEL’S DIGEST

AB 836, as amended, Skinner. Dentists: continuing education.

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

This bill would prohibit the board from requiring ~~of those licensees~~ *a retired dentist who provides only uncompensated care* more than 60% of the hours of continuing education that is required of other licensed dentists. *The bill would require the board to report on the outcome of that provision, pursuant to, and at the time of, its regular sunset review process.*

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

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

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

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

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

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

(c) For a ~~dentist described in subdivision (a) of Section 1716.1~~ *retired dentist who provides only uncompensated care*, the board shall not require more than 60 percent of the hours of continuing education that is required of other licensed dentists. Nothing in this subdivision shall be construed to reduce any requirements imposed by the board pursuant to subdivision (b).

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

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 1174

**AUTHOR:** Bocanegra and Logue

**SPONSOR:**

**VERSION:** Amended 04/09//2013

**INTRODUCED:** 02/22/2013

**BILL STATUS:** 04/30/2013 – Com. on Health

**BILL LOCATION:** Assembly

**SUBJECT:** Dental Professionals:  
Teledentistry under Medi-Cal.

**RELATED  
BILLS:**

**SUMMARY**

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

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

(2) Existing law provides for the Medi-Cal program, which is (2) administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including certain dental services, as specified. Existing law provides that, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal



program for “teleophthalmology and teledermatology by store and forward,” as defined to mean the asynchronous transmission of medical information to be reviewed at a later time by a licensed physician or optometrist, as specified, at a distant site.

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

This bill will amend Sections 1752.4, 1753.5, 1753.6, and 1910 of the Business and Professions Code to add the additional RDA and RDAEF duties and educational requirements, and to add the responsibilities of the supervising dentist. The bill will add Section 14132.726 to the Welfare and Institution Code, relating to oral health.

### **ANALYSIS**

Although unknown at this time, staff is in the process of researching the potential impact of the provisions of this bill upon the Board

### **REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

### **STAFF RECOMMENDATION**

Watch.

### **BOARD POSITION**

**SUPPORT:** \_\_\_\_ **OPPOSE:** \_\_\_\_ **NEUTRAL:** \_\_\_\_ **WATCH:** \_\_\_\_

AMENDED IN ASSEMBLY APRIL 9, 2013  
AMENDED IN ASSEMBLY MARCH 21, 2013  
CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1174**

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**Introduced by Assembly ~~Member~~ *Members Bocanegra and Logue***

February 22, 2013

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An act to amend Sections 1752.4, 1753.5, 1753.6, and 1910 of the Business and Professions Code, and to add Section 14132.726 to the Welfare and Institution Code, relating to oral health.

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would authorize a registered dental assistant to determine which radiographs to perform if he or she has completed a specified educational program. The bill would authorize a registered dental assistant in extended functions licensed on or after January 1, 2010, to place interim therapeutic restorations, as defined, pursuant to the order, control, and full professional responsibility of a licensed dentist, as

specified. The bill would authorize a registered dental hygienist to ~~operate dental radiography equipment for the purpose of oral radiography, and~~, after submitting to the committee evidence of satisfactory completion of a course of instruction approved by the committee, determine which radiographs to perform and place interim therapeutic restorations upon the order of a licensed dentist.

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

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

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

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

- 1 SECTION 1. Section 1752.4 of the Business and Professions
- 2 Code is amended to read:

1 1752.4. (a) A registered dental assistant may perform all of  
2 the following duties:

3 (1) All duties that a dental assistant is allowed to perform.

4 (2) Mouth-mirror inspections of the oral cavity, to include  
5 charting of obvious lesions, existing restorations, and missing  
6 teeth.

7 (3) Apply and activate bleaching agents using a nonlaser  
8 light-curing device.

9 (4) Use of automated caries detection devices and materials to  
10 gather information for diagnosis by the dentist.

11 (5) Obtain intraoral images for computer-aided design (CAD),  
12 milled restorations.

13 (6) Pulp vitality testing and recording of findings.

14 (7) Place bases, liners, and bonding agents.

15 (8) Chemically prepare teeth for bonding.

16 (9) Place, adjust, and finish direct provisional restorations.

17 (10) Fabricate, adjust, cement, and remove indirect provisional  
18 restorations, including stainless steel crowns when used as a  
19 provisional restoration.

20 (11) Place post-extraction dressings after inspection of the  
21 surgical site by the supervising licensed dentist.

22 (12) Place periodontal dressings.

23 (13) Dry endodontically treated canals using absorbent paper  
24 points.

25 (14) Adjust dentures extra-orally.

26 (15) Remove excess cement from surfaces of teeth with a hand  
27 instrument.

28 (16) Polish coronal surfaces of the teeth.

29 (17) Place ligature ties and archwires.

30 (18) Remove orthodontic bands.

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

32 (b) A registered dental assistant may only perform the following  
33 additional duties if he or she has completed a board-approved  
34 registered dental assistant educational program in those duties, or  
35 if he or she has provided evidence, satisfactory to the board, of  
36 having completed a board-approved course in those duties.

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

39 (2) The allowable duties of an orthodontic assistant permitholder  
40 as specified in Section 1750.3. A registered dental assistant shall

1 not be required to complete further instruction in the duties of  
2 placing ligature ties and archwires, removing orthodontic bands,  
3 and removing excess cement from tooth surfaces with a hand  
4 instrument.

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

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

8 (5) Determine which radiographs to perform.

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

13 ~~(d) This section shall become operative on January 1, 2010.~~

14 SEC. 2. Section 1753.5 of the Business and Professions Code  
15 is amended to read:

16 1753.5. (a) A registered dental assistant in extended functions  
17 licensed on or after January 1, 2010, is authorized to perform all  
18 duties and procedures that a registered dental assistant is authorized  
19 to perform as specified in and limited by Section 1752.4, and those  
20 duties that the board may prescribe by regulation.

21 (b) A registered dental assistant in extended functions licensed  
22 on or after January 1, 2010, is authorized to perform the following  
23 additional procedures under direct supervision and pursuant to the  
24 order, control, and full professional responsibility of a licensed  
25 dentist:

26 (1) Conduct preliminary evaluation of the patient's oral health,  
27 including, but not limited to, charting, intraoral and extra-oral  
28 evaluation of soft tissue, classifying occlusion, and myofunctional  
29 evaluation.

30 (2) Perform oral health assessments in school-based, community  
31 health project settings under the direction of a dentist, registered  
32 dental hygienist, or registered dental hygienist in alternative  
33 practice.

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

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

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

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

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

39 (8) Polish and contour existing amalgam restorations.

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

1 (10) Adjust and cement permanent indirect restorations.

2 (11) Other procedures authorized by regulations adopted by the  
3 board.

4 (c) All procedures required to be performed under direct  
5 supervision shall be checked and approved by the supervising  
6 licensed dentist prior to the patient's dismissal from the office.

7 (d) (1) A registered dental assistant in extended functions  
8 licensed on or after January 1, 2010, is authorized to place interim  
9 therapeutic restorations, defined as the removal of ~~earries~~ *caries*  
10 using hand instruments and placement of an adhesive restorative  
11 material, upon the order of the supervising dentist under general  
12 supervision, except as authorized pursuant to paragraph ~~(2)~~ (3),  
13 and pursuant to the order, control, and full professional  
14 responsibility of a licensed dentist.

15 (2) *A registered dental assistant in extended function may only*  
16 *perform the functions authorized pursuant to paragraph (1) if he*  
17 *or she has completed a board-approved registered dental assistant*  
18 *in extended function education program in performing those*  
19 *functions, or if he or she has provided evidence, satisfactory to*  
20 *the board, of having completed a board-approved course in those*  
21 *functions.*

22 ~~(2)~~

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

26 SEC. 3. Section 1753.6 of the Business and Professions Code  
27 is amended to read:

28 1753.6. (a) Each person who holds a license as a registered  
29 dental assistant in extended functions on the operative date of this  
30 section may only perform those procedures that a registered dental  
31 assistant is allowed to perform as specified in and limited by  
32 Section 1752.4, and the procedures specified in paragraphs (1) to  
33 (6), inclusive, until he or she provides evidence of having  
34 completed a board-approved course in the additional procedures  
35 specified in paragraphs (1), (2), (5), and (7) to (11), inclusive, of  
36 subdivision (b), and paragraph (1) of subdivision (d), of Section  
37 1753.5, and an examination as specified in Section 1753.4:

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

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

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

(4) Fit trial endodontic filling points.

(5) Apply pit and fissure sealants.

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

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

SEC. 4. Section 1910 of the Business and Professions Code is amended to read:

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

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

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

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

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

~~(e) Operate dental radiography equipment for the purpose of oral radiography.~~

~~(f)~~

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

(1) Determine which radiographs to perform.

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

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

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

(b) A patient receiving teledentistry by store and forward shall be notified of the right to receive interactive communication with the distant dentist, and shall receive an interactive communication

1 with the distant dentist, upon request. If requested, communication  
2 with the distant dentist may occur either at the time of the  
3 consultation, or within 30 days of the patient's notification of the  
4 results of the consultation.

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

10 (d) Notwithstanding Chapter 3.5 (commencing with Section  
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
12 the department may implement, interpret, and make specific this  
13 section by means of all-county letters, provider bulletins, and  
14 similar instructions.

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

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

20 (1) "Asynchronous store and forward" means the transmission  
21 of a patient's dental information from an originating site to the  
22 health care provider at a distant site without the presence of the  
23 patient.

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

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

30 (4) "Originating site" means a site where a patient is located at  
31 the time health care services are provided via a telecommunications  
32 system or where the asynchronous store and forward service  
33 originates.

34 (5) "Synchronous interaction" means a real-time interaction  
35 between a patient and a health care provider located at a distant  
36 site.

37 (6) "Teledentistry" means the mode of delivering dental health  
38 care services and public dental health via information and  
39 communication technologies to facilitate the diagnosis,  
40 consultation, treatment, education, care management, and





5	4	3	2	1	0
<ul style="list-style-type: none"><li>• Verifies that restoration meets all accepted criteria</li><li>• Verifies errors in restoration and proposes changes, if needed</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of major deviation from optimal that can be corrected</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of <u>multiple</u> major deviations from optimal</li></ul>	<ul style="list-style-type: none"><li>• Critical errors that require restoration to be redone</li></ul>



5	4	3	2	1	0
<ul style="list-style-type: none"><li>• Meets all accepted criteria for pre-cementation:<ul style="list-style-type: none"><li>a) Occlusal form and function</li><li>b) Proximal contact</li><li>c) Axial contours</li><li>d) Marginal fit</li><li>e) External surfaces smooth and polished without pits, voids, or debris</li><li>f) Optimal internal adaptation</li><li>g) Retention</li><li>h) Esthetics</li><li>i) Patient acceptance</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of slight deviations from accepted criteria and minimal impact on treatment</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of moderate deviations from accepted criteria with minimal impact on treatment</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of major deviation that can be corrected</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of <u>multiple</u> major deviations from optimal</li></ul>	<ul style="list-style-type: none"><li>• Lack of recognition of critical errors which <u>cannot</u> be corrected</li></ul>



5	4	3	2	1	0
<ul style="list-style-type: none"><li>• Meets all accepted criteria for optimal cementation<ul style="list-style-type: none"><li>a) Occlusal form and function</li><li>b) Proximal contact</li><li>c) Axial contours</li><li>d) Marginal fit</li><li>e) External surfaces smooth and polished without pits, voids, or debris</li><li>f) Optimal internal adaptation</li><li>g) Retention</li><li>h) Esthetics</li><li>i) All excess cement removed</li><li>j) No unnecessary tissue trauma</li><li>k) Appropriate postoperative instructions</li></ul></li></ul>	<ul style="list-style-type: none"><li>• Slight deviations from optimal; minimal impact on treatment</li></ul>	<ul style="list-style-type: none"><li>• Moderate deviations from accepted criteria; minimal impact on treatment</li></ul>	<ul style="list-style-type: none"><li>• Major deviation from accepted that can be corrected</li></ul>	<ul style="list-style-type: none"><li>• <u>Multiple</u> major deviations from optimal</li></ul>	<ul style="list-style-type: none"><li>• Critical errors which require restoration to be redone</li><li>• Procedure is not completed within allotted time</li><li>• Unnecessary, gross damage to hard and soft tissue as related to finishing</li></ul>

# Chapter 9 - Removable Prosthodontics

## **Purpose**

The purpose of the competency examinations for removable prosthodontics are designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a prosthesis from diagnosis and treatment planning to delivery of the prosthetic device and post-insertion follow-up.

## **Clinical experiences**

The documentation of removable prosthodontic clinical experiences shall include five (5) prostheses.

One of the five prostheses may be used as a Portfolio competency examination provided that it is completed in an independent manner with no faculty intervention.

A prosthesis is defined to include any of the following:

- > Full denture,
- > Partial denture (cast framework),
- > Partial denture (acrylic base with distal extension replacing a minimum number of three posterior teeth),
- > Immediate treatment denture, or,
- > Overdenture retained by natural or dental implants.

## **Overview**

- Twelve (12) scoring factors.
- One (1) of the following prosthetic treatments from start to finish on the same patient
  - > Denture or overdenture for a single edentulous arch, or,
  - > Cast metal framework removable partial denture (RPD) for a single Kennedy Class I or Class II partially edentulous arch
- An immediate or interim denture..
- No patient sharing; cannot split patients between candidates.
- Requires patient management. Candidate must be familiar with patient's medical and dental history.
- Medical conditions must be managed appropriately.
- Case complexity is not a criteria.

## ***Patient parameters***



Procedures may be performed on patients with supported soft tissue, implants or natural tooth retained overdentures.

## ***Scoring***

Scoring points for removable prosthodontics are defined as follows:

- A score of 1 is unacceptable with gross errors
- A score of 2 is unacceptable with major errors
- A score of 3 is minimum competence with moderate errors that do not compromise outcome
- A score of 4 is acceptable with minor errors that do not compromise outcome
- A score of 5 is optimal with no errors evident

## ***Elements of the Removable Prosthodontics Portfolio***

- a) Documentation the candidate developed a diagnosis, determined treatment options and prognosis for the patient to receive a removable prosthesis. The documentation may include, but is not limited to the following:
  - Evidence the candidate obtained a patient history, (e.g. medical, dental and psychosocial).
  - Evaluation of the patient's chief complaint.
  - Radiographs and photographs of the patient.
  - Evidence the candidate performed a clinical examination, (e.g. hard/soft tissue charting, endodontic evaluation, occlusal examination, skeletal/jaw relationship, VDO, DR, MIP).
  - Evaluation of existing prosthesis and the patient's concerns.
  - Evidence the candidate obtained and mounted a diagnostic cast.
  - Evidence the candidate determined the complexity of the case based on ACP classifications.
  - Evidence the patient was presented with treatment plan options and assessment of the prognosis, (e.g. complete dentures, partial denture, overdenture, implant options, FPD).
  - Evidence the candidate analyzed the patient risks/benefits for the various treatment options.
  - Evidence the candidate exercised critical thinking and made evidence based treatment decisions.
- b) Documentation of the candidate's competency to successfully restore edentulous spaces with removable prosthesis. The documentations may include but is not limited to the following:

- Evidence the candidate developed a diagnosis and treatment plan for the removable prosthesis.
  - Evidence the candidate obtained diagnostic casts.
  - Evidence the candidate performed diagnostic wax-up/survey framework designs.
  - Evidence the candidate performed an assessment to determine the need for pre-prosthetic surgery and made the necessary referral.
  - Evidence the candidate performed tooth modifications and/or survey crowns, when indicated.
  - Evidence the candidate obtained master impressions and casts.
  - Evidence the candidate obtained occlusal records.
  - Evidence the candidate performed a try-in and evaluated the trial dentures.
  - Evidence the candidate inserted the prosthesis and provided the patient with post-insertion care.
  - Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).
- c) Documentation of the candidate's competency to manage tooth loss transitions with immediate or transitional prostheses. The documentation may include, but is limited to the following:
- Evidence the candidate developed a diagnosis and treatment plan that identified teeth that could be salvaged and or teeth that needed extraction.
  - Evidence the candidate educated the patient regarding the healing process, denture experience, and future treatment need.
  - Evidence the candidate developed prosthetic phases which included surgical plans.
  - Evidence the candidate obtained casts (preliminary and final impressions).
  - Evidence the candidate obtained the occlusal records.
  - Evidence the candidate did try-ins and evaluated trial dentures.
  - Evidence the candidate competently managed and coordinated the surgical phase.
  - Evidence the candidate provided the patient post insertion care including adjustment, relines and patient counseling.
  - Documentation the candidate followed established standards of care in the restoration of the edentulous spaces, (e. g. informed consent, and infection control).

d) Documentation of the candidate's competency to manage prosthetic problems. The documentation may include, but is not limited to the following:

- Evidence the candidate competently managed real or perceived patient problems.
- Evidence the candidate evaluated existing prosthesis.
- Evidence the candidate performed uncomplicated repairs, relines, re-base, re-set or re-do, if needed.
- Evidence the candidate made a determination if specialty referral was necessary.
- Evidence the candidate obtained impressions/records/information for laboratory use.
- Evidence the candidate competently communicated needed prosthetic procedure to laboratory technician.
- Evidence the candidate inserted the prosthesis and provided the patient follow-up care.
- Evidence the candidate performed in-office maintenance, (e.g. prosthesis cleaning, clasp tightening and occlusal adjustments).

e) Documentation the candidate directed and evaluated the laboratory services for the prosthesis. The documentation may include, but is not limited to the following:

- Complete laboratory prescriptions sent to the dental technician.
- Copies of all communications with the laboratory technicians.
- Evaluations of the laboratory work product, (e.g. frameworks, processed dentures).

## ***Removable Prosthodontics scoring criteria***

### **FACTOR 1: PATIENT EVALUATION AND DIAGNOSIS**

5	4	3	2	1
<ul style="list-style-type: none"> <li>• <input type="checkbox"/></li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> <li>•</li> </ul>

## FACTOR 2: TREATMENT PLAN AND SEQUENCING

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Presents/ formulates all treatment options and understands clinical nuances of each option</li> <li>• Presents comprehensive treatment plan based on clinical evidence, patient history and direct examination</li> <li>• Performs risk-based analysis to present appropriate treatment options and prognosis</li> <li>• Demonstrates critical thinking as evidenced in steps in treatment plan</li> <li>• No errors in planning and sequencing</li> </ul>	<ul style="list-style-type: none"> <li>• Presents/formulates most treatment options and understands rationale of each option</li> <li>• Treatment plan is appropriate some contributing factors NOT considered</li> <li>• <u>Minor</u> errors that do NOT affect planning and sequencing</li> </ul>	<ul style="list-style-type: none"> <li>• Presents/formulates appropriate treatment options with less than ideal understanding of chief complaint, diagnosis, and prognosis</li> <li>• <u>Moderate</u> errors that do NOT compromise planning and sequencing</li> </ul>	<ul style="list-style-type: none"> <li>• Does NOT address patient's chief complaint</li> <li>• Treatment plan NOT based on diagnosis</li> <li>• <u>Major</u> errors in evidenced based, critical thinking, risk-based, and prognostic assessment</li> <li>• Treatment sequence inappropriate</li> </ul>	<ul style="list-style-type: none"> <li>• Treatment plan NOT based on diagnostic findings or prognostic information</li> <li>• Treatment plan grossly inadequate</li> <li>• Treatment sequence grossly inappropriate</li> </ul>



### FACTOR 3: PRELIMINARY IMPRESSIONS

5	4	3	2	1
<ul style="list-style-type: none"> <li>Perform and recognize adequate capture of anatomy; free of distortions and voids</li> </ul>	<ul style="list-style-type: none"> <li>Performs impression with <u>minor</u> errors that do NOT affect final outcome</li> </ul>	<ul style="list-style-type: none"> <li>Performs impression with <u>moderate</u> errors that do NOT compromise final outcome</li> </ul>	<ul style="list-style-type: none"> <li>Performs impression with <u>major</u> errors, <u>or</u> fails to recognize that final outcome is compromised</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate capture of anatomy or gross distortion/voids</li> <li>Fails to recognize that subsequent steps are impossible</li> </ul>

### FACTOR 4: RPD DESIGN (IF APPLICABLE)

5	4	3	2	1
<ul style="list-style-type: none"> <li>Design demonstrates understanding of biomechanical and esthetic principles</li> <li>Casts are surveyed accurately</li> <li>Design is drawn with detail</li> </ul>	<ul style="list-style-type: none"> <li>Design demonstrates understanding of biomechanical and esthetic principles with <u>minor</u> errors</li> <li>Minor errors in cast survey and design</li> </ul>	<ul style="list-style-type: none"> <li>Design is functional but includes rests, clasp assembly or major connector that are NOT first choices</li> <li><u>Moderate</u> errors in survey and design</li> <li>Moderate errors in understanding of RPD design principles</li> </ul>	<ul style="list-style-type: none"> <li>Demonstrates lack of understanding of biomechanical or esthetic principles</li> <li><u>Major</u> errors in cast survey and design</li> </ul>	<ul style="list-style-type: none"> <li>Design is grossly inappropriate</li> <li>Inaccurate survey</li> <li>Illegible drawing</li> </ul>

## FACTOR 5: TOOTH MODIFICATION (IF APPLICABLE)

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Parallel guiding planes</li> <li>• Optimal size and location of rest preparations</li> <li>• Conservative recontouring of abutment teeth for optimal location of clasp and to optimize occlusal plane</li> <li>• Survey crowns as needed</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Minor</u> deficiencies in tooth modification; RPD fit and service unaffected</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Moderate</u> deficiencies in tooth modifications but no compromise in RPD fit and service</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Major</u> errors in tooth modifications leading to compromised RPD fit and service</li> <li>• Tooth modifications may require restorations</li> </ul>	<ul style="list-style-type: none"> <li>• RPD abutment teeth are grossly over-prepared</li> </ul>

## FACTOR 6: BORDER MOLDING AND FINAL IMPRESSIONS

5	4	3	2	1
<ul style="list-style-type: none"> <li>Obtain optimal vestibular extension and peripheral seal</li> <li>Perform and recognize adequate capture of anatomy</li> <li>Impression free of distortions/voids</li> </ul>	<ul style="list-style-type: none"> <li>Border molding and/or impression have <u>minor</u> errors that do NOT affect final outcome</li> </ul>	<ul style="list-style-type: none"> <li>Border molding and/or impression have <u>moderate</u> deviations that do NOT compromise final outcome</li> </ul>	<ul style="list-style-type: none"> <li>Border molding and/or impression have <u>major</u> errors that affect final outcome</li> </ul>	<ul style="list-style-type: none"> <li>Border molding and/or impression do NOT adequately capture of anatomy or gross distortion/voids so that final outcome impossible</li> </ul>

## FACTOR 7: FRAMEWORK TRY-IN (IF APPLICABLE)

5	4	3	2	1
<ul style="list-style-type: none"> <li>Perform and recognize functional and occlusal adjustment</li> <li>Complete seating of framework is achieved</li> <li>Determine sequence for establishing denture-base support</li> </ul>	<ul style="list-style-type: none"> <li><u>Minor</u> deficiencies in ability to recognize and correct minor discrepancies in framework fit but do NOT affect RPD service</li> </ul>	<ul style="list-style-type: none"> <li><u>Moderate</u> deficiencies in ability to recognize or correct discrepancies in framework fit but no significant compromise to RPD service</li> </ul>	<ul style="list-style-type: none"> <li><u>Major</u> errors in framework fit NOT recognized</li> <li>Errors in judgment regarding sequence of correction</li> </ul>	<ul style="list-style-type: none"> <li><u>Gross</u> errors in framework fit NOT recognized</li> <li>Unable to determine sequence of correction</li> </ul>

## FACTOR 8: JAW RELATION RECORDS

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Smooth record bases with appropriate peripheral extensions/thickness</li> <li>• Smoothly contoured wax rim establishes esthetic parameters</li> <li>• Vertical dimension is physiologically appropriate</li> <li>• Accurately captures centric relation</li> <li>• Relates opposing casts without interference</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Minor</u> discrepancies in jaw relation records that do NOT adversely affect prosthetic service</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Moderate</u> discrepancies in jaw relation records that do NOT compromise prosthetic service; records do NOT require repeating</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Major</u> errors in jaw relation records that adversely affect prosthetic service; records should be redone</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Gross</u> errors in jaw relation records with poor understanding and judgment; records should be redone</li> </ul>

## FACTOR 9: TRIAL DENTURES

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Recognizes optimal <u>esthetic</u> (midline, incisal length, tooth mold and shade, arrangement), <u>occlusal</u> (MIP=CR, VDO &lt; VDR, bilateral posterior contact), <u>speech and contour</u> aspects of trial dentures</li> <li>• Deviations from the optimal are corrected or managed appropriately</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Minor</u> deficiencies in ability to recognize and correct discrepancies in esthetics, vertical dimension, occlusion, phonetics and contour</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Moderate</u> deficiencies in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which do NOT compromise final outcome</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Major</u> errors in ability to recognize or correct discrepancies in esthetics, vertical dimension, occlusion and phonetics which adversely affect final outcome</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrates inability to recognize or correct gross errors which will result in failure of final outcome</li> </ul>

## FACTOR 10: INSERTION OF REMOVABLE PROSTHESIS

5	4	3	2	1
<ul style="list-style-type: none"> <li>Optimize definitive prosthesis, recognizing errors and correcting if necessary, including the following:               <ul style="list-style-type: none"> <li>&gt; Tissue fit</li> <li>&gt; Prosthetic support, stability and retention</li> <li>&gt; RPD extension base tissue support</li> <li>&gt; Vestibular extension and bulk</li> <li>&gt; Occlusion; clinical remount required</li> <li>&gt; Phonetics</li> <li>&gt; Contours and polish</li> <li>&gt; Patient home care instructions</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li><u>Minor</u> discrepancies in judgment and/or performance of optimizing prosthesis fit and function; no adverse affect on prosthesis service</li> </ul>	<ul style="list-style-type: none"> <li><u>Moderate</u> discrepancies in judgment and performance of optimizing prosthesis fit/function; no compromise on prosthesis service</li> </ul>	<ul style="list-style-type: none"> <li><u>Major</u> errors in judgment and performance of optimizing prosthesis fit/function</li> <li>Prosthesis service adversely affected; may require significant correction of prosthesis</li> </ul>	<ul style="list-style-type: none"> <li><u>Gross</u> errors in judgment and performance results in failure of prosthesis with no possibility to correct; prosthesis must be redone</li> </ul>

### FACTOR 11: POST-INSERTION (1 WEEK)

5	4	3	2	1
<ul style="list-style-type: none"><li>• Perform an appropriate recall sequence to evaluate and diagnose prosthesis problem and make adjustments until patient is satisfied with fit, form and function of new prosthesis</li><li>• Enroll patient in maintenance program</li><li>• Demonstrate familiarity with common prosthesis complications and solutions</li></ul>	<ul style="list-style-type: none"><li>• <u>Minor</u> discrepancies in ability to evaluate and solve prosthesis problems; no affect on patient comfort and function</li></ul>	<ul style="list-style-type: none"><li>• <u>Moderate</u> discrepancies in ability to evaluate and solve prosthesis problems that do NOT compromise patient comfort and function</li></ul>	<ul style="list-style-type: none"><li>• <u>Major</u> errors in ability to evaluate and solve prosthesis problems that adversely affect patient comfort and function</li></ul>	<ul style="list-style-type: none"><li>• <u>Gross</u> errors in ability to evaluate and solve prosthesis problems</li><li>• Patient confidence is compromised</li></ul>

## FACTOR 12: LABORATORY SERVICES FOR PROSTHESIS

5	4	3	2	1
<ul style="list-style-type: none"> <li>• Prescription clearly communicates desired laboratory work and materials</li> <li>• Complies with infection control protocols between clinic and laboratory environments</li> <li>• Accurately evaluates laboratory work products</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services has <u>minor</u> errors that do NOT adversely affect prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services has <u>moderate</u> discrepancies that do NOT compromise prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services, has <u>major</u> errors that adversely affect prosthesis</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription, or management of laboratory services has <u>gross</u> errors that result in prosthesis failure</li> </ul>

# Chapter 10 - Endodontics

## ***Purpose***

The purpose of the competency examination for endodontics is designed to assess the candidate's independent ability to demonstrate clinical skills in all aspects of a case from diagnosis to completion of conventional nonsurgical endodontic interventions.

## ***Clinical experiences***

The documentation of endodontic clinical experiences on patients must include five (5) canals or any combination of canals in three separate teeth.

## ***Overview***

- Ten (10) scoring factors.
- One (1) clinical case.
- Requires patient management; therefore, candidate must be familiar with the patient's medical and dental history.
- Medical conditions must be managed appropriately.

## ***Patient parameters***

- Any tooth to completion by the same candidate clinician on the same patient.
- Completed case is defined as a tooth with an acceptable and durable coronal seal.

## ***Scoring***

Scoring points for endodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal



## ***Elements of the Endodontics Portfolio***

The Endodontics portfolio may include, but is not limited to the following:

- a) Documentation the candidate applied case selection criteria for endodontic cases. The Portfolio must contain evidence the cases selected met American Association of Endodontics case criteria for minimum difficulty such that treated teeth have uncomplicated morphologies, have signs and symptoms of swelling and acute inflammation and have not had previously completed or initiated endodontic therapy.
  - Candidates determine a diagnostic need for endodontic therapy.
  - Candidates performed charting and diagnostic testing
  - Candidates took and interpreted radiographs of the patient oral condition.
  - Candidates made a pulpal diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the pulpal diagnosis was within approved parameters (within normal limits, reversible pulpitis, irreversible pulpitis, necrotic pulp).
  - Candidates make a periapical diagnosis within approved parameters. Evidence the candidate considered the following in his/her determination the periapical diagnosis was within approved parameters (normal pulp, asymptomatic apical periodontitis, symptomatic apical periodontitis, acute apical abscess, chronic apical abscess).
  - Evidence the candidate developed an endodontic treatment plan that included trauma treatment, management of emergencies and referrals when indicated.
- b) Documentation the candidate performed pretreatment preparation for endodontic treatment. Documentation may include, but is not limited to the following:
  - Evidence the candidate competently managed the patient's pain.
  - Evidence the candidate removed caries and failed restorations.
  - Evidence the candidate determined the tooth restorability.
  - Evidence the candidate achieved isolation.
- c) The candidate competently performed access opening. Documentation may include, but is not limited to the following:
  - Evidence the candidate created the indicated outline form.
  - Evidence the candidate created straight line access.
  - Evidence the candidate maintained structural integrity.
  - Evidence the candidate completed un-roofing of pulp chamber.
  - Evidence the candidate identified all canal systems.

- d) Documentation the candidate performed proper cleaning and shaping techniques. Documentation may include, but is not limited to the following:
- Evidence the candidate maintained canal integrity.
  - Evidence the candidate preserved canal shape and flow.
  - Evidence the candidate applied protocols for establishing working length.
  - Evidence the candidate demonstrated apical control.
  - Evidence the candidate applied disinfection protocols.
- e) Documentation the candidate performed proper obturation protocols. Documentation may include, but is not limited to evidence the candidate applied obturation protocols, including selection and fitting of master cone, determination of canal condition before obturation, and verification of sealer consistency and adequacy of coating.
- f) Documentation the candidate demonstrated proper length control of obturation, including achievement of dense obturation of filling material, obturation achieved to a clinically appropriate coronal height.
- g) Documentation the candidate competently completed the endodontic case including evidence that the candidate achieved coronal seal to prevent re-contamination and the candidate created diagnostic, radiographic and narrative documentation.
- h) Documentation the candidate provided recommendations for post-endodontic treatment, including evidence that the candidate recommended final restoration alternatives and provided the patient with recommendations for outcome assessment and follow-up.

## Endodontics scoring criteria

### FACTOR 1: PRETREATMENT CLINICAL TESTING AND RADIOGRAPHIC IMAGING

4	3	2	1	0
<ul style="list-style-type: none"> <li>Clinical tests and radiographic imaging completed and recorded accurately</li> <li>Radiographic images are of diagnostic quality</li> </ul>	<ul style="list-style-type: none"> <li>Clinical tests and radiographic imaging completed and recorded accurately with minor discrepancies</li> </ul>	<ul style="list-style-type: none"> <li>Some clinical tests and radiographic images are lacking <u>but</u> diagnosis can be determined</li> </ul>	<ul style="list-style-type: none"> <li>Some clinical tests and radiographic images are lacking <u>and</u> diagnosis is questionable</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Clinical tests and radiographic images are lacking and diagnosis CANNOT be determined</li> <li>Radiographic images are missing or are NOT of diagnostic quality</li> </ul>

### FACTOR 2: ENDODONTIC DIAGNOSIS

4	3	2	1	0
<ul style="list-style-type: none"> <li>Establishes correct pulpal and periapical diagnosis with accurate interpretation of clinical tests and radiographic images</li> </ul>	<ul style="list-style-type: none"> <li>Establishes correct pulpal and periapical diagnosis with accurate interpretation, <u>but</u> missing <u>one</u> clinical test and/or radiographic image</li> </ul>	<ul style="list-style-type: none"> <li>Establishes correct pulpal and periapical diagnosis with adequate interpretation, <u>but</u> missing <u>multiple</u> clinical tests and radiographic images that do NOT impact diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>Establishes inaccurate pulpal or periapical diagnosis, <u>and</u> missing <u>multiple</u> clinical tests and radiographic images that impact diagnosis</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Demonstrates lack of understanding of endodontic diagnosis</li> <li>No clinical tests were done</li> </ul>

### FACTOR 3: ENDODONTIC TREATMENT PLAN

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Prognosis of treatment outcomes determined</li> <li>• Comprehensive evaluation of medical and dental history</li> <li>• Selects appropriate treatments based on clinical evidence</li> <li>• Understands complexities of the case such that all treatment risks identified</li> <li>• Informed consent obtained including alternative treatments</li> </ul>	<ul style="list-style-type: none"> <li>• Prognosis of treatment outcomes determined <u>and</u> adequate evaluation of medical and dental history</li> <li>• Selects appropriate treatment(s)</li> <li>• Significant treatment risks identified</li> <li>• Informed consent obtained</li> </ul>	<ul style="list-style-type: none"> <li>• Prognosis of treatment outcomes determined <u>and</u> minimal evaluation of <u>one</u> of the following: <ul style="list-style-type: none"> <li>&gt; Medical or dental history</li> <li>&gt; Appropriate treatment(s) selected,</li> <li>&gt; Most treatment risks identified,</li> <li>&gt; Informed consent obtained</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Prognosis of treatment outcomes unclear</li> <li>• Inadequate evaluation of medical and dental history despite appropriate treatments selected</li> <li>• Key treatment risks NOT identified</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Demonstrates lack of evaluation of relevant medical and dental history</li> <li>• Inappropriate treatment planning</li> <li>• No treatment risks identified</li> <li>• No informed consent obtained</li> <li>• Demonstrates inappropriate case selection</li> <li>• Prognosis of treatment outcomes NOT determined</li> </ul>

#### FACTOR 4: ANESTHESIA AND PAIN CONTROL

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Thorough knowledge of technique and materials used</li> <li>• Monitors vital signs and patient response throughout anesthesia</li> <li>• Anesthesia administration effective</li> </ul>	<ul style="list-style-type: none"> <li>• Thorough knowledge of technique</li> <li>• Profound anesthesia achieved</li> <li>• Monitors patient response throughout anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>• Can proceed with treatment without faculty assistance</li> <li>• Adequate anesthesia achieved</li> </ul>	<ul style="list-style-type: none"> <li>• Elements of anesthesia or pain control absent <u>but</u> patient care NOT compromised</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Incorrect anesthetic technique</li> <li>• Inadequate pain control and patient care is compromised</li> <li>• Requires faculty assistance</li> </ul>

#### FACTOR 5: CARIES REMOVAL, REMOVAL OF FAILING RESTORATIONS, EVALUATION OF RESTORABILITY, SITE ISOLATION

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Complete removal of visible caries</li> <li>• Removal of failing restoration</li> <li>• Establishes complete structural restorability</li> <li>• Achieves complete isolation with dental dam</li> </ul>	<ul style="list-style-type: none"> <li>• No visible caries <u>and</u> failing restorations removed</li> <li>• Establishes significant aspects of structural restorability <u>and</u> achieves effective isolation with dental dam</li> </ul>	<ul style="list-style-type: none"> <li>• No visible caries present</li> <li>• Establishes likely restorability <u>and</u> achieves adequate isolation with dental dam</li> </ul>	<ul style="list-style-type: none"> <li>• Caries removal compromised that potentially impacts procedure</li> <li>• Compromised coronal seal</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Gross visible caries</li> <li>• Failing restoration present</li> <li>• Nonrestorable excluding medical indications</li> <li>• Ineffective isolation</li> </ul>

## FACTOR 10: COMPLETION OF CASE

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Optimum coronal seal placed prior to permanent restoration</li> <li>• Optimum evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes</li> <li>• Evidence of comprehensive and inclusive post-operative instructions</li> </ul>	<ul style="list-style-type: none"> <li>• Effective coronal seal placed prior to permanent restoration</li> <li>• Thorough evidence of documentation; e.g., radiographs, clinical notes, assessment of outcomes <u>and</u> evidence of post-operative instructions</li> </ul>	<ul style="list-style-type: none"> <li>• Acceptable durable coronal seal placed</li> <li>• Acceptable documentation; e.g., radiographs, clinical notes, assessment of outcomes <u>and</u> evidence of post-operative instructions</li> </ul>	<ul style="list-style-type: none"> <li>• Acceptable coronal seal placed with limited longevity</li> <li>• Evidence of incomplete documentation</li> <li>• Evidence of incomplete post-operative instructions</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Poor coronal seal</li> <li>• Prognosis likely impacted by iatrogenic treatment factors</li> <li>• Improper or no documentation</li> <li>• No evidence of post-operative instruction</li> </ul>

# Chapter 11 - Periodontics

## **Purpose**

The competency examinations for periodontics are designed to assess the candidate's ability to demonstrate clinical skills in all aspects of a case from treatment planning to patient management.

## **Clinical experiences**

The documentation of periodontal clinical experiences shall include 25 cases. A periodontal experience may include, but is not limited to:

- > An adult prophylaxis,
- > Treatment of periodontal disease such as scaling and root planing,
- > Any periodontal surgical procedure, and,
- > Assisting on a periodontal surgical procedure when performed by a faculty or an advanced dental education candidate in periodontics

The combined clinical periodontal experience must include a minimum of five (5) quadrants of scaling and root planing procedures.

## **Overview**

- Nine (9) scoring factors.
- One (1) case to be scored in three parts:
  - Part A. Review medical and dental history, radiographic findings, comprehensive periodontal data collection, evaluate periodontal etiology/risk factors, comprehensive periodontal diagnosis, treatment plan.
  - Part B. Calculus detection, effectiveness of calculus removal.
  - Part C. Periodontal re-evaluation.
- Ideally, all three parts are to be performed on the same patient.
- In the event that the patient does not return for periodontal re-evaluation, Part C may be performed on a different patient.

## ***Patient parameters***

### **a) Examination, diagnosis and treatment planning**

- Minimum twenty (20) natural teeth with at least 4 molars
- At least one probing depth of 5 mm or greater must be present on at least four (4) of the teeth, excluding third molars, with at least two of these teeth with clinical attachment loss of 2 mm or greater
- Full mouth assessment or examination
- No previous periodontal treatment at this institution, and no nonsurgical or surgical treatment within past 6 months

### **b) Calculus detection and periodontal instrumentation (scaling and root planing)**

- Minimum of six (6) natural teeth in one quadrant, with at least two (2) adjacent posterior teeth in contact, one of which must be a molar.
- Third molars can be used but they must be fully erupted
- At least one probing depth of 5 mm or greater must be present on at least two (2) of the teeth that require scaling and root planing.
- Minimum of six (6) surfaces of clinically demonstrable subgingival calculus must be present in one or two quadrants. Readily clinically demonstrable calculus is defined as easily explorer detectable, heavy ledges. At least four (4) surfaces of the subgingival calculus must be on posterior teeth. Each tooth is divided into four surfaces for qualifying calculus: mesial, distal, facial, and lingual.  
If additional teeth are needed to obtain the required calculus and pocket depths two quadrants may be used.

### **c) Re-evaluation**

- Candidate must be able to demonstrate a thorough knowledge of the case
- Candidate must perform at least two (2) quadrants of scaling and root planing on the patient being reevaluated
- Candidate must perform at least two documented oral hygiene care (OHC) instructions with the patient being reevaluated 4-6 weeks after scaling and root planing is completed. The scaling and root planing should have been completed within an interval of 6 weeks or less.
- Minimum twenty (20) natural teeth with at least four (4) molars
- Baseline probing depth of at least 5 mm on at least four (4) of the teeth, excluding third molars



## **Scoring**

Scoring points for periodontics are defined as follows:

- A score of 0 is unacceptable; candidate exhibits a critical error
- A score of 1 is unacceptable; major deviations that are correctable
- A score of 2 is acceptable; minimum competence
- A score of 3 is adequate; less than optimal
- A score of 4 is optimal

## ***Elements of the Periodontics Portfolio***

- a) Documentation the candidate performed a comprehensive periodontal examination. The comprehensive periodontal examination may include, but is not limited to the following:
  - (1) Evidence the candidate reviewed the patient's medical and dental history.
  - (2) Evidence the candidate evaluated the patient's radiographs.
  - (3) Evidence the candidate performed extra- and intra-oral examinations of the patient.
  - (4) Evidence the candidate performed comprehensive periodontal data collection.
    - Evidence the candidate evaluated the patient's plaque index, probing depths, bleeding on probing, suppurations, cemento-enamel junction to the gingival margin (CEJ-GM), clinical attachment level tooth mobility and furcations
    - Evidence the candidate performed an occlusal assessment
- b) Documentation the candidate diagnosed and developed a periodontal treatment plan that documents the following:
  - (1) The candidate determined the periodontal diagnosis.
  - (2) The candidate formulated an initial periodontal treatment plan that demonstrated the candidate:
    - Determined to treat or refer the patient.
    - Discussed with patient the etiology, periodontal disease, benefits of treatment, consequences of no treatment, specific risk factors, and patient-specific oral hygiene instructions.
    - Determined non-surgical periodontal therapy.
    - Determined need for re-evaluation.
    - Determined recall interval.

- c) Documentation the candidate performed nonsurgical periodontal therapy that he/she:
- (1) Detected supra- and subgingival calculus
  - (2) Performed periodontal instrumentation:
    - Removed calculus
    - Removed plaque
    - Removed stains
  - (3) Demonstrated that the candidate did not inflict excessive soft tissue trauma
  - (4) Demonstrated that the candidate provided the patient with anesthesia
- d) Documentation the candidate performed periodontal re-evaluation
- (1) Evidence the candidate evaluated effectiveness of oral hygiene
  - (2) Evidence the candidate assessed periodontal outcomes:
    - Reviewed the medical and dental history
    - Reviewed the patient's radiographs
    - Performed comprehensive periodontal data collections ( e. g. , evaluation of plaque index, probing depths, bleeding on probing, suppurations, cemento-enamel junction to the gingival margin (CEJ-GM), clinical attachment level, furcations, and tooth mobility
  - (3) Evidence the candidate discussed with the patient his/her periodontal status as compared to the baseline, patient-specific oral hygiene instructions and modifications of specific risk factors
  - (4) Evidence the candidate determined further periodontal needs including need for referral to a periodontist and periodontal surgery.
  - (5) Evidence the candidate established a recall interval for periodontal treatment.

## ***Periodontics scoring criteria***

### **FACTOR 1: REVIEW MEDICAL AND DENTAL HISTORY (Part A)**

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Demonstrates complete knowledge and understanding of implications to dental care</li> <li>• Provides clear presentation of case</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrates complete understanding of implications to dental care <u>but</u> presentation could be improved</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes significant findings</li> <li>• Misses some information <u>but</u> minimal impact on patient care</li> </ul>	<ul style="list-style-type: none"> <li>• Recognizes medical conditions <u>but</u> fails to place in context of dental care</li> <li>• Unaware of medications or required precautions for dental appointment</li> <li>• Lack of information compromises patient care</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Lacks current information</li> <li>• Endangers patient</li> <li>• Does NOT include vital signs</li> <li>• Leaves questions regarding medical or dental history unanswered</li> <li>• Does NOT identify need for medical consult</li> </ul>

### **FACTOR 2: RADIOGRAPHIC FINDINGS (Part A)**

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Identifies and interprets all radiographic findings</li> </ul>	<ul style="list-style-type: none"> <li>• Identifies and interprets significant radiographic findings</li> </ul>	<ul style="list-style-type: none"> <li>• Interprets radiographic findings with minor deviations that do NOT substantially alter treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Misses significant radiographic findings</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Grossly misinterprets radiographic findings</li> <li>• Fails to identify non-diagnostic radiographs</li> <li>• Presents with outdated radiographs</li> </ul>

**FACTOR 3: COMPREHENSIVE PERIODONTAL DATA COLLECTION (Part A - applies to one quadrant selected by examiner)**

4	3	2	1	0
<ul style="list-style-type: none"> <li>Provides accurate assessment of all parameters in quadrant</li> </ul>	<ul style="list-style-type: none"> <li>Deviations of pocket depth up to 1 mm</li> <li>Correctly identifies all furcations</li> <li>Correctly identifies all tooth mobility</li> <li>Correctly identifies gingival recession</li> <li>Correctly identifies areas with no attached gingiva</li> </ul>	<ul style="list-style-type: none"> <li>Not more than <u>one</u> deviation of 2 mm or more in pocket depth</li> <li>Correctly identifies Class II or III furcations involvement</li> <li>Incorrectly identifies tooth mobility by one step in no more than <u>one</u> tooth</li> <li>Over/underestimates gingival recession by <math>\leq</math> 1 mm on any surface</li> <li>Recognizes concept of clinical attachment level and differentiate from probing pocket depth</li> </ul>	<ul style="list-style-type: none"> <li><u>More than one deviation</u> of 2 mm or more in pocket depth</li> <li>Fails to correctly identify Class II or III furcations involvement</li> <li>Fails to identify areas with no attached gingiva</li> <li>Overestimates Class 0 and 1 furcations</li> <li>Over/underestimates tooth mobility by two steps on any tooth</li> <li>Fails to correctly identify Grade 2 or 3 mobility</li> <li>Over/underestimates gingival recession by more than 2 mm on any surface</li> <li>Performs incomplete periodontal examination</li> <li>Fails to recognize concept of clinical attachment level and differentiate from probing pocket depth</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Performs periodontal examination which has no diagnostic value</li> <li>Provides inaccurate assessment of key parameters</li> </ul>

#### FACTOR 4: EVALUATE PERIODONTAL ETIOLOGY/RISK FACTORS (Part A)

4	3	2	1	0
<ul style="list-style-type: none"><li>Identifies all systemic, local etiologic and risk factors</li></ul>	<ul style="list-style-type: none"><li>Misses <u>one</u> risk factor</li></ul>	<ul style="list-style-type: none"><li>Misses <u>two</u> risk factors <u>but</u> treatment is NOT substantially impacted</li></ul>	<ul style="list-style-type: none"><li>Misses risk factors which compromise treatment planning and patient care</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Fails to identify all risk factors</li></ul>

#### FACTOR 5: COMPREHENSIVE PERIODONTAL DIAGNOSIS (Part A)

4	3	2	1	0
<ul style="list-style-type: none"><li>Provides accurate and complete diagnosis based on comprehensive clinical examination and findings</li><li>Demonstrates comprehensive understanding of periodontal diagnosis</li></ul>	<ul style="list-style-type: none"><li>Provides accurate and complete diagnosis based on clinical examination and findings pertinent to the case</li></ul>	<ul style="list-style-type: none"><li>Differentiates between periodontal health, gingivitis and periodontitis</li><li>Makes acceptable diagnosis with minimal deviations from ideal but treatment NOT impacted</li></ul>	<ul style="list-style-type: none"><li>Fails to diagnose periodontitis</li><li>Makes diagnosis with critical deviations from optimal</li><li>Provides a diagnosis which lacks rationale</li></ul>	Critical errors <u>include</u> : <ul style="list-style-type: none"><li>Fails to make a diagnosis</li><li>Provides diagnosis which is grossly incorrect</li></ul>

### FACTOR 6: TREATMENT PLAN (Part A)

4	3	2	1	0
<ul style="list-style-type: none"> <li>Provides comprehensive and clinically appropriate treatment plan including clear description of etiology, benefits of treatment, alternatives, and risk factors</li> </ul>	<ul style="list-style-type: none"> <li>Provides comprehensive and clinically appropriate treatment plan including clinically appropriate alternative treatment plan (if any)</li> <li>Provides adequate description of risks and benefits of treatment and alternatives</li> </ul>	<ul style="list-style-type: none"> <li>Provides clinically appropriate treatment plan but fails to address some factors that are unlikely to affect outcome</li> <li>Does NOT provide clear description of risks and benefits of treatment and alternatives</li> </ul>	<ul style="list-style-type: none"> <li>Provides treatment plan which fails to address relevant factors which are likely to affect outcome</li> <li>Provides incomplete periodontal treatment plan that is below the standard of care and adversely affects outcome</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Provides clinically inappropriate treatment plan which could harm the patient</li> </ul>

### FACTOR 7: CALCULUS DETECTION (Part B)

4	3	2	1	0
<ul style="list-style-type: none"> <li>Demonstrates complete detection of all subgingival calculus present in quadrant(s)</li> </ul>	<ul style="list-style-type: none"> <li>Incorrectly identifies absence or presence of <u>one</u> area of clinically demonstrable subgingival calculus</li> </ul>	<ul style="list-style-type: none"> <li>Incorrectly identifies absence or presence of <u>two</u> areas of clinically demonstrable subgingival calculus</li> </ul>	<ul style="list-style-type: none"> <li>Misses <u>three</u> areas of clinically demonstrable subgingival calculus</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Misses or incorrectly identifies four or more areas of clinically demonstrable subgingival calculus</li> </ul>

## FACTOR 8: EFFECTIVENESS OF CALCULUS REMOVAL (Part B)

4	3	2	1	0
<ul style="list-style-type: none"> <li>• Demonstrates complete removal of all calculus plaque and stains from tooth surfaces</li> <li>• Does NOT cause any tissue trauma</li> <li>• Does NOT cause any patient discomfort</li> </ul>	<ul style="list-style-type: none"> <li>• Demonstrates complete removal of all other deposits except for stains in pits and fissures</li> <li>• Minimizes patient discomfort</li> </ul>	<ul style="list-style-type: none"> <li>• Misses <u>one</u> area of clinically demonstrable subgingival calculus</li> <li>• Demonstrates removal of all other deposits <u>but</u> some remaining minor stains on accessible surfaces</li> <li>• Provides sufficient pain management for treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Misses <u>two</u> areas of clinically demonstrable subgingival calculus</li> <li>• Causes major tissue trauma</li> <li>• Leaves moderate plaque and supragingival calculus</li> <li>• Inadequate pain management</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>• Misses three areas of clinically demonstrable subgingival calculus</li> <li>• Leaves heavy stain, plaque, supragingival calculus</li> <li>• No pain management</li> </ul>

## FACTOR 9: PERIODONTAL RE-EVALUATION (Part C)

4	3	2	1	0
<ul style="list-style-type: none"> <li>Identifies all clinical changes of periodontal condition and describes the biological basis of changes</li> <li>Evaluates patient's oral hygiene, provides patient-specific oral hygiene instruction, <u>and</u> educates patient on the significance of plaque removal and periodontal disease treatment</li> <li>Evaluates and determines all of the patient's <u>specific</u> periodontal needs with detailed rationale for further periodontal procedures</li> </ul>	<ul style="list-style-type: none"> <li>Identifies all clinical changes of periodontal condition</li> <li>Evaluates and determines specific needs for periodontal care with rationale for further periodontal procedures</li> <li>Accurately assesses all of patient's oral hygiene problems</li> <li>Provides oral hygiene instructions that addresses all of patient's needs</li> <li>Evaluates and determines all of the patient's <u>specific</u> periodontal needs <u>without</u> detailed rationale</li> </ul>	<ul style="list-style-type: none"> <li>Identifies most clinical changes of periodontal condition but fails to identify minor changes</li> <li>Accurately assesses most of patient's oral hygiene problems</li> <li>Provides oral hygiene instructions that only address most of the patient's needs</li> <li>Evaluates and determines <u>general</u> needs for periodontal care including recall intervals and referral, if indicated</li> </ul>	<ul style="list-style-type: none"> <li>Fails to identify persistent signs and symptoms of periodontal disease</li> <li>Fails to present an oral hygiene plan</li> <li>Makes recommendation for further periodontal treatment that is inappropriate and demonstrates lack of understanding of patient's periodontal needs</li> </ul>	<p>Critical errors <u>include</u>:</p> <ul style="list-style-type: none"> <li>Fails to recognize any clinical change in periodontal condition</li> <li>Did NOT assess patient's oral hygiene care or needs</li> <li>Has NOT evaluated and/or determined patient's periodontal needs</li> <li>Fails to recognize need for referral</li> </ul>



## Chapter 12 - Checklist

- ☐ Complete the Request for Portfolio Candidate ID number and Law and Ethics Examination Eligibility
- ☐ Complete the Application for Determination of Licensure Eligibility (Portfolio)
- ☐ Pay fees for application and examination
- ☐ Submit copy of LIVESCAN fingerprint form
- ☐ Submit original scorecard of NBDE examination passing results
- ☐ Complete Portfolio competency examinations
- ☐ Make arrangements for completion of the letter from the Dean's office certifying good academic standing and graduation
- ☐ Make arrangements for the completed Portfolio to be sent to the Board.

## Chapter 13 - Frequently Asked Questions

Q: Why did the Board decide to develop the Portfolio Examination alternative?

A: The Portfolio Examination is an initial licensure pathway that allows the Dental Board of California to delegate the administration of the clinical examination as legally mandated by the California State Business and Professions Code to the six (6) American Dental Association, Commission on Dental Accreditation (CODA) approved dental schools in California.

The Portfolio Examination offers candidates an option of completing a series of clinical competency examinations to be conducted during the clinical phase of dental education. The Portfolio clinical competency examinations will be administered under direct oversight by the Board and will utilize the psychometric (measurement) principles of standardization, calibration, and verification. After the examinations are completed and minimum clinical experiences are fulfilled, candidates will be granted a license to practice dentistry.

Currently, there are two pathways to initial dental licensure in California. One pathway is the clinical examination that is administered at the various dental schools within the state by WREB, a private examining group. A second pathway involves completion of a postdoctoral residency program in either Advanced Education in General Dentistry (AEGD) or General Practice Residency (GPR).

Q: How does this alternative compare to the other options for obtaining initial dental licensure?

A:	Portfolio Examination	Licensure by WREB	Licensure by Residency
	Portfolio Competency examination completed with patients of record during your final year of dental school.	Must pass WREB examination.	Must complete a one year general practice residency (GPR) or advanced education in general residency program (AEGD)
	Application/Examination fee of \$350.00.	Application fee of \$100.00 plus cost of WREB examination.	Application fee of \$100.00 plus cost of residency program of 1 year.
	Must complete the California Law and Ethics written examination.	Must complete the California Law and Ethics written examination.	Must complete the California Law and Ethics written examination.
	Must complete the National Board Dental Examination.	Must complete the National Board Dental Examination.	Must complete the National Board Dental Examination.

Q: How was the Portfolio Examination developed?

A: The Portfolio Examination has been developed by dental school faculty of the six Board approved dental schools under the guidance of psychometric (measurement) consultants and in accordance with psychometric standards.

The Portfolio Examination consists of sequential candidate evaluation and passing a competency examination performed on patients of record in each of the following areas:

- a) Oral Diagnosis and Treatment Planning
- b) Direct Restoration
- c) Indirect Restoration
- d) Removable Prosthodontics
- e) Endodontics
- f) Periodontics

The six (6) competency examinations of the Portfolio Examination process will be evaluated by dental school faculty who have been calibrated according to grading criteria set forth by the Board.

Q: How were the minimum clinical experiences determined?

A: All six (6) dental schools agreed to minimum clinical experiences that their candidates will achieve to enable them to submit their Portfolio Examination to the Board.

These minimum clinical experiences are common requirements, and are within the individual school requirements for graduation. Consequently, a candidate will still need to meet all academic requirements for that dental school for graduation, allowing for academic autonomy of individual dental schools.

The competency components of the Portfolio Examination may be taken prior to completion of clinical experiences at the discretion of the dental school in which the candidate is enrolled.

Q: What procedures are in place for Board oversight?

A: In order to ensure public safety, the Board will maintain oversight of the process with dentist consultants contracted to the Board. Moreover, the Board will continue to maintain authority over this process and perform periodic audits of Portfolio competency examination results at each school.

Q: Why not use Objective Structured Clinical Examinations (OSCE) for maximum standardization?

A: The schools and the Board chose to have candidates provide services to actual patients rather than manikins so that they are confident that candidates can provide services in actual clinical settings during the normal course of treatment. For example, candidates would be performing procedures and understand the consequences of their procedures on actual tissue and structures rather than cadaver teeth and artificial tissue.

Q: What are the advantages of the Portfolio Examination?

A: First, the Portfolio Examination costs a fraction of what it costs to participate in other pathways to licensure (WREB, postdoctoral residency programs).

Second, the candidate can perform the required competency components throughout their dental school tenure utilizing normal standards of patient care while insuring patient protection in the process.

Third, the procedures are performed on patients of record at the individual dental schools, ensuring that follow-up care can be obtained if necessary for those involved with this process. The pressure of acquiring patients is alleviated, as the competency components can be performed at any time during the final year of dental school. This allows for public protection and safety, minimizing the potential exposure of the patient involved in the current “snapshot” examination process.

Q: What is different about the Portfolio competency examinations compared with my school’s competency examinations?

A: The Portfolio Examination is much broader based and is standardized across schools. The Portfolio requires minimum clinical experiences in six domains plus successful completion of standardized competency examinations in six subject areas to be performed on patients of record during the normal course of treatment: Oral Diagnosis and Treatment Planning, Direct Restoration, Indirect Restoration, Removable Prosthodontics, Endodontics and Periodontics. All procedures require an “on demand” level of acceptable clinical performance.

Q: What if I decide that the Portfolio Examination pathway is not for me?

A: If you choose not to participate in the Portfolio pathway, you can still acquire your license by taking the WREB or participating in a postdoctoral residency program in general dentistry (GPR or AEGD).

- Q. Do I have to complete the minimum number of clinical experiences before attempting a Portfolio competency examination?
- A. You can take a Portfolio competency examination once clinical faculty has approved your readiness for the examination regardless of the number of clinical experiences you have completed.
- Q. When can I begin taking the Portfolio competency examinations?
- A. You can begin taking Portfolio competency examinations as soon as your Clinic Director determines your readiness. Most students will take their Portfolio competency examinations in their final year of dental school; however, students may take them earlier at the discretion of the Clinic Director.
- Q. How do I begin the Portfolio Examination process?
- A. You will need to submit the “Request for Portfolio Candidate Identification Number and Law and Ethics Examination Eligibility” form. The Board will send you confirmation of your identification number which will be used to identify you throughout the application and examination process.
- Q. Can the registrar of my dental school certify that I will graduate on my application?
- A. No, only the Dean of your dental school can certify that you will graduate and are in good standing.
- Q. How soon will I know the results of a given Portfolio competency examination?
- A. Your results should be given immediately following completion of a Portfolio competency examination.
- Q. What should I do if I fail a Portfolio competency examination?
- A. You will need to make arrangements with the Portfolio competency examiner to retest. If you have failed a Portfolio competency examination three times, you will need to complete remedial education before retesting.
- Q. Who will submit the completed Portfolio Examination after I have completed my minimum clinical experiences and Portfolio competency examinations?
- A. Your dental school will submit the completed portfolio. You will need to verify with your school that your application is on file with the Board or submit your application and fee with the Portfolio.

- Q. What if I decide that the Portfolio Examination pathway is not for me?
- A. If a candidate chooses not to utilize the Portfolio pathway, he/she can still acquire their license by taking WREB or completing a postdoctoral residency program.
- Q. Can my application fee be refunded if I decide that I no longer want to participate in the Portfolio pathway?
- A. Application fees are non-refundable and cannot be transferred to another licensure pathway.

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1 self-management of a patient’s dental health care while the patient  
2 is at the originating site and the dental health care provider is at a  
3 distant site. Teledentistry includes synchronous interactions and  
4 asynchronous store and forward transfers.  
5 (7) “Teledentistry by store and forward” means an asynchronous  
6 transmission of dental information to be reviewed at a later time  
7 by a licensed dentist at a distant site, where the dentist at the distant  
8 site reviews the dental information without the patient being present  
9 in real time.

## O

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Assembly Bill 1231

**AUTHOR:** Perez

**SPONSOR:**

**VERSION:** 5/7/13 – Amended Assembly

**INTRODUCED:** 02/22/2013

**BILL STATUS:** 5/7/13 Read second time and amended.

**BILL LOCATION:** Assembly

**SUBJECT:** Regional centers: telehealth and teledentistry

**RELATED  
BILLS:**

**SUMMARY**

The Lanterman Developmental Disabilities Services Act authorizes the State Department of Developmental Services to contract with regional centers to provide services and support to individuals with developmental disabilities, including autism.

This bill would, until January 1, 2019, require the department to inform all regional centers that any appropriate health service may be provided through the use of telehealth, as defined, and that dentistry may be provided through the use of teledentistry, as defined. The bill would require the department to provide technical assistance to regional centers on the use of telehealth and teledentistry and to request those centers to include a consideration of telehealth and teledentistry in individual program plans and individualized family services plans, as specified, and to consider the use of telehealth and teledentistry services for inclusion in training programs for parents.

The bill would provide that the provision of a service through the use of telehealth and teledentistry shall be voluntary and may be discontinued at the request of the consumer, as specified. The bill would require the department, on or before December 1, 2017, to forward to the fiscal and appropriate policy committees of the Legislature information provided by the regional centers to assess the effectiveness and appropriateness of providing telehealth and teledentistry services to regional center consumers, as specified.

## **ANALYSIS**

Staff is in the process of researching the potential impact of the provisions of this bill upon the Board. This bill is tied to HWPP #172 Project by Paul Glassman, DDS.

## **REGISTERED SUPPORT/OPPOSITION**

### **Support**

Center for Autism and Related Disorders  
ACT Today!  
Association of Regional Center Agencies  
Autism Research Group  
Children's Partnership  
Institute for Behavioral Training  
Law Offices of Bonnie Z. Yates, Inc.  
Special Needs Network  
One individual

### **Opposition**

None on file.

## **STAFF RECOMMENDATION**

Watch

## **BOARD POSITION**

SUPPORT: \_\_\_\_ OPPOSE: \_\_\_\_ NEUTRAL: \_\_\_\_ WATCH: \_\_\_\_

AMENDED IN ASSEMBLY MAY 7, 2013  
AMENDED IN ASSEMBLY APRIL 24, 2013  
AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1231**

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**Introduced by Assembly Member V. Manuel Pérez**

February 22, 2013

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An act to add and repeal Section 4686.21 of the Welfare and Institutions Code, relating to regional center services.

LEGISLATIVE COUNSEL’S DIGEST

AB 1231, as amended, V. Manuel Pérez. Regional centers: telehealth and teledentistry.

The Lanterman Developmental Disabilities Services Act authorizes the State Department of Developmental Services to contract with regional centers to provide services and support to individuals with developmental disabilities, including autism.

This bill would, until January 1, 2019, require the department to inform all regional centers that ~~behavioral~~ *any appropriate health treatment to treat pervasive developmental disorder or autism service* may be provided through the use of telehealth, as defined, and that dentistry may be provided through the use of teledentistry, as defined. The bill would require the department to provide technical assistance to regional centers on the use of telehealth and teledentistry and to request those centers to include a consideration of telehealth and teledentistry in individual program plans and individualized family services plans, as specified, *and to consider the use of telehealth and teledentistry services for inclusion in training programs for parents.*

The bill would ~~require providers of telehealth and teledentistry services to maintain the privacy and security of all confidential consumer information. The bill would~~ provide that the provision of a service through the use of telehealth and teledentistry shall be voluntary and may be discontinued at the request of the consumer, as specified. The bill would require the department, on or before December 1, 2017, to forward to the fiscal and appropriate policy committees of the Legislature information provided by the regional centers to assess the effectiveness and appropriateness of providing telehealth and teledentistry services to regional center consumers, as specified.

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

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

- 1     SECTION 1. (a) The Legislature finds and declares all of the
- 2     following:
- 3         (1) Autism spectrum disorders (ASD) now affect one in every
- 4     88 children of all ethnic, racial, and socioeconomic backgrounds.
- 5         (2) ASD is now the fastest growing developmental disability in
- 6     California and the nation and is more common than childhood
- 7     cancer, juvenile diabetes, and pediatric AIDS combined.
- 8         (3) Approximately two-thirds of all new consumers who are
- 9     entering the regional center system are now diagnosed with ASD.
- 10        (4) Behavioral health treatment (BHT), also known as early
- 11     intervention therapy or applied behavior analysis, is established
- 12     to improve brain function, cognitive abilities, and activities of
- 13     daily living for a significant number of individuals with ASD, but
- 14     may not be accessible or available in underserved communities.
- 15        (5) A significant number of individuals with ASD suffer from
- 16     inadequate dental care.
- 17     (b) It is the intent of the Legislature to do all of the following:
- 18         (1) Improve access to treatments and intervention services for
- 19     individuals with ASD or other developmental disabilities and their
- 20     families in underserved populations.
- 21         (2) Provide more cost-effective treatments and intervention
- 22     services for individuals with ASD or other developmental
- 23     disabilities and their families.

(3) Maximize the effectiveness of the interpersonal and face-to-face interactions that are utilized for the treatment of individuals with ASD or other developmental disabilities.

(4) Continue maintenance and support of the existing service workforce for individuals with ASD or other developmental disabilities.

(5) Utilize telehealth and teledentistry to improve services for individuals with ASD and other developmental disabilities.

SEC. 2. Section 4686.21 is added to the Welfare and Institutions Code, to read:

4686.21. (a) The department shall do all of the following:

(1) Inform all regional centers that ~~behavioral health treatment~~ *any appropriate health service, including, but not limited to, behavioral health treatment* may be provided through the use of telehealth.

(2) Inform all regional centers that dentistry may be provided through the use of teledentistry.

(3) Request regional centers to include a consideration of telehealth and teledentistry in each individual program plan (IPP) and individualized family service plan (IFSP) that includes a discussion of behavioral health treatment or dental health care.

*(4) Request regional centers to consider the use of telehealth and teledentistry services for inclusion in training programs for parents, including, but not limited to, group training programs as described in clause (i) of subparagraph (B) of paragraph (3) of subdivision (c) of Section 4685.*

~~(4)~~

(5) Provide, using existing resources, and in partnership with other organizations, resources, and stakeholders, technical assistance to regional centers regarding the use of telehealth and teledentistry.

~~(b) The use of telehealth and teledentistry services shall be considered for inclusion in training programs for parents, including, but not limited to, group training programs as described in clause (i) of subparagraph (B) of paragraph (3) of subdivision (c) of Section 4685.~~

~~(e)~~

*(b)* The department may implement appropriate vendorization subcodes for telehealth and teledentistry services and programs.

~~(d) Providers of telehealth and teledentistry services shall maintain the privacy and security of all confidential consumer information.~~

~~(e)~~

(c) The provision of a service through the use of telehealth and teledentistry shall be voluntary and may be discontinued at the request of the consumer or, as appropriate, the consumer's parent, legal guardian, or conservator. If, at any time, a consumer or, as appropriate, the consumer's parent, legal guardian, or conservator requests to discontinue the provision of a service through the use of telehealth or teledentistry, the regional center shall convene a review to determine alternative, appropriate means for providing the service.

~~(f)~~

(d) On or before December 1, 2017, the department shall forward to the fiscal and appropriate policy committees of the Legislature any information provided by the regional centers to the department to assess the effectiveness and appropriateness of providing telehealth and teledentistry services to regional center consumers through the IPP and IFSP processes.

~~(g)~~

(e) A provider of telehealth or teledentistry services shall be responsible for all expenses and costs related to the equipment, transmission, storage, infrastructure, and other expenses related to telehealth and teledentistry.

~~(h)~~

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

(1) "Behavioral health treatment" has the same meaning as set forth in paragraph (1) of subdivision (c) of Section 1374.73 of the Health and Safety Code.

(2) "Department" means the State Department of Developmental Services.

~~(3) "Teledentistry" is the use of information technology and telecommunications for dental care, consultation, education, and public awareness in the same manner as described in paragraph (6) of subdivision (a) of Section 2290.5 of the Business and Professions Code means telehealth used to deliver dental health care services and public dental health.~~

1     (4) “Telehealth” has the same meaning as set forth in paragraph  
2     (6) of subdivision (a) of Section 2290.5 of the Business and  
3     Professions Code.

4     (i)

5     (g) This section shall remain in effect only until January 1, 2019,  
6     and as of that date is repealed, unless a later enacted statute, that  
7     is enacted before January 1, 2019, deletes or extends that date.

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**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
MAY 16 - MAY 17, 2013 BOARD MEETING**

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**BILL NUMBER:** Senate Bill 456

**AUTHOR:** Padilla

**SPONSOR:**

**VERSION:** Introduced 02/21/2013

**INTRODUCED:** 02/21/2013

**BILL STATUS:** 02/21/2013 – Introduced.

**BILL LOCATION:** Senate

**SUBJECT:** Health Care Coverage

**RELATED  
BILLS:**

**SUMMARY**

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the establishment and operation of a principal office and branch offices of the Director of the Department of Managed Health Care.

This bill would make technical, non-substantive changes to that provision.□

**ANALYSIS**

This is currently a spot bill and the potential impact of the provisions of this bill upon the Board is unknown. Board staff has been advised that the author intends to utilize this bill as a placeholder for provisions that were contained in last year's SB 694. The author is continuing discussions related to the state dental director, workforce study, and funding issues related to SB 694.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**STAFF RECOMMENDATION**

Watch

**BOARD POSITION:**

**SUPPORT:**\_\_\_\_\_ **OPPOSE:**\_\_\_\_\_ **NEUTRAL:**\_\_\_\_\_ **WATCH:**\_\_\_\_\_

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Introduced by Senator Padilla

February 21, 2013

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An act to amend Section 1341.1 of the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

SB 456, as introduced, Padilla. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the establishment and operation of a principal office and branch offices of the Director of the Department of Managed Health Care.

This bill would make technical, nonsubstantive changes to that provision.

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

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

- 1 SECTION 1. Section 1341.1 of the Health and Safety Code is
- 2 amended to read:
- 3 1341.1. The director shall have his or her principal office in
- 4 the City of Sacramento, and may establish branch offices in the
- 5 City and County of San Francisco, in the City of Los Angeles, and
- 6 in the City of San Diego. The director shall from time to time
- 7 obtain the necessary furniture, stationery, fuel, light, and *any* other

- 1 proper ~~conveniences~~ *convenience* for the transaction of the business
- 2 of the Department of Managed Health Care.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Senate Bill 562

**AUTHOR:** Galgiani

**SPONSOR:** California Dental Association

**VERSION:** 04/30/13 – Amended Senate

**INTRODUCED:** 02/22/2013

**BILL STATUS:** 02/22/2013 – Introduced.

**BILL LOCATION:** Assembly

**SUBJECT:** Dentists: Mobile or Portable  
Dental Units

**RELATED  
BILLS:**

**SUMMARY**

The Dental Practice Act provides for the licensure and regulation by the Dental Board of California of those engaged in the practice of dentistry. Existing law provides that a person practices dentistry if the person, among other things, manages or conducts as manager, proprietor, conductor, lessor, or otherwise, in any place where dental operations are performed. Existing law authorizes a dentist to operate one mobile dental clinic or unit that is registered and operated in accordance with regulations adopted by the board. Existing law also imposes specified registration requirements on a dentist who maintains additional places of practice.

This bill would authorize a licensed dentist to operate one mobile or portable dental unit registered and operated in accordance with those regulations. The bill would add definitions for mobile dental unit and portable dental unit, as well as, authorize the regulations to include, but not be limited to, requirements for availability of follow-up and emergency care, maintenance, and availability of provider and patient records, and treatment information to be provided to patients and other appropriate parties.

**ANALYSIS**

The Dental Board of California will need to promulgate regulations to implement the provision contained in Section 1657 to implement the additional requirements for operating mobile or portable dental units.

During 2012, the California Dental Association (CDA) submitted a letter to the Board's Executive Officer seeking consideration of the Board to promulgate additional regulatory requirements relative to mobile dental clinics. The CDA had reviewed the Board's regulations governing mobile and portable dental providers and found the regulations lacking appropriate measures to ensure accountability and public safety. The CDA requested the issue of amending the Board's mobile dental clinic regulations be placed on the agenda for a future meeting.

At its May 2012 meeting, the Board reviewed the CDA's proposed amendments to the California Code of Regulations, Title 16, §1049 relative to mobile dental clinics. Board Legal Counsel commented that the proposed language would need some more work and expressed concern regarding authority, clarity, and consistency with current law and noted that the proposed exemptions look overly broad. Dr. Whitcher, Board President, appointed a subcommittee to work with staff to evaluate the CDA's proposed amendments and bring recommendations back to the Board.

At the August 2012 Board meeting, the subcommittee found that the language proposed by the CDA would not meet the approval standards of the Office of Administrative Law (OAL). Many of the proposed amendments were not authorized by statute and would not meet the necessity and clarity standards of the Administrative Procedure Act and such proposed regulatory language would not gain the approval of the OAL. The subcommittee therefore recommended considering a statutory change.

#### **REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

#### **STAFF RECOMMENDATION**

Neutral

#### **BOARD POSITION**

SUPPORT: \_\_\_\_ OPPOSE: \_\_\_\_ NEUTRAL: \_\_\_\_ WATCH: \_\_\_\_

**Introduced by Senator Galgiani**

February 22, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

This bill would authorize a licensed dentist to operate one mobile or portable dental unit, *as defined*, registered and operated in accordance with those regulations. The bill would authorize the regulations to include, but not be limited to, requirements for availability of followup and emergency care, maintenance, and availability of provider and

patient records, and treatment information to be provided to patients and other appropriate parties.

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

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

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

3 1657. (a) *For the purposes of this section, the following*  
4 *definitions shall apply:*

5 (1) *“Mobile dental unit” means a facility in which dentistry is*  
6 *practiced and that is routinely towed, moved, or transported from*  
7 *one location to another.*

8 (2) *“Portable dental unit” means a nonfacility in which dental*  
9 *equipment used in the practice of dentistry is transported to, and*  
10 *used on a temporary basis at, an out-of-office location.*

11 (b) A licensed dentist may operate one mobile or portable dental  
12 unit. The mobile or portable dental unit shall be registered and  
13 operated in accordance with regulations established by the board,  
14 provided these regulations are not designed to prevent or lessen  
15 competition in service areas. The regulations may include, but  
16 shall not be limited to, requirements for availability of followup  
17 and emergency care, maintenance, and availability of provider and  
18 patient records, and treatment information to be provided to patients  
19 and other appropriate parties. A mobile or portable dental unit  
20 registered and operated in accordance with the board’s regulations  
21 and that has paid the fees established by the board, including a  
22 mobile dental unit registered for the purpose specified in  
23 subdivision ~~(d)~~ (e), shall otherwise be exempted from this article  
24 and Article 3.5 (commencing with Section 1658).

25 ~~(b)~~

26 (c) A mobile service unit, as defined in subdivision (b) of  
27 Section 1765.105 of the Health and Safety Code, and a mobile  
28 unit operated by an entity that is exempt from licensure pursuant  
29 to subdivision (b), (c), or (h) of Section 1206 of the Health and  
30 Safety Code, are exempt from this article and Article 3.5  
31 (commencing with Section 1658). Notwithstanding this exemption,  
32 the owner or operator of the mobile unit shall notify the board  
33 within 60 days of the date on which dental services are first

1 delivered in the mobile unit, or the date on which the mobile unit's  
2 application pursuant to Section 1765.130 of the Health and Safety  
3 Code is approved, whichever is earlier.

4 ~~(e)~~

5 *(d)* A licensee practicing in a mobile unit described in  
6 subdivision-~~(b)~~ *(c)* is not subject to subdivision-~~(a)~~ *(b)* as to that  
7 mobile unit.

8 ~~(d)~~

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

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

16 (2) The licensee's insurer registers the unit with the board in  
17 compliance with subdivision-~~(a)~~ *(b)*.



**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Senate Bill 690

**AUTHOR:** Price

**SPONSOR:**

**VERSION:** Introduced 02/22/2013

**INTRODUCED:** 02/22/2013

**BILL STATUS:** 02/22/2013 – Introduced

**BILL LOCATION:** Senate

**SUBJECT:** Licenses

**RELATED  
BILLS:**

**SUMMARY**

Existing law provides for the licensing of various professions and vocations by boards within the Department of Consumer Affairs. Existing law defines license to mean a license, certificate, registration, or other means to engage in a business or profession, as provided.

This bill would expand the definition of license to include a permit.

**ANALYSIS**

Staff contacted the author's office. This is currently a spot bill and there is no intent to move the bill forward at this time.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**STAFF RECOMMENDATION**

Watch

**BOARD POSITION**

**SUPPORT:** \_\_\_\_ **OPPOSE:** \_\_\_\_ **NEUTRAL:** \_\_\_\_ **WATCH:** \_\_\_\_

Introduced by Senator Price

February 22, 2013

An act to amend Section 23.7 of the Business and Professions Code, relating to licenses.

LEGISLATIVE COUNSEL’S DIGEST

SB 690, as introduced, Price. Licenses.

Existing law provides for the licensing of various professions and vocations by boards within the Department of Consumer Affairs. Existing law defines license to mean a license, certificate, registration, or other means to engage in a business or profession, as provided.

This bill would expand the definition of license to include a permit.

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

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

- 1 SECTION 1. Section 23.7 of the Business and Professions
- 2 Code is amended to read:
- 3 23.7. Unless otherwise expressly provided, “license” means
- 4 license, certificate, registration, *permit*, or other means to engage
- 5 in a business or profession regulated by this code or referred to in
- 6 Section 1000 or 3600.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
MAY 16 – 17, 2013 BOARD MEETING**

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**BILL NUMBER:** Senate Bill 809

**AUTHOR:** DeSaulnier (S) Steinberg (S)      **SPONSOR:**

**VERSION:** Amended 05/01/13      **INTRODUCED:** 02/22/2013

**BILL STATUS:** From Committee with author's amendments. Read second time and amended. Re-referred to Committee on Governance and Finance.      **BILL LOCATION:** Senate

**SUBJECT:** Controlled substances: reporting      **RELATED BILLS:**

**SUMMARY**

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

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

CURES is a valuable investigative, preventive, and educational tool for law enforcement, regulatory boards, educational researchers, and the health care community.

Recent budget cuts to the Attorney General's Division of Law Enforcement (DLE) have resulted in insufficient funding to support the CURES Prescription Drug Monitoring Program (PDMP). The PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs and without a dedicated funding source; the CURES PDMP is not sustainable.

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

This bill would require the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized to prescribe or dispense controlled substances, by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

This bill would also require the California State Board of Pharmacy to increase the licensure, certification and renewal fees charged to wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

This bill would also levy a one-time tax assessment on health insurance plans and workers compensation insurers to fund the CURES modernization upgrade. It imposes annual taxes on drug manufacturers of Schedule II, III, and IV controlled substances doing business in California to maintain the CURES PDMP.

## **ANALYSIS**

Board staff is tracking this bill because of its potential impact relating to the increased licensing fees. Staff will continue to monitor this bill and advise the Board of its impact on the practice of dentistry.

## **REGISTERED SUPPORT/OPPOSITION**

To date, registered support from:

- California Attorney General Kamala Harris (Sponsor)
- California Narcotics Officers Association
- California Pharmacists Association
- California Police Chiefs Association
- California State Sheriffs' Association
- Center for Public Interest Law (CPIL)
- City and County of San Francisco
- Healthcare Distribution Management Association
- Troy and Alanna Pack Foundation
- University of California

To date, support if amended from:

- California Medical Association (CMA)

To date, opposition from:

- Pharmaceutical Research and Manufacturers of America (PhRMA)
- Consultant: Sara Mason

### **STAFF RECOMMENDATION**

Watch

### **BOARD POSITION**

**SUPPORT:** \_\_\_\_ **OPPOSE:** \_\_\_\_ **NEUTRAL:** \_\_\_\_ **WATCH:** \_\_\_\_

AMENDED IN SENATE MAY 1, 2013

**SENATE BILL**

**No. 809**

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**Introduced by Senators DeSaulnier and Steinberg**  
**(Coauthors: Senators Hancock, Lieu, Pavley, and Price)**  
(Coauthor: Assembly Member Blumenfield)

February 22, 2013

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An act to add Section 805.8 to the Business and Professions Code, to amend Sections 11165 and 11165.1 of the Health and Safety Code, and to add Part 21 (commencing with Section 42001) to Division 2 of the Revenue and Taxation Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as amended, DeSaulnier. Controlled substances: reporting.

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

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

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

This bill would require the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized to prescribe or dispense controlled substances, by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified. This bill would also require the California State Board of Pharmacy to increase the licensure, certification, and renewal fees charged to wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision by up to 1.16%, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified.

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

This bill would require licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care, and, upon the happening of specified events, to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Existing law imposes various taxes, including taxes on the privilege of engaging in certain activities. The Fee Collection Procedures Law, the violation of which is a crime, provides procedures for the collection of certain fees and surcharges.

This bill would impose a tax upon qualified manufacturers, as defined; ~~for the privilege of doing business in this state, as specified. This bill would also impose a tax upon specified insurers, as defined, for the privilege of doing business in this state, as specified.~~ The tax would be administered by the State Board of Equalization and would be collected *by the State Board of Equalization* pursuant to the procedures set forth

in the Fee Collection Procedures Law. The bill would require the board to deposit all taxes, penalties, and interest collected pursuant to these provisions in the CURES Fund, as provided. *This bill would also allow specified insurers, as defined, to voluntarily contribute to the CURES Fund, as described.* Because this bill would expand application of the Fee Collection Procedures Law, the violation of which is a crime, it would impose a state-mandated local program.

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

- 1 SECTION 1. The Legislature finds and declares all of the
- 2 following:
- 3 (a) The Controlled Substance Utilization Review and Evaluation
- 4 System (CURES) is a valuable investigative, preventive, and
- 5 educational tool for law enforcement, regulatory boards,
- 6 educational researchers, and the health care community. Recent
- 7 budget cuts to the Attorney General's Division of Law Enforcement
- 8 have resulted in insufficient funding to support the CURES
- 9 Prescription Drug Monitoring Program (PDMP). The PDMP is
- 10 necessary to ensure health care professionals have the necessary
- 11 data to make informed treatment decisions and to allow law
- 12 enforcement to investigate diversion of prescription drugs. Without
- 13 a dedicated funding source, the CURES PDMP is not sustainable.
- 14 (b) Each year CURES responds to more than 60,000 requests
- 15 from practitioners and pharmacists regarding all of the following:
- 16 (1) Helping identify and deter drug abuse and diversion of
- 17 prescription drugs through accurate and rapid tracking of Schedule
- 18 II, Schedule III, and Schedule IV controlled substances.
- 19 (2) Helping practitioners make better prescribing decisions.
- 20 (3) Helping reduce misuse, abuse, and trafficking of those drugs.



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

SEC. 2. Section 805.8 is added to the Business and Professions Code, to read:

805.8. (a) (1) The Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall increase the licensure, certification, and renewal fees charged to practitioners under their supervision who are authorized pursuant to Section 11150 of the Health and Safety Code to prescribe or dispense Schedule II, Schedule III, or Schedule IV controlled substances by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

(2) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.

(3) The California State Board of Pharmacy shall increase the licensure, certification, and renewal fees charged to veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, by up to 1.16 percent annually, but in no case shall the fee increase exceed the reasonable costs associated with maintaining CURES for the

1 purpose of regulating veterinary food-animal drug retailers licensed  
2 or certificated by that board.

3 (b) The funds collected pursuant to subdivision (a) shall be  
4 deposited in the CURES accounts, which are hereby created, within  
5 the Contingent Fund of the Medical Board of California, the State  
6 Dentistry Fund, the Pharmacy Board Contingent Fund, the  
7 Veterinary Medical Board Contingent Fund, the Board of  
8 Registered Nursing Fund, the Osteopathic Medical Board of  
9 California Contingent Fund, the Optometry Fund, and the Board  
10 of Podiatric Medicine Fund. Moneys in the CURES accounts of  
11 each of those funds shall, upon appropriation by the Legislature,  
12 be available to the Department of Justice solely for maintaining  
13 CURES for the purposes of regulating prescribers and dispensers  
14 of controlled substances. All moneys received by the Department  
15 of Justice pursuant to this section shall be deposited in the CURES  
16 Fund described in Section 11165 of the Health and Safety Code.

17 SEC. 3. Section 11165 of the Health and Safety Code is  
18 amended to read:

19 11165. (a) To assist law enforcement and regulatory agencies  
20 in their efforts to control the diversion and resultant abuse of  
21 Schedule II, Schedule III, and Schedule IV controlled substances,  
22 and for statistical analysis, education, and research, the Department  
23 of Justice shall, contingent upon the availability of adequate funds  
24 in the CURES accounts within the Contingent Fund of the Medical  
25 Board of California, the Pharmacy Board Contingent Fund, the  
26 State Dentistry Fund, the Board of Registered Nursing Fund, the  
27 Osteopathic Medical Board of California Contingent Fund, the  
28 Veterinary Medical Board Contingent Fund, the Optometry Fund,  
29 the Board of Podiatric Medicine Fund, and the CURES Fund,  
30 maintain the Controlled Substance Utilization Review and  
31 Evaluation System (CURES) for the electronic monitoring of, and  
32 Internet access to information regarding, the prescribing and  
33 dispensing of Schedule II, Schedule III, and Schedule IV controlled  
34 substances by all practitioners authorized to prescribe or dispense  
35 these controlled substances.

36 (b) The reporting of Schedule III and Schedule IV controlled  
37 substance prescriptions to CURES shall be contingent upon the  
38 availability of adequate funds for the Department of Justice for  
39 the purpose of finding CURES. The department may seek and use  
40 grant funds to pay the costs incurred from the reporting of

1 controlled substance prescriptions to CURES. The department  
2 shall make information about the amount and the source of all  
3 private grant funds it receives for support of CURES available to  
4 the public. Grant funds shall not be appropriated from the  
5 Contingent Fund of the Medical Board of California, the Pharmacy  
6 Board Contingent Fund, the State Dentistry Fund, the Board of  
7 Registered Nursing Fund, the Naturopathic Doctor's Fund, or the  
8 Osteopathic Medical Board of California Contingent Fund to pay  
9 the costs of reporting Schedule III and Schedule IV controlled  
10 substance prescriptions to CURES.

11 (c) CURES shall operate under existing provisions of law to  
12 safeguard the privacy and confidentiality of patients. Data obtained  
13 from CURES shall only be provided to appropriate state, local,  
14 and federal persons or public agencies for disciplinary, civil, or  
15 criminal purposes and to other agencies or entities, as determined  
16 by the Department of Justice, for the purpose of educating  
17 practitioners and others in lieu of disciplinary, civil, or criminal  
18 actions. Data may be provided to public or private entities, as  
19 approved by the Department of Justice, for educational, peer  
20 review, statistical, or research purposes, provided that patient  
21 information, including any information that may identify the  
22 patient, is not compromised. Further, data disclosed to any  
23 individual or agency, as described in this subdivision, shall not be  
24 disclosed, sold, or transferred to any third party.

25 (d) For each prescription for a Schedule II, Schedule III, or  
26 Schedule IV controlled substance, as defined in the controlled  
27 substances schedules in federal law and regulations, specifically  
28 Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21  
29 of the Code of Federal Regulations, the dispensing pharmacy or  
30 clinic shall provide the following information to the Department  
31 of Justice on a weekly basis and in a format specified by the  
32 Department of Justice:

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

37 (2) The prescriber's category of licensure and license number,  
38 the federal controlled substance registration number, and the state  
39 medical license number of any prescriber using the federal

1 controlled substance registration number of a government-exempt  
2 facility.

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

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

7 (5) Quantity of the controlled substance dispensed.

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

10 (7) Number of refills ordered.

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

13 (9) Date of origin of the prescription.

14 (10) Date of dispensing of the prescription.

15 (e) The CURES Fund is hereby established within the State  
16 Treasury. The CURES Fund shall consist of all funds made  
17 available to the Department of Justice for the purpose of funding  
18 CURES. Money in the CURES Fund shall, upon appropriation by  
19 the Legislature, be available for allocation to the Department of  
20 Justice for the purpose of funding CURES.

21 SEC. 4. Section 11165.1 of the Health and Safety Code is  
22 amended to read:

23 11165.1. (a) (1) A licensed health care practitioner eligible  
24 to prescribe Schedule II, Schedule III, or Schedule IV controlled  
25 substances or a pharmacist shall provide a notarized application  
26 developed by the Department of Justice to obtain approval to access  
27 information stored on the Internet regarding the controlled  
28 substance history of a patient maintained within the Department  
29 of Justice, and, upon approval, the department shall release to that  
30 practitioner or pharmacist, the electronic history of controlled  
31 substances dispensed to an individual under his or her care based  
32 on data contained in the CURES Prescription Drug Monitoring  
33 Program (PDMP).

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

37 (i) Materially falsifying an application for a subscriber.

38 (ii) Failure to maintain effective controls for access to the patient  
39 activity report.

1 (iii) Suspended or revoked federal Drug Enforcement  
2 Administration (DEA) registration.

3 (iv) Any subscriber who is arrested for a violation of law  
4 governing controlled substances or any other law for which the  
5 possession or use of a controlled substance is an element of the  
6 crime.

7 (v) Any subscriber accessing information for any other reason  
8 than caring for his or her patients.

9 (B) Any authorized subscriber shall notify the Department of  
10 Justice within 10 days of any changes to the subscriber account.

11 (2) To allow sufficient time for licensed health care practitioners  
12 eligible to prescribe Schedule II, Schedule III, or Schedule IV  
13 controlled substances and a pharmacist to apply and receive access  
14 to PDMP, a written request may be made, until July 1, 2012, and  
15 the Department of Justice may release to that practitioner or  
16 pharmacist the history of controlled substances dispensed to an  
17 individual under his or her care based on data contained in CURES.

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

21 (c) (1) Until the Department of Justice has issued the  
22 notification described in paragraph (3), in order to prevent the  
23 inappropriate, improper, or illegal use of Schedule II, Schedule  
24 III, or Schedule IV controlled substances, the Department of Justice  
25 may initiate the referral of the history of controlled substances  
26 dispensed to an individual based on data contained in CURES to  
27 licensed health care practitioners, pharmacists, or both, providing  
28 care or services to the individual.

29 (2) Upon the Department of Justice issuing the notification  
30 described in paragraph (3) and approval of the application required  
31 pursuant to subdivision (a), licensed health care practitioners  
32 eligible to prescribe Schedule II, Schedule III, or Schedule IV  
33 controlled substances and pharmacists shall access and consult the  
34 electronic history of controlled substances dispensed to an  
35 individual under his or her care prior to prescribing or dispensing  
36 a Schedule II, Schedule III, or Schedule IV controlled substance.

37 (3) The Department of Justice shall notify licensed health care  
38 practitioners and pharmacists who have submitted the application  
39 required pursuant to subdivision (a) when the department  
40 determines that CURES is capable of accommodating the mandate

contained in paragraph (2). The department shall provide a copy of the notification to the Secretary of the State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the notification on the department's Internet Web site.

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

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

SEC. 5. Part 21 (commencing with Section 42001) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 21. CONTROLLED SUBSTANCE UTILIZATION  
REVIEW AND EVALUATION SYSTEM (CURES) TAX LAW

42001. For purposes of this part, the following definitions apply:

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

(b) "Insurer" means ~~a health insurer licensed pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code, a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code), and a workers' compensation insurer licensed pursuant to Part 3 (commencing with Section 11550) of Division 2~~ *an admitted insurer writing health insurance, as defined in Section 106 of the Insurance Code, and an admitted insurer writing workers' compensation insurance, as defined in Section 109 of the Insurance Code.*

(c) “Qualified manufacturer” means a manufacturer of a controlled substance ~~doing business in this state, as defined in Section 23101,~~ but does not mean a wholesaler or nonresident wholesaler of dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section 4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

42003. (a) For the privilege of doing business in this state, an annual tax is hereby imposed on all qualified manufacturers in an amount of        dollars (\$      ) *determined pursuant to Section 42005*, for the purpose of establishing and maintaining enforcement of the Controlled Substance Utilization Review and Evaluation System (CURES), established pursuant to Section 11165 of the Health and Safety Code.

~~(b) For the privilege of doing business in this state, a tax is hereby imposed on a one-time basis on all insurers in an amount of        dollars (\$      ), for the purpose of upgrading CURES.~~

~~(b) The Department of Justice may seek grant moneys from insurers for the purpose of upgrading and modernizing the CURES. Insurers may contribute by submitting their payment to the Controller for deposit into the CURES Fund established pursuant to subdivision (e) of Section 11165 of the Health and Safety Code. The department shall make information about the amount and the source of all private grant funds it receives for support of CURES available to the public.~~

42005. ~~Each qualified manufacturer and insurer shall prepare and file with the board a return, in the form prescribed by the board, containing information as the board deems necessary or appropriate for the proper administration of this part. The return shall be filed on or before the last day of the calendar month following the calendar quarter to which it relates, together with a remittance payable to the board for the amount of tax due for that period.~~

1     ~~42007. The board shall administer and collect the tax imposed~~  
2 ~~by this part pursuant to the Fee Collection Procedures Law (Part~~  
3 ~~30 (commencing with Section 55001)). For purposes of this part,~~  
4 ~~the references in the Fee Collection Procedures Law (Part 30~~  
5 ~~(commencing with Section 55001)) to “fee” shall include the tax~~  
6 ~~imposed by this part and references to “feepayer” shall include a~~  
7 ~~person required to pay the tax imposed by this part.~~

8     42005. (a) *The board shall collect the annual tax imposed by*  
9 *this part pursuant to the Fee Collection Procedures Law (Part 30*  
10 *(commencing with Section 55001)). For purposes of this part, a*  
11 *reference in the Fee Collection Procedures Law to a “fee” shall*  
12 *include this tax and a reference to a “feepayer” shall include a*  
13 *person liable for the payment for the taxes collected pursuant to*  
14 *that law.*

15     (b) (1) *The board shall not accept or consider a petition for*  
16 *redetermination that is based on the assertion that a determination*  
17 *by the Department of Justice incorrectly determined that a qualified*  
18 *manufacturer is subject to the tax or that a determination by the*  
19 *Department of Justice improperly or erroneously calculated the*  
20 *amount of that tax. The board shall forward to the Department of*  
21 *Justice any appeal of a determination that asserts that a*  
22 *determination by the Department of Justice incorrectly determined*  
23 *that a qualified manufacturer is subject to the tax or that a*  
24 *determination by the Department of Justice improperly or*  
25 *erroneously calculated the amount of that tax.*

26     (2) *The board shall not accept or consider a claim for refund*  
27 *that is based on the assertion that a determination by the*  
28 *Department of Justice improperly or erroneously calculated the*  
29 *amount of a tax, or incorrectly determined that the qualified*  
30 *manufacturer is subject to the tax. The board shall forward to the*  
31 *Department of Justice any claim for refund that asserts that a*  
32 *determination by the Department of Justice incorrectly determined*  
33 *that a qualified manufacturer is subject to the tax or that a*  
34 *determination by the Department of Justice improperly or*  
35 *erroneously calculated the amount of that tax.*

36     42007. (a) *The Department of Justice shall determine the*  
37 *annual tax by dividing the cost to establish and maintain*  
38 *enforcement of CURES by the number of qualified manufacturers.*  
39 *For calendar year 2014, the CURES cost shall be four million two*  
40 *hundred thousand dollars (\$4,200,000). Beginning with the 2015*



1 *calendar year, and for each calendar year thereafter, the*  
2 *Department of Justice shall adjust the rate annually to reflect*  
3 *increases or decreases in the cost of living during the prior fiscal*  
4 *year, as measured by the California Consumer Price Index for all*  
5 *items.*

6 *(b) The Department of Justice shall provide to the board the*  
7 *name and address of each qualified manufacturer that is liable*  
8 *for the annual tax, the amount of tax, and the due date.*

9 *(c) All annual taxes referred to the board for collection pursuant*  
10 *to Section 42005 shall be paid to the board.*

11 42009. All taxes, interest, penalties, and other amounts  
12 collected pursuant to this part, less refunds and costs of  
13 administration, shall be deposited into the CURES Fund.

14 42011. The board shall prescribe, adopt, and enforce rules and  
15 regulations relating to the administration and enforcement of this  
16 part.

17 SEC. 6. No reimbursement is required by this act pursuant to  
18 Section 6 of Article XIII B of the California Constitution because  
19 the only costs that may be incurred by a local agency or school  
20 district will be incurred because this act creates a new crime or  
21 infraction, eliminates a crime or infraction, or changes the penalty  
22 for a crime or infraction, within the meaning of Section 17556 of  
23 the Government Code, or changes the definition of a crime within  
24 the meaning of Section 6 of Article XIII B of the California  
25 Constitution.

26 SEC. 7. This act is an urgency statute necessary for the  
27 immediate preservation of the public peace, health, or safety within  
28 the meaning of Article IV of the Constitution and shall go into  
29 immediate effect. The facts constituting the necessity are:

30 In order to protect the public from the continuing threat of  
31 prescription drug abuse at the earliest possible time, it is necessary  
32 this act take effect immediately.

**DENTAL BOARD OF CALIFORNIA  
BILL ANALYSIS  
May 16-17, 2013 BOARD MEETING**

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**BILL NUMBER:** Senate Bill 821

**AUTHOR:** Committee on Business,  
Professions and Economic  
Development

**SPONSOR:**

**VERSION:** 4/23/13 – Amended Senate

**INTRODUCED:** 3/20/2013

**BILL STATUS:** 5/7/13 – Hearing postponed by  
committee

**BILL LOCATION:** Senate

**SUBJECT:** Healing Arts

**RELATED  
BILLS:**

**SUMMARY**

This bill would make several non-controversial minor, non-substantive or technical changes to various provisions pertaining to the health-related regulatory Board of the Department of Consumer Affairs (DCA).

**ANALYSIS**

The provisions relating to the Board would change any reference to the Board of Dental Examiners to the Dental Board of California.

**REGISTERED SUPPORT/OPPOSITION**

To date, there is no registered support or opposition on file.

**STAFF RECOMMENDATION**

Neutral

**BOARD POSITION**

**SUPPORT:** \_\_\_\_ **OPPOSE:** \_\_\_\_ **NEUTRAL:** \_\_\_\_ **WATCH:** \_\_\_\_

**Introduced by Committee on Business, Professions and Economic Development (Senators Price (Chair), Block, Corbett, Emmerson, Galgiani, Hernandez, Hill, Padilla, Wyland, and Yee)**

March 20, 2013

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An act to amend Sections 1613, 1915, 1926.2, 3024, 3025, 3040, 3041.2, 3051, 3057.5, 3077, 3093, 3098, 3103, 3106, 3107, 3109, 3163, 4053, 4107, 4980.36, 4980.43, 4980.72, 4989.68, 4996.3, 4996.9, 4996.18, 4996.23, 4999.20, 4999.33, 4999.46, 4999.47, and 4999.60 of, *and to add Section 4021.5 to*, the Business and Professions Code, and to amend Section 14132 of the Welfare and Institutions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

(2) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of

Optometry. That act refers to the authorization to practice optometry issued by the board as a certificate of registration.

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

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

*This bill would additionally authorize the board to issue more than one site license to a single premises to issue a centralized hospital packaging license. The bill would also establish a definition for the term “correctional pharmacy.”*

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

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

~~(3)~~

*(4) Existing law provides for the licensure and regulation of marriage and family therapists, licensed educational psychologists, licensed clinical social workers, and licensed professional clinical counselors by the Board of Behavioral Sciences.*

Existing law requires all persons applying for marriage and family therapist licensure examinations to have specified hours of experience, not including experience gained by interns or trainees as independent contractors.

This bill would specify that experience *shall not be gained by interns or trainees for work performed as an independent contractor or reported on an IRS Form 1099 does not count towards the necessary experience.* 1099.

Existing law also authorizes the board to issue a license to a person who, at the time of submitting an application for a license pursuant to this chapter, holds a valid license in good standing issued by a board of marriage counselor examiners, board of marriage and family therapists, or corresponding authority, of any state or country if certain conditions are met, considering hours of experience obtained outside of California during the 6-year period immediately preceding the date the applicant initially obtained the license.

This bill would instead require time actively licensed as a marriage and family therapist to be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours if the applicant has fewer than 3,000 hours of qualifying supervised experience.

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

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

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

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

Existing law requires a licensed professional clinical counselor, to qualify for a clinical examination for licensure, to complete clinical mental health experience, as specified, including not more than 250 hours of experience providing counseling or crisis counseling on the telephone.

This bill instead would require not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth.

(4)

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

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

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

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

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

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

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

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

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

(1) Applying nonaerosol and noncaustic topical agents.

(2) Applying topical fluoride.

(3) Taking impressions for bleaching trays.

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

(1) Polishing the coronal surfaces of teeth.

(2) Applying bleaching agents.

(3) Activating bleaching agents with a nonlaser light-curing device.

(4) Applying pit and fissure ~~sealant~~ sealants.

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

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

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

1 1926.2. (a) Notwithstanding any other provision of law, a  
2 registered dental hygienist in alternative practice may operate one  
3 mobile dental hygiene clinic registered as a dental hygiene office  
4 or facility. The owner or operator of the mobile dental hygiene  
5 clinic or unit shall be registered and operated in accordance with  
6 regulations established by the committee, which regulations shall  
7 not be designed to prevent or lessen competition in service areas,  
8 and shall pay the fees described in Section 1944.

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

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

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

24 3024. The board may grant or refuse to grant an optometrist  
25 license as provided in this chapter and may revoke or suspend the  
26 license of any optometrist for any of the causes specified in this  
27 chapter.

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

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

32 3025. The board may make and promulgate rules and  
33 regulations governing procedure of the board, the admission of  
34 applicants for examination for a license as an optometrist, and the  
35 practice of optometry. All of those rules and regulations shall be  
36 in accordance with and not inconsistent with the provisions of this  
37 chapter. The rules and regulations shall be adopted, amended, or  
38 repealed in accordance with the provisions of the Administrative  
39 Procedure Act.

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

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

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

SEC. 7. Section 3041.2 of the Business and Professions Code is amended to read:

3041.2. (a) The State Board of Optometry shall, by regulation, establish educational and examination requirements for licensure to ~~insure~~ *ensure* the competence of optometrists to practice pursuant to subdivision (a) of Section 3041. Satisfactory completion of the educational and examination requirements shall be a condition for the issuance of an original optometrist license under this chapter, on and after January 1, 1980. Only those optometrists who have successfully completed educational and examination requirements as determined by the State Board of Optometry shall be permitted the use of pharmaceutical agents specified by subdivision (a) of Section 3041.

(b) Nothing in this section shall authorize an optometrist issued an original optometrist license under this chapter before January 1, 1996, to use or prescribe therapeutic pharmaceutical agents specified in subdivision (d) of Section 3041 without otherwise meeting the requirements of Section 3041.3.

SEC. 8. Section 3051 of the Business and Professions Code is amended to read:

3051. All applicants for examination for an optometrist license in accordance with the educational and examination requirements adopted pursuant to Section 3023.1 shall show the board by satisfactory evidence that he or she has received education in child abuse detection and the detection of alcoholism and other chemical substance dependency. This section shall apply only to applicants who matriculate in a school of optometry on or after September 1, 1997.



1 SEC. 9. Section 3057.5 of the Business and Professions Code  
2 is amended to read:

3 3057.5. Notwithstanding any other provision of this chapter,  
4 the board shall permit a graduate of a foreign university who meets  
5 all of the following requirements to take the examinations for an  
6 optometrist license:

7 (a) Is over ~~the age of~~ 18 years *of age*.

8 (b) Is not subject to denial of a license under Section 480.

9 (c) Has a degree as a doctor of optometry issued by a university  
10 located outside of the United States.

11 SEC. 10. Section 3077 of the Business and Professions Code  
12 is amended to read:

13 3077. As used in this section, "office" means any office or  
14 other place for the practice of optometry.

15 (a) No person, singly or in combination with others, may have  
16 an office unless he or she is licensed to practice optometry under  
17 this chapter.

18 (b) An optometrist, or two or more optometrists jointly, may  
19 have one office without obtaining a branch office license from the  
20 board.

21 (c) On and after October 1, 1959, no optometrist, and no two  
22 or more optometrists jointly, may have more than one office unless  
23 he or she or they comply with the provisions of this chapter as to  
24 an additional office. The additional office, for the purposes of this  
25 chapter, constitutes a branch office.

26 (d) Any optometrist who has, or any two or more optometrists,  
27 jointly, who have, a branch office prior to January 1, 1957, and  
28 who desire to continue the branch office on or after that date shall  
29 notify the board in writing of that desire in a manner prescribed  
30 by the board.

31 (e) On and after January 1, 1957, any optometrist, or any two  
32 or more optometrists, jointly, who desire to open a branch office  
33 shall notify the board in writing in a manner prescribed by the  
34 board.

35 (f) On and after January 1, 1957, no branch office may be  
36 opened or operated without a branch office license. Branch office  
37 licenses shall be valid for the calendar year in or for which they  
38 are issued and shall be renewable on January ~~1st~~ 1 of each year  
39 thereafter. Branch office licenses shall be issued or renewed only  
40 upon the payment of the fee therefor prescribed by this chapter.

1 On or after October 1, 1959, no more than one branch office  
2 license shall be issued to any optometrist or to any two or more  
3 optometrists, jointly.

4 (g) Any failure to comply with the provisions of this chapter  
5 relating to branch offices or branch office licenses as to any branch  
6 office shall work the suspension of the optometrist license of each  
7 optometrist who, individually or with others, has a branch office.  
8 An optometrist license so suspended shall not be restored except  
9 upon compliance with those provisions and the payment of the fee  
10 prescribed by this chapter for restoration of a license after  
11 suspension for failure to comply with the provisions of this chapter  
12 relating to branch offices.

13 (h) The holder or holders of a branch office license shall pay  
14 the annual renewal fee therefor in the amount required by this  
15 chapter between the first day of January and the first day of  
16 February of each year. The failure to pay the fee in advance on or  
17 before February ~~1st~~ 1 of each year during the time it is in force  
18 shall ipso facto work the suspension of the branch office license.  
19 The license shall not be restored except upon written application  
20 and the payment of the penalty prescribed by this chapter, and, in  
21 addition, all delinquent branch office fees.

22 (i) Nothing in this chapter shall limit or authorize the board to  
23 limit the number of branch offices that are in operation on October  
24 1, 1959, and that conform to this chapter, nor prevent an  
25 optometrist from acquiring any branch office or offices of his or  
26 her parent. The sale after October 1, 1959, of any branch office  
27 shall terminate the privilege of operating the branch office, and  
28 no new branch office license shall be issued in place of the license  
29 issued for the branch office, unless the branch office is the only  
30 one operated by the optometrist or by two or more optometrists  
31 jointly.

32 Nothing in this chapter shall prevent an optometrist from owning,  
33 maintaining, or operating more than one branch office if he or she  
34 is in personal attendance at each of his or her offices 50 percent  
35 of the time during which the office is open for the practice of  
36 optometry.

37 (j) The board shall have the power to adopt, amend, and repeal  
38 rules and regulations to carry out the provisions of this section.

39 (k) Notwithstanding any other provision of this section, neither  
40 an optometrist nor an individual practice association shall be

1 deemed to have an additional office solely by reason of the  
2 optometrist's participation in an individual practice association or  
3 the individual practice association's creation or operation. As used  
4 in this subdivision, the term "individual practice association" means  
5 an entity that meets all of the following requirements:

6 (1) Complies with the definition of an optometric corporation  
7 in Section 3160.

8 (2) Operates primarily for the purpose of securing contracts  
9 with health care service plans or other third-party payers that make  
10 available eye/vision services to enrollees or subscribers through a  
11 panel of optometrists.

12 (3) Contracts with optometrists to serve on the panel of  
13 optometrists, but does not obtain an ownership interest in, or  
14 otherwise exercise control over, the respective optometric practices  
15 of those optometrists on the panel.

16 Nothing in this subdivision shall be construed to exempt an  
17 optometrist who is a member of an individual practice association  
18 and who practices optometry in more than one physical location,  
19 from the requirement of obtaining a branch office license for each  
20 of those locations, as required by this section. However, an  
21 optometrist shall not be required to obtain a branch office license  
22 solely as a result of his or her participation in an individual practice  
23 association in which the members of the individual practice  
24 association practice optometry in a number of different locations,  
25 and each optometrist is listed as a member of that individual  
26 practice association.

27 SEC. 11. Section 3093 of the Business and Professions Code  
28 is amended to read:

29 3093. Before setting aside the revocation or suspension of any  
30 optometrist license, the board may require the applicant to pass  
31 the regular examination given for applicants for an optometrist  
32 license.

33 SEC. 12. Section 3098 of the Business and Professions Code  
34 is amended to read:

35 3098. When the holder uses the title of "Doctor" or "Dr." as a  
36 prefix to his or her name, without using the word "optometrist" as  
37 a suffix to his or her name or in connection with it, or, without  
38 holding a diploma from an accredited school of optometry, the  
39 letters "Opt. D." or "O.D." as a suffix to his or her name, it

1 constitutes a cause to revoke or suspend his or her optometrist  
2 license.

3 SEC. 13. Section 3103 of the Business and Professions Code  
4 is amended to read:

5 3103. It is unlawful to include in any advertisement relating  
6 to the sale or disposition of goggles, sunglasses, colored glasses,  
7 or occupational eye-protective devices, any words or figures that  
8 advertise or have a tendency to advertise the practice of optometry.

9 This section does not prohibit the advertising of the practice of  
10 optometry by a licensed optometrist in the manner permitted by  
11 law.

12 SEC. 14. Section 3106 of the Business and Professions Code  
13 is amended to read:

14 3106. Knowingly making or signing any license, certificate,  
15 or other document directly or indirectly related to the practice of  
16 optometry that falsely represents the existence or nonexistence of  
17 a state of facts constitutes unprofessional conduct.

18 SEC. 15. Section 3107 of the Business and Professions Code  
19 is amended to read:

20 3107. It is unlawful to use or attempt to use any license or  
21 certificate issued by the board that has been purchased, fraudulently  
22 issued, counterfeited, or issued by mistake, as a valid license or  
23 certificate.

24 SEC. 16. Section 3109 of the Business and Professions Code  
25 is amended to read:

26 3109. Directly or indirectly accepting employment to practice  
27 optometry from any person not having a valid, unrevoked license  
28 as an optometrist or from any company or corporation constitutes  
29 unprofessional conduct. Except as provided in this chapter, no  
30 optometrist may, singly or jointly with others, be incorporated or  
31 become incorporated when the purpose or a purpose of the  
32 corporation is to practice optometry or to conduct the practice of  
33 optometry.

34 The terms “accepting employment to practice optometry” as  
35 used in this section shall not be construed so as to prevent a  
36 licensed optometrist from practicing optometry upon an individual  
37 patient.

38 Notwithstanding the provisions of this section or the provisions  
39 of any other law, a licensed optometrist may be employed to  
40 practice optometry by a physician and surgeon who holds a license

1 under this division and who practices in the specialty of  
2 ophthalmology or by a health care service plan pursuant to the  
3 provisions of Chapter 2.2 (commencing with Section 1340) of  
4 Division 2 of the Health and Safety Code.

5 SEC. 17. Section 3163 of the Business and Professions Code  
6 is amended to read:

7 3163. Except as provided in Section 3078, the name of an  
8 optometric corporation and any name or names under which it  
9 may be rendering professional services shall contain and be  
10 restricted to the name or the last name of one or more of the  
11 present, prospective, or former shareholders and shall include the  
12 words optometric corporation or wording or abbreviations denoting  
13 corporate existence, provided that the articles of incorporation  
14 shall be amended to delete the name of a former shareholder from  
15 the name of the corporation within two years from the date the  
16 former shareholder dies or otherwise ceases to be a shareholder.

17 SEC. 18. Section 4021.5 is added to the Business and  
18 Professions Code, to read:

19 4021.5. “Correctional pharmacy” means a pharmacy, licensed  
20 by the board, located within a state correctional facility for the  
21 purpose of providing pharmaceutical care to inmates of the state  
22 correctional facility.

23 SEC. 19. Section 4053 of the Business and Professions Code  
24 is amended to read:

25 4053. (a) Notwithstanding Section 4051, the board may issue  
26 a license as a designated representative to provide sufficient and  
27 qualified supervision in a wholesaler or veterinary food-animal  
28 drug retailer. The designated representative shall protect the public  
29 health and safety in the handling, storage, and shipment of  
30 dangerous drugs and dangerous devices in the wholesaler or  
31 veterinary food-animal drug retailer.

32 (b) An individual may apply for a designated representative  
33 license. In order to obtain and maintain that license, the individual  
34 shall meet all of the following requirements:

35 (1) He or she shall be a high school graduate or possess a general  
36 education development *certificate* equivalent.

37 (2) He or she shall have a minimum of one year of paid work  
38 experience *in a licensed pharmacy, or with a drug wholesaler,*  
39 *drug distributor, or drug manufacturer,* in the past three years,  
40 related to the distribution or dispensing of dangerous drugs or

1 dangerous devices or meet all of the prerequisites to take the  
2 examination required for licensure as a pharmacist by the board.

3 (3) He or she shall complete a training program approved by  
4 the board that, at a minimum, addresses each of the following  
5 subjects:

6 (A) Knowledge and understanding of California law and federal  
7 law relating to the distribution of dangerous drugs and dangerous  
8 devices.

9 (B) Knowledge and understanding of California law and federal  
10 law relating to the distribution of controlled substances.

11 (C) Knowledge and understanding of quality control systems.

12 (D) Knowledge and understanding of the United States  
13 Pharmacopoeia standards relating to the safe storage and handling  
14 of drugs.

15 (E) Knowledge and understanding of prescription terminology,  
16 abbreviations, dosages and format.

17 (4) The board may, by regulation, require training programs to  
18 include additional material.

19 (5) The board may not issue a license as a designated  
20 representative until the applicant provides proof of completion of  
21 the required training to the board.

22 (c) The veterinary food-animal drug retailer or wholesaler shall  
23 not operate without a pharmacist or a designated representative  
24 on its premises.

25 (d) Only a pharmacist or a designated representative shall  
26 prepare and affix the label to veterinary food-animal drugs.

27 (e) Section 4051 shall not apply to any laboratory licensed under  
28 Section 351 of Title III of the Public Health Service Act (Public  
29 Law 78-410).

30 *SEC. 20. Section 4107 of the Business and Professions Code*  
31 *is amended to read:*

32 4107. (a) The board may not issue more than one site license  
33 to a single premises except ~~to~~ *as follows:*

34 (1) *To issue a veterinary food-animal drug retailer license to a*  
35 *wholesaler ~~or to~~ pursuant to Section 4196.*

36 (2) *To issue a license to compound sterile injectable drugs to a*  
37 *pharmacy pursuant to Section 4127.1. ~~For~~*

38 (3) *To issue a centralized hospital packaging license pursuant*  
39 *to Section 4128.*

1 (b) For the purposes of this subdivision, “premises” means a  
2 location with its own address and an independent means of ingress  
3 and egress.

4 ~~SEC. 18.~~

5 *SEC. 21.* Section 4980.36 of the Business and Professions  
6 Code is amended to read:

7 4980.36. (a) This section shall apply to the following:

8 (1) Applicants for licensure or registration who begin graduate  
9 study before August 1, 2012, and do not complete that study on  
10 or before December 31, 2018.

11 (2) Applicants for licensure or registration who begin graduate  
12 study before August 1, 2012, and who graduate from a degree  
13 program that meets the requirements of this section.

14 (3) Applicants for licensure or registration who begin graduate  
15 study on or after August 1, 2012.

16 (b) To qualify for a license or registration, applicants shall  
17 possess a ~~doctor’s~~ *doctoral* or master’s degree meeting the  
18 requirements of this section in marriage, family, and child  
19 counseling, marriage and family therapy, couple and family  
20 therapy, psychology, clinical psychology, counseling psychology,  
21 or counseling with an emphasis in either marriage, family, and  
22 child counseling or marriage and family therapy, obtained from a  
23 school, college, or university approved by the Bureau for Private  
24 Postsecondary Education or accredited by either the Commission  
25 ~~on the~~ Accreditation ~~of~~ *for* Marriage and Family Therapy  
26 Education or a regional accrediting agency recognized by the  
27 United States Department of Education. The board has the authority  
28 to make the final determination as to whether a degree meets all  
29 requirements, including, but not limited to, course requirements,  
30 regardless of accreditation or approval.

31 (c) A ~~doctor’s~~ *doctoral* or master’s degree program that qualifies  
32 for licensure or registration shall do the following:

33 (1) Integrate all of the following throughout its curriculum:

34 (A) Marriage and family therapy principles.

35 (B) The principles of mental health recovery-oriented care and  
36 methods of service delivery in recovery-oriented practice  
37 environments, among others.

38 (C) An understanding of various cultures and the social and  
39 psychological implications of socioeconomic position, and an

1 understanding of how poverty and social stress impact an  
2 individual's mental health and recovery.

3 (2) Allow for innovation and individuality in the education of  
4 marriage and family therapists.

5 (3) Encourage students to develop the personal qualities that  
6 are intimately related to effective practice, including, but not  
7 limited to, integrity, sensitivity, flexibility, insight, compassion,  
8 and personal presence.

9 (4) Permit an emphasis or specialization that may address any  
10 one or more of the unique and complex array of human problems,  
11 symptoms, and needs of Californians served by marriage and  
12 family therapists.

13 (5) Provide students with the opportunity to meet with various  
14 consumers and family members of consumers of mental health  
15 services to enhance understanding of their experience of mental  
16 illness, treatment, and recovery.

17 (d) The degree described in subdivision (b) shall contain no less  
18 than 60 semester or 90 quarter units of instruction that includes,  
19 but is not limited to, the following requirements:

20 (1) Both of the following:

21 (A) No less than 12 semester or 18 quarter units of coursework  
22 in theories, principles, and methods of a variety of  
23 psychotherapeutic orientations directly related to marriage and  
24 family therapy and marital and family systems approaches to  
25 treatment and how these theories can be applied therapeutically  
26 with individuals, couples, families, adults, including elder adults,  
27 children, adolescents, and groups to improve, restore, or maintain  
28 healthy relationships.

29 (B) Practicum that involves direct client contact, as follows:

30 (i) A minimum of six semester or nine quarter units of practicum  
31 in a supervised clinical placement that provides supervised  
32 fieldwork experience.

33 (ii) A minimum of 150 hours of face-to-face experience  
34 counseling individuals, couples, families, or groups.

35 (iii) A student must be enrolled in a practicum course while  
36 counseling clients, except as specified in subdivision (c) of Section  
37 4980.42.

38 (iv) The practicum shall provide training in all of the following  
39 areas:

40 (I) Applied use of theory and psychotherapeutic techniques.



1 (II) Assessment, diagnosis, and prognosis.

2 (III) Treatment of individuals and premarital, couple, family,  
3 and child relationships, including trauma and abuse, dysfunctions,  
4 healthy functioning, health promotion, illness prevention, and  
5 working with families.

6 (IV) Professional writing, including documentation of services,  
7 treatment plans, and progress notes.

8 (V) How to connect people with resources that deliver the  
9 quality of services and support needed in the community.

10 (v) Educational institutions are encouraged to design the  
11 practicum required by this subparagraph to include marriage and  
12 family therapy experience in low income and multicultural mental  
13 health settings.

14 (vi) In addition to the 150 hours required in clause (ii), 75 hours  
15 of either of the following:

16 (I) Client centered advocacy, as defined in Section 4980.03.

17 (II) Face-to-face experience counseling individuals, couples,  
18 families, or groups.

19 (2) Instruction in all of the following:

20 (A) Diagnosis, assessment, prognosis, and treatment of mental  
21 disorders, including severe mental disorders, evidence-based  
22 practices, psychological testing, psychopharmacology, and  
23 promising mental health practices that are evaluated in peer  
24 reviewed literature.

25 (B) Developmental issues from infancy to old age, including  
26 instruction in all of the following areas:

27 (i) The effects of developmental issues on individuals, couples,  
28 and family relationships.

29 (ii) The psychological, psychotherapeutic, and health  
30 implications of developmental issues and their effects.

31 (iii) Aging and its biological, social, cognitive, and  
32 psychological aspects.

33 (iv) A variety of cultural understandings of human development.

34 (v) The understanding of human behavior within the social  
35 context of socioeconomic status and other contextual issues  
36 affecting social position.

37 (vi) The understanding of human behavior within the social  
38 context of a representative variety of the cultures found within  
39 California.

- 1 (vii) The understanding of the impact that personal and social  
2 insecurity, social stress, low educational levels, inadequate housing,  
3 and malnutrition have on human development.
- 4 (C) The broad range of matters and life events that may arise  
5 within marriage and family relationships and within a variety of  
6 California cultures, including instruction in all of the following:
- 7 (i) A minimum of seven contact hours of training or coursework  
8 in child abuse assessment and reporting as specified in Section 28,  
9 and any regulations promulgated thereunder.
- 10 (ii) Spousal or partner abuse assessment, detection, intervention  
11 strategies, and same gender abuse dynamics.
- 12 (iii) Cultural factors relevant to abuse of partners and family  
13 members.
- 14 (iv) Childbirth, child rearing, parenting, and stepparenting.
- 15 (v) Marriage, divorce, and blended families.
- 16 (vi) Long-term care.
- 17 (vii) End of life and grief.
- 18 (viii) Poverty and deprivation.
- 19 (ix) Financial and social stress.
- 20 (x) Effects of trauma.
- 21 (xi) The psychological, psychotherapeutic, community, and  
22 health implications of the matters and life events described in  
23 clauses (i) to (x), inclusive.
- 24 (D) Cultural competency and sensitivity, including a familiarity  
25 with the racial, cultural, linguistic, and ethnic backgrounds of  
26 persons living in California.
- 27 (E) Multicultural development and cross-cultural interaction,  
28 including experiences of race, ethnicity, class, spirituality, sexual  
29 orientation, gender, and disability, and their incorporation into the  
30 psychotherapeutic process.
- 31 (F) The effects of socioeconomic status on treatment and  
32 available resources.
- 33 (G) Resilience, including the personal and community qualities  
34 that enable persons to cope with adversity, trauma, tragedy, threats,  
35 or other stresses.
- 36 (H) Human sexuality, including the study of physiological,  
37 psychological, and social cultural variables associated with sexual  
38 behavior and gender identity, and the assessment and treatment of  
39 psychosexual dysfunction.

1 (I) Substance use disorders, co-occurring disorders, and  
2 addiction, including, but not limited to, instruction in all of the  
3 following:

4 (i) The definition of substance use disorders, co-occurring  
5 disorders, and addiction. For purposes of this subparagraph,  
6 “co-occurring disorders” means a mental illness and substance  
7 abuse diagnosis occurring simultaneously in an individual.

8 (ii) Medical aspects of substance use disorders and co-occurring  
9 disorders.

10 (iii) The effects of psychoactive drug use.

11 (iv) Current theories of the etiology of substance abuse and  
12 addiction.

13 (v) The role of persons and systems that support or compound  
14 substance abuse and addiction.

15 (vi) Major approaches to identification, evaluation, and treatment  
16 of substance use disorders, co-occurring disorders, and addiction,  
17 including, but not limited to, best practices.

18 (vii) Legal aspects of substance abuse.

19 (viii) Populations at risk with regard to substance use disorders  
20 and co-occurring disorders.

21 (ix) Community resources offering screening, assessment,  
22 treatment, and followup for the affected person and family.

23 (x) Recognition of substance use disorders, co-occurring  
24 disorders, and addiction, and appropriate referral.

25 (xi) The prevention of substance use disorders and addiction.

26 (J) California law and professional ethics for marriage and  
27 family therapists, including instruction in all of the following areas  
28 of study:

29 (i) Contemporary professional ethics and statutory, regulatory,  
30 and decisional laws that delineate the scope of practice of marriage  
31 and family therapy.

32 (ii) The therapeutic, clinical, and practical considerations  
33 involved in the legal and ethical practice of marriage and family  
34 therapy, including, but not limited to, family law.

35 (iii) The current legal patterns and trends in the mental health  
36 professions.

37 (iv) The psychotherapist-patient privilege, confidentiality, the  
38 patient dangerous to self or others, and the treatment of minors  
39 with and without parental consent.

1 (v) A recognition and exploration of the relationship between  
2 a practitioner's sense of self and human values and his or her  
3 professional behavior and ethics.

4 (vi) Differences in legal and ethical standards for different types  
5 of work settings.

6 (vii) Licensing law and licensing process.

7 (e) The degree described in subdivision (b) shall, in addition to  
8 meeting the requirements of subdivision (d), include instruction  
9 in case management, systems of care for the severely mentally ill,  
10 public and private services and supports available for the severely  
11 mentally ill, community resources for persons with mental illness  
12 and for victims of abuse, disaster and trauma response, advocacy  
13 for the severely mentally ill, and collaborative treatment. This  
14 instruction may be provided either in credit level coursework or  
15 through extension programs offered by the degree-granting  
16 institution.

17 (f) The changes made to law by this section are intended to  
18 improve the educational qualifications for licensure in order to  
19 better prepare future licentiates for practice, and are not intended  
20 to expand or restrict the scope of practice for marriage and family  
21 therapists.

22 ~~SEC. 19.~~

23 *SEC. 22.* Section 4980.43 of the Business and Professions  
24 Code is amended to read:

25 4980.43. (a) Prior to applying for licensure examinations, each  
26 applicant shall complete experience that shall comply with the  
27 following:

28 (1) A minimum of 3,000 hours completed during a period of at  
29 least 104 weeks.

30 (2) Not more than 40 hours in any seven consecutive days.

31 (3) Not less than 1,700 hours of supervised experience  
32 completed subsequent to the granting of the qualifying master's  
33 or doctoral degree.

34 (4) Not more than 1,300 hours of supervised experience obtained  
35 prior to completing a master's or doctoral degree.

36 The applicant shall not be credited with more than 750 hours of  
37 counseling and direct supervisor contact prior to completing the  
38 master's or doctoral degree.

1 (5) No hours of experience may be gained prior to completing  
2 either 12 semester units or 18 quarter units of graduate instruction  
3 and becoming a trainee except for personal psychotherapy.

4 (6) No hours of experience may be gained more than six years  
5 prior to the date the application for examination eligibility was  
6 filed, except that up to 500 hours of clinical experience gained in  
7 the supervised practicum required by subdivision (c) of Section  
8 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d)  
9 of Section 4980.36 shall be exempt from this six-year requirement.

10 (7) Not more than a combined total of 1,000 hours of experience  
11 in the following:

12 (A) Direct supervisor contact.

13 (B) Professional enrichment activities. For purposes of this  
14 chapter, “professional enrichment activities” include the following:

15 (i) Workshops, seminars, training sessions, or conferences  
16 directly related to marriage and family therapy attended by the  
17 applicant that are approved by the applicant’s supervisor. An  
18 applicant shall have no more than 250 hours of verified attendance  
19 at these workshops, seminars, training sessions, or conferences.

20 (ii) Participation by the applicant in personal psychotherapy,  
21 which includes group, marital or conjoint, family, or individual  
22 psychotherapy by an appropriately licensed professional. An  
23 applicant shall have no more than 100 hours of participation in  
24 personal psychotherapy. The applicant shall be credited with three  
25 hours of experience for each hour of personal psychotherapy.

26 (8) Not more than 500 hours of experience providing group  
27 therapy or group counseling.

28 (9) For all hours gained on or after January 1, 2012, not more  
29 than 500 hours of experience in the following:

30 (A) Experience administering and evaluating psychological  
31 tests, writing clinical reports, writing progress notes, or writing  
32 process notes.

33 (B) Client centered advocacy.

34 (10) Not less than 500 total hours of experience in diagnosing  
35 and treating couples, families, and children. For up to 150 hours  
36 of treating couples and families in conjoint therapy, the applicant  
37 shall be credited with two hours of experience for each hour of  
38 therapy provided.

(11) Not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth in accordance with Section 2290.5.

(12) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by interns and trainees only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. ~~Work performed by an intern or trainee as an independent contractor or reported on an IRS Form 1099 shall not satisfy the requirements of this chapter regarding gaining hours of supervised experience. Experience shall not be gained by interns or trainees for work performed as an independent contractor or reported on an IRS Form 1099.~~

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(c) Except for experience gained pursuant to subparagraph (B) of paragraph (7) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor

1 contact for every week in which more than 10 hours of client  
2 contact is gained in each setting. No more than five hours of  
3 supervision, whether individual or group, shall be credited during  
4 any single week.

5 (3) For purposes of this section, “one hour of direct supervisor  
6 contact” means one hour per week of face-to-face contact on an  
7 individual basis or two hours per week of face-to-face contact in  
8 a group.

9 (4) Direct supervisor contact shall occur within the same week  
10 as the hours claimed.

11 (5) Direct supervisor contact provided in a group shall be  
12 provided in a group of not more than eight supervisees and in  
13 segments lasting no less than one continuous hour.

14 (6) Notwithstanding paragraph (3), an intern working in a  
15 governmental entity, a school, a college, or a university, or an  
16 institution that is both nonprofit and charitable may obtain the  
17 required weekly direct supervisor contact via two-way, real-time  
18 videoconferencing. The supervisor shall be responsible for ensuring  
19 that client confidentiality is upheld.

20 (7) All experience gained by a trainee shall be monitored by the  
21 supervisor as specified by regulation.

22 (d) (1) A trainee may be credited with supervised experience  
23 completed in any setting that meets all of the following:

24 (A) Lawfully and regularly provides mental health counseling  
25 or psychotherapy.

26 (B) Provides oversight to ensure that the trainee’s work at the  
27 setting meets the experience and supervision requirements set forth  
28 in this chapter and is within the scope of practice for the profession  
29 as defined in Section 4980.02.

30 (C) Is not a private practice owned by a licensed marriage and  
31 family therapist, a licensed psychologist, a licensed clinical social  
32 worker, a licensed physician and surgeon, or a professional  
33 corporation of any of those licensed professions.

34 (2) Experience may be gained by the trainee solely as part of  
35 the position for which the trainee volunteers or is employed.

36 (e) (1) An intern may be credited with supervised experience  
37 completed in any setting that meets both of the following:

38 (A) Lawfully and regularly provides mental health counseling  
39 or psychotherapy.

1 (B) Provides oversight to ensure that the intern's work at the  
2 setting meets the experience and supervision requirements set forth  
3 in this chapter and is within the scope of practice for the profession  
4 as defined in Section 4980.02.

5 (2) An applicant shall not be employed or volunteer in a private  
6 practice, as defined in subparagraph (C) of paragraph (1) of  
7 subdivision (d), until registered as an intern.

8 (3) While an intern may be either a paid employee or a  
9 volunteer, employers are encouraged to provide fair remuneration  
10 to interns.

11 (4) Except for periods of time during a supervisor's vacation or  
12 sick leave, an intern who is employed or volunteering in private  
13 practice shall be under the direct supervision of a licensee that has  
14 satisfied the requirements of subdivision (g) of Section 4980.03.  
15 The supervising licensee shall either be employed by and practice  
16 at the same site as the intern's employer, or shall be an owner or  
17 shareholder of the private practice. Alternative supervision may  
18 be arranged during a supervisor's vacation or sick leave if the  
19 supervision meets the requirements of this section.

20 (5) Experience may be gained by the intern solely as part of the  
21 position for which the intern volunteers or is employed.

22 (f) Except as provided in subdivision (g), all persons shall  
23 register with the board as an intern in order to be credited for  
24 postdegree hours of supervised experience gained toward licensure.

25 (g) Except when employed in a private practice setting, all  
26 postdegree hours of experience shall be credited toward licensure  
27 so long as the applicant applies for the intern registration within  
28 90 days of the granting of the qualifying master's or doctoral  
29 degree and is thereafter granted the intern registration by the board.

30 (h) Trainees, interns, and applicants shall not receive any  
31 remuneration from patients or clients, and shall only be paid by  
32 their employers.

33 (i) Trainees, interns, and applicants shall only perform services  
34 at the place where their employers regularly conduct business,  
35 which may include performing services at other locations, so long  
36 as the services are performed under the direction and control of  
37 their employer and supervisor, and in compliance with the laws  
38 and regulations pertaining to supervision. Trainees and interns  
39 shall have no proprietary interest in their employers' businesses  
40 and shall not lease or rent space, pay for furnishings, equipment,



1 or supplies, or in any other way pay for the obligations of their  
2 employers.

3 (j) Trainees, interns, or applicants who provide volunteered  
4 services or other services, and who receive no more than a total,  
5 from all work settings, of five hundred dollars (\$500) per month  
6 as reimbursement for expenses actually incurred by those trainees,  
7 interns, or applicants for services rendered in any lawful work  
8 setting other than a private practice shall be considered an  
9 employee and not an independent contractor. The board may audit  
10 applicants who receive reimbursement for expenses, and the  
11 applicants shall have the burden of demonstrating that the payments  
12 received were for reimbursement of expenses actually incurred.

13 (k) Each educational institution preparing applicants for  
14 licensure pursuant to this chapter shall consider requiring, and  
15 shall encourage, its students to undergo individual, marital or  
16 conjoint, family, or group counseling or psychotherapy, as  
17 appropriate. Each supervisor shall consider, advise, and encourage  
18 his or her interns and trainees regarding the advisability of  
19 undertaking individual, marital or conjoint, family, or group  
20 counseling or psychotherapy, as appropriate. Insofar as it is deemed  
21 appropriate and is desired by the applicant, the educational  
22 institution and supervisors are encouraged to assist the applicant  
23 in locating that counseling or psychotherapy at a reasonable cost.

24 ~~SEC. 20.~~

25 *SEC. 23.* Section 4980.72 of the Business and Professions  
26 Code is amended to read:

27 4980.72. (a) This section applies to persons who are licensed  
28 outside of California and apply for licensure on or after January  
29 1, 2014.

30 (b) The board may issue a license to a person who, at the time  
31 of submitting an application for a license pursuant to this chapter,  
32 holds a valid license in good standing issued by a board of marriage  
33 counselor examiners, board of marriage and family therapists, or  
34 corresponding authority, of any state or country, if all of the  
35 following conditions are satisfied:

36 (1) The applicant's education is substantially equivalent, as  
37 defined in Section 4980.78. The applicant's degree title need not  
38 be identical to that required by Section 4980.36 or 4980.37.

39 (2) The applicant complies with Section 4980.76, if applicable.

(3) The applicant's supervised experience is substantially equivalent to that required for a license under this chapter. If the applicant has less than 3,000 hours of qualifying supervised experience, time actively licensed as a marriage and family therapist shall be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours.

(4) The applicant passes the California law and ethics examination.

(5) The applicant passes a clinical examination designated by the board. An applicant who obtained his or her license or registration under another jurisdiction may apply for licensure with the board without taking the clinical examination if both of the following conditions are met:

(A) The applicant obtained a passing score on the licensing examination set forth in regulation as accepted by the board.

(B) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and has not been revoked, suspended, surrendered, denied, or otherwise restricted or encumbered as a result of any disciplinary proceeding brought by the licensing authority of that jurisdiction.

~~SEC. 24.~~

*SEC. 24.* Section 4989.68 of the Business and Professions Code is amended to read:

4989.68. (a) The board shall assess the following fees relating to the licensure of educational psychologists:

(1) The application fee for examination eligibility shall be one hundred dollars (\$100).

(2) The fee for issuance of the initial license shall be a maximum amount of one hundred fifty dollars (\$150).

(3) The fee for license renewal shall be a maximum amount of one hundred fifty dollars (\$150).

(4) The delinquency fee shall be a maximum amount of seventy-five dollars (\$75). A person who permits his or her license to become delinquent may have it restored only upon payment of all the fees that he or she would have paid if the license had not become delinquent, plus the payment of any and all delinquency fees.

(5) The written examination fee shall be one hundred dollars (\$100). An applicant who fails to appear for an examination, once

1 having been scheduled, shall forfeit any examination fees he or  
2 she paid.

3 (6) The fee for rescoring a written examination shall be twenty  
4 dollars (\$20).

5 (7) The fee for issuance of a replacement registration, license,  
6 or certificate shall be twenty dollars (\$20).

7 (8) The fee for issuance of a certificate or letter of good standing  
8 shall be twenty-five dollars (\$25).

9 (9) The fee for issuance of a retired license shall be forty dollars  
10 (\$40).

11 (b) With regard to all license, examination, and other fees, the  
12 board shall establish fee amounts at or below the maximum  
13 amounts specified in this chapter.

14 ~~SEC. 22.~~

15 *SEC. 25.* Section 4996.3 of the Business and Professions Code,  
16 as amended by Section 55 of Chapter 799 of the Statutes of 2012,  
17 is amended to read:

18 4996.3. (a) The board shall assess the following fees relating  
19 to the licensure of clinical social workers:

20 (1) The application fee for registration as an associate clinical  
21 social worker shall be seventy-five dollars (\$75).

22 (2) The fee for renewal of an associate clinical social worker  
23 registration shall be seventy-five dollars (\$75).

24 (3) The fee for application for examination eligibility shall be  
25 one hundred dollars (\$100).

26 (4) The fee for the clinical examination shall be one hundred  
27 dollars (\$100). The fee for the California law and ethics  
28 examination shall be one hundred dollars (\$100).

29 (A) An applicant who fails to appear for an examination, after  
30 having been scheduled to take the examination, shall forfeit the  
31 examination fees.

32 (B) The amount of the examination fees shall be based on the  
33 actual cost to the board of developing, purchasing, and grading  
34 each examination and the actual cost to the board of administering  
35 each examination. The written examination fees shall be adjusted  
36 periodically by regulation to reflect the actual costs incurred by  
37 the board.

38 (5) The fee for rescoring an examination shall be twenty dollars  
39 (\$20).

1 (6) The fee for issuance of an initial license shall be a maximum  
2 of one hundred fifty-five dollars (\$155).

3 (7) The fee for license renewal shall be a maximum of one  
4 hundred fifty-five dollars (\$155).

5 (8) The fee for inactive license renewal shall be a maximum of  
6 seventy-seven dollars and fifty cents (\$77.50).

7 (9) The renewal delinquency fee shall be a maximum of  
8 seventy-five dollars (\$75). A person who permits his or her license  
9 to expire is subject to the delinquency fee.

10 (10) The fee for issuance of a replacement registration, license,  
11 or certificate shall be twenty dollars (\$20).

12 (11) The fee for issuance of a certificate or letter of good  
13 standing shall be twenty-five dollars (\$25).

14 (12) The fee for issuance of a retired license shall be forty dollars  
15 (\$40).

16 (b) With regard to license, examination, and other fees, the  
17 board shall establish fee amounts at or below the maximum  
18 amounts specified in this chapter.

19 (c) This section shall become operative on January 1, 2014.

20 ~~SEC. 23.~~

21 *SEC. 26.* Section 4996.9 of the Business and Professions Code  
22 is amended to read:

23 4996.9. The practice of clinical social work is defined as a  
24 service in which a special knowledge of social resources, human  
25 capabilities, and the part that unconscious motivation plays in  
26 determining behavior, is directed at helping people to achieve more  
27 adequate, satisfying, and productive social adjustments. The  
28 application of social work principles and methods includes, but is  
29 not restricted to, counseling and using applied psychotherapy of  
30 a nonmedical nature with individuals, families, or groups; providing  
31 information and referral services; providing or arranging for the  
32 provision of social services; explaining or interpreting the  
33 psychosocial aspects in the situations of individuals, families, or  
34 groups; helping communities to organize, to provide, or to improve  
35 social or health services; doing research related to social work;  
36 and the use, application, and integration of the coursework and  
37 experience required by Sections 4996.2 and 4996.23.

38 Psychotherapy, within the meaning of this chapter, is the use of  
39 psychosocial methods within a professional relationship, to assist  
40 the person or persons to achieve a better psychosocial adaptation,

1 to acquire greater human realization of psychosocial potential and  
2 adaptation, and to modify internal and external conditions which  
3 affect individuals, groups, or communities in respect to behavior,  
4 emotions, and thinking, in respect to their intrapersonal and  
5 interpersonal processes.

6 ~~SEC. 24.~~

7 *SEC. 27.* Section 4996.18 of the Business and Professions  
8 Code is amended to read:

9 4996.18. (a) A person who wishes to be credited with  
10 experience toward licensure requirements shall register with the  
11 board as an associate clinical social worker prior to obtaining that  
12 experience. The application shall be made on a form prescribed  
13 by the board.

14 (b) An applicant for registration shall satisfy the following  
15 requirements:

16 (1) Possess a master's degree from an accredited school or  
17 department of social work.

18 (2) Have committed no crimes or acts constituting grounds for  
19 denial of licensure under Section 480.

20 (3) Commencing January 1, 2014, have completed training or  
21 coursework, which may be embedded within more than one course,  
22 in California law and professional ethics for clinical social workers,  
23 including instruction in all of the following areas of study:

24 (A) Contemporary professional ethics and statutes, regulations,  
25 and court decisions that delineate the scope of practice of clinical  
26 social work.

27 (B) The therapeutic, clinical, and practical considerations  
28 involved in the legal and ethical practice of clinical social work,  
29 including, but not limited to, family law.

30 (C) The current legal patterns and trends in the mental health  
31 professions.

32 (D) The psychotherapist-patient privilege, confidentiality,  
33 dangerous patients, and the treatment of minors with and without  
34 parental consent.

35 (E) A recognition and exploration of the relationship between  
36 a practitioner's sense of self and human values, and his or her  
37 professional behavior and ethics.

38 (F) Differences in legal and ethical standards for different types  
39 of work settings.

40 (G) Licensing law and process.

1 (c) An applicant who possesses a master's degree from a school  
2 or department of social work that is a candidate for accreditation  
3 by the Commission on Accreditation of the Council on Social  
4 Work Education shall be eligible, and shall be required, to register  
5 as an associate clinical social worker in order to gain experience  
6 toward licensure if the applicant has not committed any crimes or  
7 acts that constitute grounds for denial of licensure under Section  
8 480. That applicant shall not, however, be eligible for examination  
9 until the school or department of social work has received  
10 accreditation by the Commission on Accreditation of the Council  
11 on Social Work Education.

12 (d) All applicants and registrants shall be at all times under the  
13 supervision of a supervisor who shall be responsible for ensuring  
14 that the extent, kind, and quality of counseling performed is  
15 consistent with the training and experience of the person being  
16 supervised, and who shall be responsible to the board for  
17 compliance with all laws, rules, and regulations governing the  
18 practice of clinical social work.

19 (e) Any experience obtained under the supervision of a spouse  
20 or relative by blood or marriage shall not be credited toward the  
21 required hours of supervised experience. Any experience obtained  
22 under the supervision of a supervisor with whom the applicant has  
23 a personal relationship that undermines the authority or  
24 effectiveness of the supervision shall not be credited toward the  
25 required hours of supervised experience.

26 (f) An applicant who possesses a master's degree from an  
27 accredited school or department of social work shall be able to  
28 apply experience the applicant obtained during the time the  
29 accredited school or department was in candidacy status by the  
30 Commission on Accreditation of the Council on Social Work  
31 Education toward the licensure requirements, if the experience  
32 meets the requirements of Section 4996.23. This subdivision shall  
33 apply retroactively to persons who possess a master's degree from  
34 an accredited school or department of social work and who  
35 obtained experience during the time the accredited school or  
36 department was in candidacy status by the Commission on  
37 Accreditation of the Council on Social Work Education.

38 (g) An applicant for registration or licensure trained in an  
39 educational institution outside the United States shall demonstrate  
40 to the satisfaction of the board that he or she possesses a master's

1 of social work degree that is equivalent to a master's degree issued  
2 from a school or department of social work that is accredited by  
3 the Commission on Accreditation of the Council on Social Work  
4 Education. These applicants shall provide the board with a  
5 comprehensive evaluation of the degree and shall provide any  
6 other documentation the board deems necessary. The board has  
7 the authority to make the final determination as to whether a degree  
8 meets all requirements, including, but not limited to, course  
9 requirements regardless of evaluation or accreditation.

10 (h) A registrant shall not provide clinical social work services  
11 to the public for a fee, monetary or otherwise, except as an  
12 employee.

13 (i) A registrant shall inform each client or patient prior to  
14 performing any professional services that he or she is unlicensed  
15 and is under the supervision of a licensed professional.

16 ~~SEC. 25.~~

17 *SEC. 28.* Section 4996.23 of the Business and Professions  
18 Code is amended to read:

19 4996.23. The experience required by subdivision (c) of Section  
20 4996.2 shall meet the following criteria:

21 (a) All persons registered with the board on and after January  
22 1, 2002, shall have at least 3,200 hours of post-master's degree  
23 supervised experience providing clinical social work services as  
24 permitted by Section 4996.9. At least 1,700 hours shall be gained  
25 under the supervision of a licensed clinical social worker. The  
26 remaining required supervised experience may be gained under  
27 the supervision of a licensed mental health professional acceptable  
28 to the board as defined by a regulation adopted by the board. This  
29 experience shall consist of the following:

30 (1) A minimum of 2,000 hours in clinical psychosocial  
31 diagnosis, assessment, and treatment, including psychotherapy or  
32 counseling.

33 (2) A maximum of 1,200 hours in client centered advocacy,  
34 consultation, evaluation, and research.

35 (3) Of the 2,000 clinical hours required in paragraph (1), no less  
36 than 750 hours shall be face-to-face individual or group  
37 psychotherapy provided to clients in the context of clinical social  
38 work services.

39 (4) A minimum of two years of supervised experience is required  
40 to be obtained over a period of not less than 104 weeks and shall

1 have been gained within the six years immediately preceding the  
2 date on which the application for licensure was filed.

3 (5) Experience shall not be credited for more than 40 hours in  
4 any week.

5 (b) “Supervision” means responsibility for, and control of, the  
6 quality of clinical social work services being provided.  
7 Consultation or peer discussion shall not be considered to be  
8 supervision.

9 (c) (1) Prior to the commencement of supervision, a supervisor  
10 shall comply with all requirements enumerated in Section 1870 of  
11 Title 16 of the California Code of Regulations and shall sign under  
12 penalty of perjury the “Responsibility Statement for Supervisors  
13 of an Associate Clinical Social Worker” form.

14 (2) Supervised experience shall include at least one hour of  
15 direct supervisor contact for a minimum of 104 weeks. For  
16 purposes of this subdivision, “one hour of direct supervisor contact”  
17 means one hour per week of face-to-face contact on an individual  
18 basis or two hours of face-to-face contact in a group conducted  
19 within the same week as the hours claimed.

20 (3) An associate shall receive at least one additional hour of  
21 direct supervisor contact for every week in which more than 10  
22 hours of face-to-face psychotherapy is performed in each setting  
23 in which experience is gained. No more than five hours of  
24 supervision, whether individual or group, shall be credited during  
25 any single week.

26 (4) Group supervision shall be provided in a group of not more  
27 than eight supervisees and shall be provided in segments lasting  
28 no less than one continuous hour.

29 (5) Of the 104 weeks of required supervision, 52 weeks shall  
30 be individual supervision, and of the 52 weeks of required  
31 individual supervision, not less than 13 weeks shall be supervised  
32 by a licensed clinical social worker.

33 (6) Notwithstanding paragraph (2), an associate clinical social  
34 worker working for a governmental entity, school, college, or  
35 university, or an institution that is both a nonprofit and charitable  
36 institution, may obtain the required weekly direct supervisor  
37 contact via live two-way videoconferencing. The supervisor shall  
38 be responsible for ensuring that client confidentiality is preserved.

39 (d) The supervisor and the associate shall develop a supervisory  
40 plan that describes the goals and objectives of supervision. These



goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

(e) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

(f) Experience shall not be gained until the applicant has been registered as an associate clinical social worker.

(g) Employment in a private practice as defined in subdivision (h) shall not commence until the applicant has been registered as an associate clinical social worker.

(h) A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

~~(i) Work performed by an associate as an independent contractor or reported on an IRS Form 1099 shall not satisfy the requirements of this chapter regarding gaining hours of supervised experience. Experience shall not be gained by interns or trainees for work performed as an independent contractor or reported on an IRS Form 1099.00.~~

(j) If volunteering, the associate shall provide the board with a letter from his or her employer verifying his or her voluntary status upon application for licensure.

(k) If employed, the associate shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

(l) While an associate may be either a paid employee or volunteer, employers are encouraged to provide fair remuneration to associates.

(m) An associate shall not do the following:

(1) Receive any remuneration from patients or clients and shall only be paid by his or her employer.

(2) Have any proprietary interest in the employer's business.

(3) Lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

(n) An associate, whether employed or volunteering, may obtain supervision from a person not employed by the associate's employer if that person has signed a written agreement with the employer to take supervisory responsibility for the associate's social work services.

(o) Notwithstanding any other provision of law, associates and applicants for examination shall receive a minimum of one hour of supervision per week for each setting in which he or she is working.

*SEC. 29. Section 4999.20 of the Business and Professions Code is amended to read:*

4999.20. (a) (1) "Professional clinical counseling" means the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems, *and the use, application, and integration of the coursework and training required by Sections 4999.32 and 4999.33.* "Professional clinical counseling" includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed, rational decisions.

(2) "Professional clinical counseling" is focused exclusively on the application of counseling interventions and psychotherapeutic techniques for the purposes of improving mental health, and is not intended to capture other, nonclinical forms of counseling for the purposes of licensure. For purposes of this paragraph, "nonclinical" means nonmental health.

(3) "Professional clinical counseling" does not include the assessment or treatment of couples or families unless the professional clinical counselor has completed all of the following additional training and education, beyond the minimum training and education required for licensure:

(A) One of the following:

(i) Six semester units or nine quarter units specifically focused on the theory and application of marriage and family therapy.

(ii) A named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage, family, and child counseling; or couple and family therapy.

(B) No less than 500 hours of documented supervised experience working directly with couples, families, or children.

(C) A minimum of six hours of continuing education specific to marriage and family therapy, completed in each license renewal cycle.

(4) “Professional clinical counseling” does not include the provision of clinical social work services.

(b) “Counseling interventions and psychotherapeutic techniques” means the application of cognitive, affective, verbal or nonverbal, systemic or holistic counseling strategies that include principles of development, wellness, and maladjustment that reflect a pluralistic society. These interventions and techniques are specifically implemented in the context of a professional clinical counseling relationship and use a variety of counseling theories and approaches.

(c) “Assessment” means selecting, administering, scoring, and interpreting tests, instruments, and other tools and methods designed to measure an individual’s attitudes, abilities, aptitudes, achievements, interests, personal characteristics, disabilities, and mental, emotional, and behavioral concerns and development and the use of methods and techniques for understanding human behavior in relation to coping with, adapting to, or ameliorating changing life situations, as part of the counseling process. “Assessment” shall not include the use of projective techniques in the assessment of personality, individually administered intelligence tests, neuropsychological testing, or utilization of a battery of three or more tests to determine the presence of psychosis, dementia, amnesia, cognitive impairment, or criminal behavior.

(d) Professional clinical counselors shall refer clients to other licensed health care professionals when they identify issues beyond their own scope of education, training, and experience.

~~SEC. 26.~~

*SEC. 30.* Section 4999.33 of the Business and Professions Code is amended to read:

4999.33. (a) This section shall apply to the following:

1 (1) Applicants for examination eligibility or registration who  
2 begin graduate study before August 1, 2012, and do not complete  
3 that study on or before December 31, 2018.

4 (2) Applicants for examination eligibility or registration who  
5 begin graduate study before August 1, 2012, and who graduate  
6 from a degree program that meets the requirements of this section.

7 (3) Applicants for examination eligibility or registration who  
8 begin graduate study on or after August 1, 2012.

9 (b) To qualify for examination eligibility or registration,  
10 applicants shall possess a master's or doctoral degree that is  
11 counseling or psychotherapy in content and that meets the  
12 requirements of this section, obtained from an accredited or  
13 approved institution, as defined in Section 4999.12. For purposes  
14 of this subdivision, a degree is "counseling or psychotherapy in  
15 content" if it contains the supervised practicum or field study  
16 experience described in paragraph (3) of subdivision (c) and, except  
17 as provided in subdivision (f), the coursework in the core content  
18 areas listed in subparagraphs (A) to (M), inclusive, of paragraph  
19 (1) of subdivision (c).

20 (c) The degree described in subdivision (b) shall contain not  
21 less than 60 graduate semester or 90 graduate quarter units of  
22 instruction, which shall, except as provided in subdivision (f),  
23 include all of the following:

24 (1) The equivalent of at least three semester units or four and  
25 one-half quarter units of graduate study in all of the following core  
26 content areas:

27 (A) Counseling and psychotherapeutic theories and techniques,  
28 including the counseling process in a multicultural society, an  
29 orientation to wellness and prevention, counseling theories to assist  
30 in selection of appropriate counseling interventions, models of  
31 counseling consistent with current professional research and  
32 practice, development of a personal model of counseling, and  
33 multidisciplinary responses to crises, emergencies, and disasters.

34 (B) Human growth and development across the lifespan,  
35 including normal and abnormal behavior and an understanding of  
36 developmental crises, disability, psychopathology, and situational  
37 and environmental factors that affect both normal and abnormal  
38 behavior.

39 (C) Career development theories and techniques, including  
40 career development decisionmaking models and interrelationships

1 among and between work, family, and other life roles and factors,  
2 including the role of multicultural issues in career development.

3 (D) Group counseling theories and techniques, including  
4 principles of group dynamics, group process components, group  
5 developmental stage theories, therapeutic factors of group work,  
6 group leadership styles and approaches, pertinent research and  
7 literature, group counseling methods, and evaluation of  
8 effectiveness.

9 (E) Assessment, appraisal, and testing of individuals, including  
10 basic concepts of standardized and nonstandardized testing and  
11 other assessment techniques, norm-referenced and  
12 criterion-referenced assessment, statistical concepts, social and  
13 cultural factors related to assessment and evaluation of individuals  
14 and groups, and ethical strategies for selecting, administering, and  
15 interpreting assessment instruments and techniques in counseling.

16 (F) Multicultural counseling theories and techniques, including  
17 counselors' roles in developing cultural self-awareness, identity  
18 development, promoting cultural social justice, individual and  
19 community strategies for working with and advocating for diverse  
20 populations, and counselors' roles in eliminating biases and  
21 prejudices, and processes of intentional and unintentional  
22 oppression and discrimination.

23 (G) Principles of the diagnostic process, including differential  
24 diagnosis, and the use of current diagnostic tools, such as the  
25 current edition of the Diagnostic and Statistical Manual, the impact  
26 of co-occurring substance use disorders or medical psychological  
27 disorders, established diagnostic criteria for mental or emotional  
28 disorders, and the treatment modalities and placement criteria  
29 within the continuum of care.

30 (H) Research and evaluation, including studies that provide an  
31 understanding of research methods, statistical analysis, the use of  
32 research to inform evidence-based practice, the importance of  
33 research in advancing the profession of counseling, and statistical  
34 methods used in conducting research, needs assessment, and  
35 program evaluation.

36 (I) Professional orientation, ethics, and law in counseling,  
37 including California law and professional ethics for professional  
38 clinical counselors, professional ethical standards and legal  
39 considerations, licensing law and process, regulatory laws that  
40 delineate the profession's scope of practice, counselor-client

1 privilege, confidentiality, the client dangerous to self or others,  
2 treatment of minors with or without parental consent, relationship  
3 between practitioner's sense of self and human values, functions  
4 and relationships with other human service providers, strategies  
5 for collaboration, and advocacy processes needed to address  
6 institutional and social barriers that impede access, equity, and  
7 success for clients.

8 (J) Psychopharmacology, including the biological bases of  
9 behavior, basic classifications, indications, and contraindications  
10 of commonly prescribed psychopharmacological medications so  
11 that appropriate referrals can be made for medication evaluations  
12 and so that the side effects of those medications can be identified.

13 (K) Addictions counseling, including substance abuse,  
14 co-occurring disorders, and addiction, major approaches to  
15 identification, evaluation, treatment, and prevention of substance  
16 abuse and addiction, legal and medical aspects of substance abuse,  
17 populations at risk, the role of support persons, support systems,  
18 and community resources.

19 (L) Crisis or trauma counseling, including crisis theory;  
20 multidisciplinary responses to crises, emergencies, or disasters;  
21 cognitive, affective, behavioral, and neurological effects associated  
22 with trauma; brief, intermediate, and long-term approaches; and  
23 assessment strategies for clients in crisis and principles of  
24 intervention for individuals with mental or emotional disorders  
25 during times of crisis, emergency, or disaster.

26 (M) Advanced counseling and psychotherapeutic theories and  
27 techniques, including the application of counseling constructs,  
28 assessment and treatment planning, clinical interventions,  
29 therapeutic relationships, psychopathology, or other clinical topics.

30 (2) In addition to the course requirements described in paragraph  
31 (1), 15 semester units or 22.5 quarter units of advanced coursework  
32 to develop knowledge of specific treatment issues or special  
33 populations.

34 (3) Not less than six semester units or nine quarter units of  
35 supervised practicum or field study experience, or the equivalent,  
36 in a clinical setting that provides a range of professional clinical  
37 counseling experience, including the following:

38 (A) Applied psychotherapeutic techniques.

39 (B) Assessment.

40 (C) Diagnosis.

- 1 (D) Prognosis.
- 2 (E) Treatment.
- 3 (F) Issues of development, adjustment, and maladjustment.
- 4 (G) Health and wellness promotion.
- 5 (H) Professional writing including documentation of services,
- 6 treatment plans, and progress notes.
- 7 (I) How to find and use resources.
- 8 (J) Other recognized counseling interventions.
- 9 (K) A minimum of 280 hours of face-to-face supervised clinical
- 10 experience counseling individuals, families, or groups.
- 11 (d) The 60 graduate semester units or 90 graduate quarter units
- 12 of instruction required pursuant to subdivision (c) shall, in addition
- 13 to meeting the requirements of subdivision (c), include instruction
- 14 in all of the following:
- 15 (1) The understanding of human behavior within the social
- 16 context of socioeconomic status and other contextual issues
- 17 affecting social position.
- 18 (2) The understanding of human behavior within the social
- 19 context of a representative variety of the cultures found within
- 20 California.
- 21 (3) Cultural competency and sensitivity, including a familiarity
- 22 with the racial, cultural, linguistic, and ethnic backgrounds of
- 23 persons living in California.
- 24 (4) An understanding of the effects of socioeconomic status on
- 25 treatment and available resources.
- 26 (5) Multicultural development and cross-cultural interaction,
- 27 including experiences of race, ethnicity, class, spirituality, sexual
- 28 orientation, gender, and disability and their incorporation into the
- 29 psychotherapeutic process.
- 30 (6) Case management, systems of care for the severely mentally
- 31 ill, public and private services for the severely mentally ill,
- 32 community resources for victims of abuse, disaster and trauma
- 33 response, advocacy for the severely mentally ill, and collaborative
- 34 treatment. The instruction required in this paragraph may be
- 35 provided either in credit level coursework or through extension
- 36 programs offered by the degree-granting institution.
- 37 (7) Human sexuality, including the study of the physiological,
- 38 psychological, and social cultural variables associated with sexual
- 39 behavior, gender identity, and the assessment and treatment of
- 40 psychosexual dysfunction.

(8) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

(9) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting, as specified in Section 28, and any regulations promulgated thereunder.

(10) Aging and long-term care, including biological, social, cognitive, and psychological aspects of aging. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(e) A degree program that qualifies for licensure under this section shall do all of the following:

(1) Integrate the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments.

(2) Integrate an understanding of various cultures and the social and psychological implications of socioeconomic position.

(3) Provide the opportunity for students to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(f) (1) An applicant whose degree is deficient in no more than three of the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) may satisfy those deficiencies by successfully completing post-master's or postdoctoral degree coursework at an accredited or approved institution, as defined in Section 4999.12.

(2) Coursework taken to meet deficiencies in the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) shall be the equivalent of three semester units or four and one-half quarter units of study.

(3) The board shall make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation.

~~SEC. 27.~~

*SEC. 31.* Section 4999.46 of the Business and Professions Code, as amended by Section 65 of Chapter 799 of the Statutes of 2012, is amended to read:

4999.46. (a) To qualify for the licensure examination specified by paragraph (2) of subdivision (a) of Section 4999.53, applicants



1 shall complete clinical mental health experience under the general  
2 supervision of an approved supervisor as defined in Section  
3 4999.12.

4 (b) The experience shall include a minimum of 3,000 postdegree  
5 hours of supervised clinical mental health experience related to  
6 the practice of professional clinical counseling, performed over a  
7 period of not less than two years (104 weeks), which shall include:

8 (1) Not more than 40 hours in any seven consecutive days.

9 (2) Not less than 1,750 hours of direct counseling with  
10 individuals or groups in a setting described in Section 4999.44  
11 using a variety of psychotherapeutic techniques and recognized  
12 counseling interventions within the scope of practice of licensed  
13 professional clinical counselors.

14 (3) Not more than 500 hours of experience providing group  
15 therapy or group counseling.

16 (4) Not more than 375 hours of experience providing personal  
17 psychotherapy, crisis counseling, or other counseling services via  
18 telehealth in accordance with Section 2290.5.

19 (5) Not less than 150 hours of clinical experience in a hospital  
20 or community mental health setting, as defined in Section 1820 of  
21 Title 16 of the California Code of Regulations.

22 (6) Not more than a combined total of 1,250 hours of experience  
23 in the following related activities:

24 (A) Direct supervisor contact.

25 (B) Client centered advocacy.

26 (C) Not more than 250 hours of experience administering tests  
27 and evaluating psychological tests of clients, writing clinical  
28 reports, writing progress notes, or writing process notes.

29 (D) Not more than 250 hours of verified attendance at  
30 workshops, seminars, training sessions, or conferences directly  
31 related to professional clinical counseling that are approved by the  
32 applicant's supervisor.

33 (c) No hours of clinical mental health experience may be gained  
34 more than six years prior to the date the application for examination  
35 eligibility was filed.

36 (d) An applicant shall register with the board as an intern in  
37 order to be credited for postdegree hours of experience toward  
38 licensure. Postdegree hours of experience shall be credited toward  
39 licensure, provided that the applicant applies for intern registration

1 within 90 days of the granting of the qualifying degree and is  
2 registered as an intern by the board.

3 (e) All applicants and interns shall be at all times under the  
4 supervision of a supervisor who shall be responsible for ensuring  
5 that the extent, kind, and quality of counseling performed is  
6 consistent with the training and experience of the person being  
7 supervised, and who shall be responsible to the board for  
8 compliance with all laws, rules, and regulations governing the  
9 practice of professional clinical counseling.

10 (f) Experience obtained under the supervision of a spouse or  
11 relative by blood or marriage shall not be credited toward the  
12 required hours of supervised experience. Experience obtained  
13 under the supervision of a supervisor with whom the applicant has  
14 had or currently has a personal, professional, or business  
15 relationship that undermines the authority or effectiveness of the  
16 supervision shall not be credited toward the required hours of  
17 supervised experience.

18 (g) Except for experience gained pursuant to subparagraph (D)  
19 of paragraph (6) of subdivision (b), supervision shall include at  
20 least one hour of direct supervisor contact in each week for which  
21 experience is credited in each work setting.

22 (1) No more than five hours of supervision, whether individual  
23 or group, shall be credited during any single week.

24 (2) An intern shall receive at least one additional hour of direct  
25 supervisor contact for every week in which more than 10 hours of  
26 face-to-face psychotherapy is performed in each setting in which  
27 experience is gained.

28 (3) For purposes of this section, “one hour of direct supervisor  
29 contact” means one hour of face-to-face contact on an individual  
30 basis or two hours of face-to-face contact in a group of not more  
31 than eight persons in segments lasting no less than one continuous  
32 hour.

33 (4) Notwithstanding paragraph (3), an intern working in a  
34 governmental entity, a school, a college, or a university, or an  
35 institution that is both nonprofit and charitable, may obtain the  
36 required weekly direct supervisor contact via two-way, real-time  
37 videoconferencing. The supervisor shall be responsible for ensuring  
38 that client confidentiality is upheld.

39 (h) This section shall become operative on January 1, 2014.

1     ~~SEC. 28.~~

2     ~~SEC. 32.~~ Section 4999.47 of the Business and Professions  
3 Code is amended to read:

4     4999.47. (a) Clinical counselor trainees, interns, and applicants  
5 shall perform services only as an employee or as a volunteer.

6     The requirements of this chapter regarding gaining hours of  
7 clinical mental health experience and supervision are applicable  
8 equally to employees and volunteers. ~~Work performed as an~~  
9 ~~independent contractor or reported on an IRS Form 1099 shall not~~  
10 ~~satisfy the requirements of this chapter regarding gaining hours of~~  
11 ~~supervised experience. Experience shall not be gained by interns~~  
12 ~~or trainees for work performed as an independent contractor or~~  
13 ~~reported on an IRS Form 1099.~~

14     (1) If employed, a clinical counselor intern shall provide the  
15 board with copies of the corresponding W-2 tax forms for each  
16 year of experience claimed upon application for licensure as a  
17 professional clinical counselor.

18     (2) If volunteering, a clinical counselor intern shall provide the  
19 board with a letter from his or her employer verifying the intern's  
20 employment as a volunteer upon application for licensure as a  
21 professional clinical counselor.

22     (b) Clinical counselor trainees, interns, and applicants shall not  
23 receive any remuneration from patients or clients, and shall only  
24 be paid by their employers.

25     (c) While an intern may be either a paid employee or a volunteer,  
26 employers are encouraged to provide fair remuneration.

27     (d) Clinical counselor trainees, interns, and applicants who  
28 provide voluntary services or other services, and who receive no  
29 more than a total, from all work settings, of five hundred dollars  
30 (\$500) per month as reimbursement for expenses actually incurred  
31 by those clinical counselor trainees, interns, and applicants for  
32 services rendered in any lawful work setting other than a private  
33 practice shall be considered an employee and not an independent  
34 contractor.

35     (e) The board may audit an intern or applicant who receives  
36 reimbursement for expenses and the intern or applicant shall have  
37 the burden of demonstrating that the payments received were for  
38 reimbursement of expenses actually incurred.

39     (f) Clinical counselor trainees, interns, and applicants shall only  
40 perform services at the place where their employer regularly

1 conducts business and services, which may include other locations,  
2 as long as the services are performed under the direction and  
3 control of the employer and supervisor in compliance with the  
4 laws and regulations pertaining to supervision. Clinical counselor  
5 trainees, interns, and applicants shall have no proprietary interest  
6 in the employer's business.

7 (g) Each educational institution preparing applicants for  
8 licensure pursuant to this chapter shall consider requiring, and  
9 shall encourage, its students to undergo individual, marital or  
10 conjoint, family, or group counseling or psychotherapy, as  
11 appropriate. Each supervisor shall consider, advise, and encourage  
12 his or her interns and clinical counselor trainees regarding the  
13 advisability of undertaking individual, marital or conjoint, family,  
14 or group counseling or psychotherapy, as appropriate. Insofar as  
15 it is deemed appropriate and is desired by the applicant, the  
16 educational institution and supervisors are encouraged to assist  
17 the applicant in locating that counseling or psychotherapy at a  
18 reasonable cost.

19 ~~SEC. 29.~~

20 *SEC. 33.* Section 4999.60 of the Business and Professions  
21 Code is amended to read:

22 4999.60. (a) This section applies to persons who are licensed  
23 outside of California and apply for examination eligibility on or  
24 after January 1, 2014.

25 (b) The board may issue a license to a person who, at the time  
26 of submitting an application for a license pursuant to this chapter,  
27 holds a valid license as a professional clinical counselor, or other  
28 counseling license that allows the applicant to independently  
29 provide clinical mental health services, in another jurisdiction of  
30 the United States if all of the following conditions are satisfied:

31 (1) The applicant's education is substantially equivalent, as  
32 defined in Section 4999.62.

33 (2) The applicant complies with subdivision (b) of Section  
34 4999.40, if applicable.

35 (3) The applicant's supervised experience is substantially  
36 equivalent to that required for a license under this chapter. If the  
37 applicant has less than 3,000 hours of qualifying supervised  
38 experience, time actively licensed as a professional clinical  
39 counselor shall be accepted at a rate of 100 hours per month up to  
40 a maximum of 1,200 hours.

1 (4) The applicant passes the examinations required to obtain a  
2 license under this chapter. An applicant who obtained his or her  
3 license or registration under another jurisdiction may apply for  
4 licensure with the board without taking the clinical examination  
5 if both of the following conditions are met:

6 (A) The applicant obtained a passing score on the licensing  
7 examination set forth in regulation as accepted by the board.

8 (B) The applicant's license or registration in that jurisdiction is  
9 in good standing at the time of his or her application and has not  
10 been revoked, suspended, surrendered, denied, or otherwise  
11 restricted or encumbered as a result of any disciplinary proceeding  
12 brought by the licensing authority of that jurisdiction.

13 ~~SEC. 30.~~

14 *SEC. 34.* Section 14132 of the Welfare and Institutions Code  
15 is amended to read:

16 14132. The following is the schedule of benefits under this  
17 chapter:

18 (a) Outpatient services are covered as follows:

19 Physician, hospital or clinic outpatient, surgical center,  
20 respiratory care, optometric, chiropractic, psychology, podiatric,  
21 occupational therapy, physical therapy, speech therapy, audiology,  
22 acupuncture to the extent federal matching funds are provided for  
23 acupuncture, and services of persons rendering treatment by prayer  
24 or healing by spiritual means in the practice of any church or  
25 religious denomination insofar as these can be encompassed by  
26 federal participation under an approved plan, subject to utilization  
27 controls.

28 (b) (1) Inpatient hospital services, including, but not limited  
29 to, physician and podiatric services, physical therapy and  
30 occupational therapy, are covered subject to utilization controls.

31 (2) For Medi-Cal fee-for-service beneficiaries, emergency  
32 services and care that are necessary for the treatment of an  
33 emergency medical condition and medical care directly related to  
34 the emergency medical condition. This paragraph shall not be  
35 construed to change the obligation of Medi-Cal managed care  
36 plans to provide emergency services and care. For the purposes of  
37 this paragraph, "emergency services and care" and "emergency  
38 medical condition" shall have the same meanings as those terms  
39 are defined in Section 1317.1 of the Health and Safety Code.

1 (c) Nursing facility services, subacute care services, and services  
2 provided by any category of intermediate care facility for the  
3 developmentally disabled, including podiatry, physician, nurse  
4 practitioner services, and prescribed drugs, as described in  
5 subdivision (d), are covered subject to utilization controls.  
6 Respiratory care, physical therapy, occupational therapy, speech  
7 therapy, and audiology services for patients in nursing facilities  
8 and any category of intermediate care facility for the  
9 developmentally disabled are covered subject to utilization controls.

10 (d) (1) Purchase of prescribed drugs is covered subject to the  
11 Medi-Cal List of Contract Drugs and utilization controls.

12 (2) Purchase of drugs used to treat erectile dysfunction or any  
13 off-label uses of those drugs are covered only to the extent that  
14 federal financial participation is available.

15 (3) (A) To the extent required by federal law, the purchase of  
16 outpatient prescribed drugs, for which the prescription is executed  
17 by a prescriber in written, nonelectronic form on or after April 1,  
18 2008, is covered only when executed on a tamper resistant  
19 prescription form. The implementation of this paragraph shall  
20 conform to the guidance issued by the federal Centers-~~of~~ *for*  
21 Medicare and Medicaid Services but shall not conflict with state  
22 statutes on the characteristics of tamper resistant prescriptions for  
23 controlled substances, including Section 11162.1 of the Health  
24 and Safety Code. The department shall provide providers and  
25 beneficiaries with as much flexibility in implementing these rules  
26 as allowed by the federal government. The department shall notify  
27 and consult with appropriate stakeholders in implementing,  
28 interpreting, or making specific this paragraph.

29 (B) Notwithstanding Chapter 3.5 (commencing with Section  
30 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
31 the department may take the actions specified in subparagraph (A)  
32 by means of a provider bulletin or notice, policy letter, or other  
33 similar instructions without taking regulatory action.

34 (4) (A) (i) For the purposes of this paragraph, nonlegend has  
35 the same meaning as defined in subdivision (a) of Section  
36 14105.45.

37 (ii) Nonlegend acetaminophen-containing products, with the  
38 exception of children's acetaminophen-containing products,  
39 selected by the department are not covered benefits.

1 (iii) Nonlegend cough and cold products selected by the  
2 department are not covered benefits. This clause shall be  
3 implemented on the first day of the first calendar month following  
4 90 days after the effective date of the act that added this clause,  
5 or on the first day of the first calendar month following 60 days  
6 after the date the department secures all necessary federal approvals  
7 to implement this section, whichever is later.

8 (iv) Beneficiaries under the Early and Periodic Screening,  
9 Diagnosis, and Treatment Program shall be exempt from clauses  
10 (ii) and (iii).

11 (B) Notwithstanding Chapter 3.5 (commencing with Section  
12 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
13 the department may take the actions specified in subparagraph (A)  
14 by means of a provider bulletin or notice, policy letter, or other  
15 similar instruction without taking regulatory action.

16 (e) Outpatient dialysis services and home hemodialysis services,  
17 including physician services, medical supplies, drugs and  
18 equipment required for dialysis, are covered, subject to utilization  
19 controls.

20 (f) Anesthesiologist services when provided as part of an  
21 outpatient medical procedure, nurse anesthetist services when  
22 rendered in an inpatient or outpatient setting under conditions set  
23 forth by the director, outpatient laboratory services, and X-ray  
24 services are covered, subject to utilization controls. Nothing in  
25 this subdivision shall be construed to require prior authorization  
26 for anesthesiologist services provided as part of an outpatient  
27 medical procedure or for portable X-ray services in a nursing  
28 facility or any category of intermediate care facility for the  
29 developmentally disabled.

30 (g) Blood and blood derivatives are covered.

31 (h) (1) Emergency and essential diagnostic and restorative  
32 dental services, except for orthodontic, fixed bridgework, and  
33 partial dentures that are not necessary for balance of a complete  
34 artificial denture, are covered, subject to utilization controls. The  
35 utilization controls shall allow emergency and essential diagnostic  
36 and restorative dental services and prostheses that are necessary  
37 to prevent a significant disability or to replace previously furnished  
38 prostheses which are lost or destroyed due to circumstances beyond  
39 the beneficiary's control. Notwithstanding the foregoing, the  
40 director may by regulation provide for certain fixed artificial

dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes,



1 custom-made orthopedic shoes are covered, subject to utilization  
2 controls.

3 Therapeutic shoes and inserts are covered when provided to  
4 beneficiaries with a diagnosis of diabetes, subject to utilization  
5 controls, to the extent that federal financial participation is  
6 available.

7 (l) Hearing aids are covered, subject to utilization controls.  
8 Utilization controls shall allow replacement of hearing aids  
9 necessary because of loss or destruction due to circumstances  
10 beyond the beneficiary's control.

11 (m) Durable medical equipment and medical supplies are  
12 covered, subject to utilization controls. The utilization controls  
13 shall allow the replacement of durable medical equipment and  
14 medical supplies when necessary because of loss or destruction  
15 due to circumstances beyond the beneficiary's control. The  
16 utilization controls shall allow authorization of durable medical  
17 equipment needed to assist a disabled beneficiary in caring for a  
18 child for whom the disabled beneficiary is a parent, stepparent,  
19 foster parent, or legal guardian, subject to the availability of federal  
20 financial participation. The department shall adopt emergency  
21 regulations to define and establish criteria for assistive durable  
22 medical equipment in accordance with the rulemaking provisions  
23 of the Administrative Procedure Act (Chapter 3.5 (commencing  
24 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
25 Government Code).

26 (n) Family planning services are covered, subject to utilization  
27 controls.

28 (o) Inpatient intensive rehabilitation hospital services, including  
29 respiratory rehabilitation services, in a general acute care hospital  
30 are covered, subject to utilization controls, when either of the  
31 following criteria are met:

32 (1) A patient with a permanent disability or severe impairment  
33 requires an inpatient intensive rehabilitation hospital program as  
34 described in Section 14064 to develop function beyond the limited  
35 amount that would occur in the normal course of recovery.

36 (2) A patient with a chronic or progressive disease requires an  
37 inpatient intensive rehabilitation hospital program as described in  
38 Section 14064 to maintain the patient's present functional level as  
39 long as possible.

1 (p) (1) Adult day health care is covered in accordance with  
2 Chapter 8.7 (commencing with Section 14520).

3 (2) Commencing 30 days after the effective date of the act that  
4 added this paragraph, and notwithstanding the number of days  
5 previously approved through a treatment authorization request,  
6 adult day health care is covered for a maximum of three days per  
7 week.

8 (3) As provided in accordance with paragraph (4), adult day  
9 health care is covered for a maximum of five days per week.

10 (4) As of the date that the director makes the declaration  
11 described in subdivision (g) of Section 14525.1, paragraph (2)  
12 shall become inoperative and paragraph (3) shall become operative.

13 (q) (1) Application of fluoride, or other appropriate fluoride  
14 treatment as defined by the department, and other prophylaxis  
15 treatment for children 17 years of age and under are covered.

16 (2) All dental hygiene services provided by a registered dental  
17 hygienist, registered dental hygienist in extended—~~function~~  
18 *functions*, and registered dental hygienist in alternative practice  
19 licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the  
20 Business and Professions Code may be covered as long as they  
21 are within the scope of Denti-Cal benefits and they are necessary  
22 services provided by a registered dental hygienist, registered dental  
23 hygienist in extended functions, or registered dental hygienist in  
24 alternative practice.

25 (r) (1) Paramedic services performed by a city, county, or  
26 special district, or pursuant to a contract with a city, county, or  
27 special district, and pursuant to a program established under Article  
28 3 (commencing with Section 1480) of Chapter 2.5 of Division 2  
29 of the Health and Safety Code by a paramedic certified pursuant  
30 to that article, and consisting of defibrillation and those services  
31 specified in subdivision (3) of Section 1482 of the article.

32 (2) All providers enrolled under this subdivision shall satisfy  
33 all applicable statutory and regulatory requirements for becoming  
34 a Medi-Cal provider.

35 (3) This subdivision shall be implemented only to the extent  
36 funding is available under Section 14106.6.

37 (s) In-home medical care services are covered when medically  
38 appropriate and subject to utilization controls, for beneficiaries  
39 who would otherwise require care for an extended period of time  
40 in an acute care hospital at a cost higher than in-home medical

1 care services. The director shall have the authority under this  
2 section to contract with organizations qualified to provide in-home  
3 medical care services to those persons. These services may be  
4 provided to patients placed in shared or congregate living  
5 arrangements, if a home setting is not medically appropriate or  
6 available to the beneficiary. As used in this section, “in-home  
7 medical care service” includes utility bills directly attributable to  
8 continuous, 24-hour operation of life-sustaining medical equipment,  
9 to the extent that federal financial participation is available.

10 As used in this subdivision, in-home medical care services,—  
11 include, but are not limited to:

12 (1) Level of care and cost of care evaluations.

13 (2) Expenses, directly attributable to home care activities, for  
14 materials.

15 (3) Physician fees for home visits.

16 (4) Expenses directly attributable to home care activities for  
17 shelter and modification to shelter.

18 (5) Expenses directly attributable to additional costs of special  
19 diets, including tube feeding.

20 (6) Medically related personal services.

21 (7) Home nursing education.

22 (8) Emergency maintenance repair.

23 (9) Home health agency personnel benefits which permit  
24 coverage of care during periods when regular personnel are on  
25 vacation or using sick leave.

26 (10) All services needed to maintain antiseptic conditions at  
27 stoma or shunt sites on the body.

28 (11) Emergency and nonemergency medical transportation.

29 (12) Medical supplies.

30 (13) Medical equipment, including, but not limited to, scales,  
31 gurneys, and equipment racks suitable for paralyzed patients.

32 (14) Utility use directly attributable to the requirements of home  
33 care activities which are in addition to normal utility use.

34 (15) Special drugs and medications.

35 (16) Home health agency supervision of visiting staff which is  
36 medically necessary, but not included in the home health agency  
37 rate.

38 (17) Therapy services.

39 (18) Household appliances and household utensil costs directly  
40 attributable to home care activities.

1 (19) Modification of medical equipment for home use.

2 (20) Training and orientation for use of life-support systems,  
3 including, but not limited to, support of respiratory functions.

4 (21) Respiratory care practitioner services as defined in Sections  
5 3702 and 3703 of the Business and Professions Code, subject to  
6 prescription by a physician and surgeon.

7 Beneficiaries receiving in-home medical care services are entitled  
8 to the full range of services within the Medi-Cal scope of benefits  
9 as defined by this section, subject to medical necessity and  
10 applicable utilization control. Services provided pursuant to this  
11 subdivision, which are not otherwise included in the Medi-Cal  
12 schedule of benefits, shall be available only to the extent that  
13 federal financial participation for these services is available in  
14 accordance with a home- and community-based services waiver.

15 (t) Home- and community-based services approved by the  
16 United States Department of Health and Human Services may be  
17 covered to the extent that federal financial participation is available  
18 for those services under waivers granted in accordance with Section  
19 1396n of Title 42 of the United States Code. The director may  
20 seek waivers for any or all home- and community-based services  
21 approvable under Section 1396n of Title 42 of the United States  
22 Code. Coverage for those services shall be limited by the terms,  
23 conditions, and duration of the federal waivers.

24 (u) Comprehensive perinatal services, as provided through an  
25 agreement with a health care provider designated in Section  
26 14134.5 and meeting the standards developed by the department  
27 pursuant to Section 14134.5, subject to utilization controls.

28 The department shall seek any federal waivers necessary to  
29 implement the provisions of this subdivision. The provisions for  
30 which appropriate federal waivers cannot be obtained shall not be  
31 implemented. Provisions for which waivers are obtained or for  
32 which waivers are not required shall be implemented  
33 notwithstanding any inability to obtain federal waivers for the  
34 other provisions. No provision of this subdivision shall be  
35 implemented unless matching funds from Subchapter XIX  
36 (commencing with Section 1396) of Chapter 7 of Title 42 of the  
37 United States Code are available.

38 (v) Early and periodic screening, diagnosis, and treatment for  
39 any individual under 21 years of age is covered, consistent with

1 the requirements of Subchapter XIX (commencing with Section  
2 1396) of Chapter 7 of Title 42 of the United States Code.

3 (w) Hospice service which is Medicare-certified hospice service  
4 is covered, subject to utilization controls. Coverage shall be  
5 available only to the extent that no additional net program costs  
6 are incurred.

7 (x) When a claim for treatment provided to a beneficiary  
8 includes both services which are authorized and reimbursable  
9 under this chapter, and services which are not reimbursable under  
10 this chapter, that portion of the claim for the treatment and services  
11 authorized and reimbursable under this chapter shall be payable.

12 (y) Home- and community-based services approved by the  
13 United States Department of Health and Human Services for  
14 beneficiaries with a diagnosis of AIDS or ARC, who require  
15 intermediate care or a higher level of care.

16 Services provided pursuant to a waiver obtained from the  
17 Secretary of the United States Department of Health and Human  
18 Services pursuant to this subdivision, and which are not otherwise  
19 included in the Medi-Cal schedule of benefits, shall be available  
20 only to the extent that federal financial participation for these  
21 services is available in accordance with the waiver, and subject to  
22 the terms, conditions, and duration of the waiver. These services  
23 shall be provided to individual beneficiaries in accordance with  
24 the client's needs as identified in the plan of care, and subject to  
25 medical necessity and applicable utilization control.

26 The director may under this section contract with organizations  
27 qualified to provide, directly or by subcontract, services provided  
28 for in this subdivision to eligible beneficiaries. Contracts or  
29 agreements entered into pursuant to this division shall not be  
30 subject to the Public Contract Code.

31 (z) Respiratory care when provided in organized health care  
32 systems as defined in Section 3701 of the Business and Professions  
33 Code, and as an in-home medical service as outlined in subdivision  
34 (s).

35 (aa) (1) There is hereby established in the department, a  
36 program to provide comprehensive clinical family planning  
37 services to any person who has a family income at or below 200  
38 percent of the federal poverty level, as revised annually, and who  
39 is eligible to receive these services pursuant to the waiver identified

1 in paragraph (2). This program shall be known as the Family  
2 Planning, Access, Care, and Treatment (Family PACT) Program.

3 (2) The department shall seek a waiver in accordance with  
4 Section 1315 of Title 42 of the United States Code, or a state plan  
5 amendment adopted in accordance with Section  
6 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United States  
7 Code, which was added to Section 1396a of Title 42 of the United  
8 States Code by Section 2303(a)(2) of the federal Patient Protection  
9 and Affordable Care Act (PPACA) (Public Law 111-148), for a  
10 program to provide comprehensive clinical family planning  
11 services as described in paragraph (8). Under the waiver, the  
12 program shall be operated only in accordance with the waiver and  
13 the statutes and regulations in paragraph (4) and subject to the  
14 terms, conditions, and duration of the waiver. Under the state plan  
15 amendment, which shall replace the waiver and shall be known as  
16 the Family PACT successor state plan amendment, the program  
17 shall be operated only in accordance with this subdivision and the  
18 statutes and regulations in paragraph (4). The state shall use the  
19 standards and processes imposed by the state on January 1, 2007,  
20 including the application of an eligibility discount factor to the  
21 extent required by the federal Centers for Medicare and Medicaid  
22 Services, for purposes of determining eligibility as permitted under  
23 Section 1396a(a)(10)(A)(ii)(XXI)(ii)(2) of Title 42 of the United  
24 States Code. To the extent that federal financial participation is  
25 available, the program shall continue to conduct education,  
26 outreach, enrollment, service delivery, and evaluation services as  
27 specified under the waiver. The services shall be provided under  
28 the program only if the waiver and, when applicable, the successor  
29 state plan amendment are approved by the federal Centers for  
30 Medicare and Medicaid Services and only to the extent that federal  
31 financial participation is available for the services. Nothing in this  
32 section shall prohibit the department from seeking the Family  
33 PACT successor state plan amendment during the operation of the  
34 waiver.

35 (3) Solely for the purposes of the waiver or Family PACT  
36 successor state plan amendment and notwithstanding any other  
37 provision of law, the collection and use of an individual's social  
38 security number shall be necessary only to the extent required by  
39 federal law.

1 (4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005,  
2 and 24013, and any regulations adopted under these statutes shall  
3 apply to the program provided for under this subdivision. No other  
4 provision of law under the Medi-Cal program or the State-Only  
5 Family Planning Program shall apply to the program provided for  
6 under this subdivision.

7 (5) Notwithstanding Chapter 3.5 (commencing with Section  
8 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
9 the department may implement, without taking regulatory action,  
10 the provisions of the waiver after its approval by the federal Health  
11 Care Financing Administration and the provisions of this section  
12 by means of an all-county letter or similar instruction to providers.  
13 Thereafter, the department shall adopt regulations to implement  
14 this section and the approved waiver in accordance with the  
15 requirements of Chapter 3.5 (commencing with Section 11340) of  
16 Part 1 of Division 3 of Title 2 of the Government Code. Beginning  
17 six months after the effective date of the act adding this  
18 subdivision, the department shall provide a status report to the  
19 Legislature on a semiannual basis until regulations have been  
20 adopted.

21 (6) In the event that the Department of Finance determines that  
22 the program operated under the authority of the waiver described  
23 in paragraph (2) or the Family PACT successor state plan  
24 amendment is no longer cost effective, this subdivision shall  
25 become inoperative on the first day of the first month following  
26 the issuance of a 30-day notification of that determination in  
27 writing by the Department of Finance to the chairperson in each  
28 house that considers appropriations, the chairpersons of the  
29 committees, and the appropriate subcommittees in each house that  
30 considers the State Budget, and the Chairperson of the Joint  
31 Legislative Budget Committee.

32 (7) If this subdivision ceases to be operative, all persons who  
33 have received or are eligible to receive comprehensive clinical  
34 family planning services pursuant to the waiver described in  
35 paragraph (2) shall receive family planning services under the  
36 Medi-Cal program pursuant to subdivision (n) if they are otherwise  
37 eligible for Medi-Cal with no share of cost, or shall receive  
38 comprehensive clinical family planning services under the program  
39 established in Division 24 (commencing with Section 24000) either

1 if they are eligible for Medi-Cal with a share of cost or if they are  
2 otherwise eligible under Section 24003.

3 (8) For purposes of this subdivision, “comprehensive clinical  
4 family planning services” means the process of establishing  
5 objectives for the number and spacing of children, and selecting  
6 the means by which those objectives may be achieved. These  
7 means include a broad range of acceptable and effective methods  
8 and services to limit or enhance fertility, including contraceptive  
9 methods, federal Food and Drug Administration approved  
10 contraceptive drugs, devices, and supplies, natural family planning,  
11 abstinence methods, and basic, limited fertility management.  
12 Comprehensive clinical family planning services include, but are  
13 not limited to, preconception counseling, maternal and fetal health  
14 counseling, general reproductive health care, including diagnosis  
15 and treatment of infections and conditions, including cancer, that  
16 threaten reproductive capability, medical family planning treatment  
17 and procedures, including supplies and followup, and  
18 informational, counseling, and educational services.  
19 Comprehensive clinical family planning services shall not include  
20 abortion, pregnancy testing solely for the purposes of referral for  
21 abortion or services ancillary to abortions, or pregnancy care that  
22 is not incident to the diagnosis of pregnancy. Comprehensive  
23 clinical family planning services shall be subject to utilization  
24 control and include all of the following:

25 (A) Family planning related services and male and female  
26 sterilization. Family planning services for men and women shall  
27 include emergency services and services for complications directly  
28 related to the contraceptive method, federal Food and Drug  
29 Administration approved contraceptive drugs, devices, and  
30 supplies, and followup, consultation, and referral services, as  
31 indicated, which may require treatment authorization requests.

32 (B) All United States Department of Agriculture, federal Food  
33 and Drug Administration approved contraceptive drugs, devices,  
34 and supplies that are in keeping with current standards of practice  
35 and from which the individual may choose.

36 (C) Culturally and linguistically appropriate health education  
37 and counseling services, including informed consent, that include  
38 all of the following:

39 (i) Psychosocial and medical aspects of contraception.

40 (ii) Sexuality.



- 1 (iii) Fertility.
- 2 (iv) Pregnancy.
- 3 (v) Parenthood.
- 4 (vi) Infertility.
- 5 (vii) Reproductive health care.
- 6 (viii) Preconception and nutrition counseling.
- 7 (ix) Prevention and treatment of sexually transmitted infection.
- 8 (x) Use of contraceptive methods, federal Food and Drug
- 9 Administration approved contraceptive drugs, devices, and
- 10 supplies.
- 11 (xi) Possible contraceptive consequences and followup.
- 12 (xii) Interpersonal communication and negotiation of
- 13 relationships to assist individuals and couples in effective
- 14 contraceptive method use and planning families.
- 15 (D) A comprehensive health history, updated at the next periodic
- 16 visit (between 11 and 24 months after initial examination) that
- 17 includes a complete obstetrical history, gynecological history,
- 18 contraceptive history, personal medical history, health risk factors,
- 19 and family health history, including genetic or hereditary
- 20 conditions.
- 21 (E) A complete physical examination on initial and subsequent
- 22 periodic visits.
- 23 (F) Services, drugs, devices, and supplies deemed by the federal
- 24 Centers for Medicare and Medicaid Services to be appropriate for
- 25 inclusion in the program.
- 26 (9) In order to maximize the availability of federal financial
- 27 participation under this subdivision, the director shall have the
- 28 discretion to implement the Family PACT successor state plan
- 29 amendment retroactively to July 1, 2010.
- 30 (ab) (1) Purchase of prescribed enteral nutrition products is
- 31 covered, subject to the Medi-Cal list of enteral nutrition products
- 32 and utilization controls.
- 33 (2) Purchase of enteral nutrition products is limited to those
- 34 products to be administered through a feeding tube, including, but
- 35 not limited to, a gastric, nasogastric, or jejunostomy tube.
- 36 Beneficiaries under the Early and Periodic Screening, Diagnosis,
- 37 and Treatment Program shall be exempt from this paragraph.
- 38 (3) Notwithstanding paragraph (2), the department may deem
- 39 an enteral nutrition product, not administered through a feeding
- 40 tube, including, but not limited to, a gastric, nasogastric, or

1 jejunostomy tube, a benefit for patients with diagnoses, including,  
2 but not limited to, malabsorption and inborn errors of metabolism,  
3 if the product has been shown to be neither investigational nor  
4 experimental when used as part of a therapeutic regimen to prevent  
5 serious disability or death.

6 (4) Notwithstanding Chapter 3.5 (commencing with Section  
7 11340) of Part 1 of Division 3 of Title 2 of the Government Code,  
8 the department may implement the amendments to this subdivision  
9 made by the act that added this paragraph by means of all-county  
10 letters, provider bulletins, or similar instructions, without taking  
11 regulatory action.

12 (5) The amendments made to this subdivision by the act that  
13 added this paragraph shall be implemented June 1, 2011, or on the  
14 first day of the first calendar month following 60 days after the  
15 date the department secures all necessary federal approvals to  
16 implement this section, whichever is later.

17 (ac) Diabetic testing supplies are covered when provided by a  
18 pharmacy, subject to utilization controls.



**Friday, May 17, 2013**

**Agenda**

**Dental Board of California**

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 www.dbc.ca.gov



**NOTICE OF PUBLIC MEETING** – Notice is hereby given that a public meeting of the Dental Board of California will be held as follows:

**Friday, May 17, 2013**

Waterfront Hotel  
10 Washington Street, Oakland, CA 94607  
(510)379-5293 or (916)263-2300

**Notice Regarding This Two-Day Meeting:** During this two-day meeting, the Dental Board of California will consider and may take action on any of the agenda items. It is anticipated that the items of business before the Board on the first day of this meeting will be fully completed on that date. However, should items not be completed, it is possible that it could be carried over and be heard beginning at 8:30 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.

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

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

**Friday, May 17, 2013**

**8:30 a.m. – FULL BOARD**

ROLL CALL - Establishment of a Quorum

**CLOSED SESSION – FULL BOARD\***

(a) Deliberate and Take Action on Disciplinary Matters

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

(b) Receive Advice from Counsel

*Shahab Ebrahimian et al. v. Dental Board of California*, Los Angeles County Sup. Ct., Case No. BS131882

\*The Board will meet in Closed Session as authorized by Government Code § 11126(e)

**CLOSED SESSION – LICENSING, CERTIFICATION, AND PERMITS COMMITTEE\*\***

**Issuance of New License(s) to Replace Cancelled License(s)**

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

**RETURN TO OPEN SESSION**

- AGENDA ITEM 6 ..... Executive Officer's Report
- Staffing Report
  - BreEZe
  - Strategic Plan
  - Mandatory Training
  - Upcoming Projects
- AGENDA ITEM 7 ..... Budget Process Overview and Report
- AGENDA ITEM 8 ..... Update from the Dental Hygiene Committee of California (DHCC)
- AGENDA ITEM 9 ..... Update from the Department of Consumer Affairs Executive Office
- AGENDA ITEM 10 ..... Regulatory Process Overview
- AGENDA ITEM 11 ..... Discussion and Possible Action Regarding:
- (A) Comments Received During the 45-day Public Comment Period for the Board's Proposed Rulemaking to Amend § 1018 and Adopt § 1018.01 of *Title 16 of the California Code of Regulations* Regarding Uniform Standards for Substance Abusing Healing Arts Licensees
  - (B) Adoption of Proposed Amendment of §1018 and Addition of §1018.01 of *Title 16 of the California Code of Regulations* Relevant to Uniform Standards for Substance Abusing Licensees
- AGENDA ITEM 12 ..... Licensing, Certification and Permits Program Report:
- A. Dental and Dental Assisting Licensure and Permit Statistics
  - B. General Anesthesia/Conscious Sedation Evaluation Statistics
  - C. The Board may take action on recommendations by the Licensing Certification and Permits Committee regarding issuance of new licenses to replace cancelled licenses
- AGENDA ITEM 13 ..... Enforcement Program Report:
- A. Program Status
  - B. Enforcement Statistics (Complaints and Investigations)
  - C. Performance Measures
  - D. Diversion Program Report
- AGENDA ITEM 14 ..... Report on the April 19, 2013 Meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permits

#### **PUBLIC COMMENT FOR ITEMS NOT ON THE AGENDA**

*Note: 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)]*

#### **BOARD MEMBER COMMENTS FOR ITEMS NOT ON THE AGENDA**

*Note: 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.*

#### **ADJOURNMENT**



## **Agenda Item 6**

### **Executive Officer's Report**

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 [www.dbc.ca.gov](http://www.dbc.ca.gov)



## MEMORANDUM

<b>DATE</b>	May 16, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 6:</b> Executive Officer's Report

Karen M. Fischer, Executive Officer of the Dental Board of California, will give a verbal report.



## **Agenda Item 7**

# **Budget Process Overview and Report**





## MEMORANDUM

DATE	May 6, 2013
TO	Dental Board Members
FROM	Genie Albertsen, Budget/Contract Analyst Dental Board of California
SUBJECT	<b>Agenda Item 7: Budget Process Overview and Report</b>

The Executive Officer and/or a representative from the DCA Budget Office will begin this discussion with a brief overview of the budget process. During the overview, Board members will have the opportunity to review and discuss the attached Budget Summary, Fund Condition, and Expenditure Reports for both the Dental and Dental Assisting programs.

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For the current Fiscal Year (FY), the Board's budget is broken into two separate appropriation accounts which together total a Board appropriation of \$13,246,000 [\$11,410,000 (Dentistry Fund) + \$1,836,000 (Dental Assisting Fund)]. The following documents are intended to provide an expenditure summary of the current fiscal year (2012-13) for the Dentistry and Dental Assisting funds.

The specifics surrounding the Board's two appropriations and expenditures are as follows:

### **Dentistry**

The Board's Dentistry expenditures are based upon the March CALSTARS report that came out in April 2013. According to that report, the Board has spent roughly \$7.7 million of its current year Dentistry budget appropriation. Approximately \$3.9 million was spent for Personnel Services; and roughly \$3.7 million for Operating Expense & Equipment (OE&E). Based on these expenditures, the Board is projected to revert back to the Dentistry Fund approximately \$1.1 million.

## **Dental Assisting**

The Board's Dental Assisting expenditures is based on the March CALSTARS report that came out in April 2013. According to that report, the Board has spent roughly \$1.1 million of its current year Dental Assisting budget appropriation. Approximately \$380,000 was spent for Personnel Services; and roughly \$734,000 for Operating Expense & Equipment (OE&E). Based on these expenditures, the Board is projected to revert back to the Dental Assisting Fund approximately \$147,000.

Since the Dental Assisting program migrated to the Dental Board, the Attorney General (AG) budget line item has been overspent. This is due in part to the programs attempt to stay within the guidelines of the Department of Consumer Affairs, Consumer Protection Initiative (CPEI). In order to do this, the Dental Board received 12.5 enforcement positions and has implemented a number of strategies to reduce overall investigative times. As a result, this has increased the number of enforcement cases filed with the Attorney General.

It was reported at the last Board Meeting that on February 1, 2013, pursuant to the 2012 Budget Act (AB 1464-Chapter 21/2012), Item 1110-402, and based on the FY 2012/13 expenditure projections (through Dec. 2012), the Dental Assisting Program of the Dental Board requested a total augmentation of \$105,000 to the AG budget line item. The Department of Finance approved the request around March 1, 2013.

In an attempt to alleviate the issue of over spending this line item, a Budget Change Proposal (BCP) Concept Paper was submitted to the Departments Budget Office on April 15, 2013. The Executive Officer will be working closely with the Budget Office to develop a BCP for FY 2014-15 that will indicate that the current minimum level of funding to the AG to prosecute the Board's most egregious enforcement cases is not sufficient to adequately address public protection. Therefore, additional money is necessary to address the increased number of enforcement cases filed with the AG.

**DENTAL**

# 36 - DENTAL BOARD OF CALIFORNIA

Item 1110-001-0741

## BUDGET SUMMARY

	<u>CY 2012/13</u>	<u>Governor's Budget BY 2013/14</u>		
2012 Governor's Budget	11,814,000			
Change Book / Governor's Veto:				
2011 Budget Act	11,814,000	11,814,000		
One-Time Costs:				
BCP 1111-01 (BreEZe)		-157,000		
Full-Year Costs:				
BCP 1110-1A (CPEI)		-40,000		
Baseline Adjustments:				
Retirement Rate Adjustment (BL 12-20)	103,534	104,000		
Employee Compensation (BL 12-21)	-268,509	0		
Health Benefit Adjustment (BL 12-24)	32,336	56,000		
Otech Rate Reduction	-4,438	-4,000		
Department Distributed Costs				
OIS		59,943		
Admin/Exec.		-42,819		
DOI Internal		-5,394		
Public Affairs		-7,943		
CCED		-16,862		
DOI Investigative		14,792		
Statewide (Central Admin.) Prorata		24,000		
Equipment Adjustment *		-5,000		
Budget Change Proposals (BCPs):				
Board BCPs:				
Department-wide:				
BCP 1111-01 (BreEZe & Credit Card)		264,000		
BCP 1111-03 (Agency GRP)		34,000		
<b>REVISED APPROPRIATION</b>	<b>11,676,923</b>	<b>12,092,000</b>	<b>Net Change</b>	
Reimbursements	-267,000	-267,000	<b>415,077</b>	<b>3.6%</b>
<b>Revised Net Appropriation (from fund)</b>	<b>11,409,923</b>	<b>11,825,000</b>		
<b>PERSONNEL YEARS</b>	<b>65.4</b>	<b>65</b>	<b>(0.4)</b>	<b>-0.6%</b>
Authorized Positions	62.7	60.7		
Blanket	6.1	4.7		
Salary Savings	-3.4	0.0		
BCP 1110-1A (CPEI)	0.0	-0.4		

\* 12/13 major/minor equipment base = 46,000

13/14 major/minor equipment base = 41,000

difference = (5,000)

# 0741 - Dental Board of California

## Analysis of Fund Condition

Prepared 5/3/13

(Dollars in Thousands)

**NOTE: \$2.7 Million General Fund Repayment in FY 2013-14**

### Governor's Budget 13-14

#### BEGINNING BALANCE

Prior Year Adjustment

Adjusted Beginning Balance

#### REVENUES AND TRANSFERS

Revenues:

125600 Other regulatory fees  
125700 Other regulatory licenses and permits  
125800 Renewal fees  
125900 Delinquent fees  
131700 Misc. Revenue from Local Agencies  
141200 Sales of documents  
142500 Miscellaneous services to the public  
150300 Income from surplus money investments  
150500 Interest Income From Interfund Loans  
160400 Sale of fixed assets  
161000 Escheat of unclaimed checks and warrants  
161400 Miscellaneous revenues  
164300 Penalty Assessments  
Totals, Revenues

Transfers from Other Funds

F00001 Repayment Per Item 1250-011-0741, Budget Act of 2003  
F00683 Teale Data Center (CS 15.00, Bud Act of 2005)  
Proposed GF Loan Repayment BA of 2011

Transfers to Other Funds

T00001 GF loan per Item 1250-011-0741, BA of 2002  
T00001 GF loan per Item 1250-011-0741, BA of 2003  
T03039 Transfer to Dentally Underserved Account

Totals, Revenues and Transfers

Totals, Resources

#### EXPENDITURES

Disbursements:

0840 State Controller (State Operations)  
8880 Financial Information System of California (State Operations)  
1110 Program Expenditures (State Operations)  
Total Disbursements

#### FUND BALANCE

Reserve for economic uncertainties

Months in Reserve

	Actual 2011-12	CY 2012-13	Governor's Budget BY 2013-14	BY+1 2014-15	BY+2 2015-16
BEGINNING BALANCE	\$ 6,087	\$ 6,180	\$ 2,707	\$ 1,575	\$ -2,441
Prior Year Adjustment	\$ 73	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 6,160	\$ 6,180	\$ 2,707	\$ 1,575	\$ -2,441
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	\$ 26	\$ 28	\$ 26	\$ 26	\$ 26
125700 Other regulatory licenses and permits	\$ 709	\$ 738	\$ 738	\$ 738	\$ 738
125800 Renewal fees	\$ 7,180	\$ 7,166	\$ 7,208	\$ 7,208	\$ 7,208
125900 Delinquent fees	\$ 74	\$ 73	\$ 74	\$ 74	\$ 74
131700 Misc. Revenue from Local Agencies	\$ -	\$ -	\$ -	\$ -	\$ -
141200 Sales of documents	\$ -	\$ -	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 21	\$ 8	\$ -	\$ -	\$ -
150500 Interest Income From Interfund Loans	\$ 210	\$ -	\$ -	\$ -	\$ -
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 4	\$ -	\$ -	\$ -	\$ -
161400 Miscellaneous revenues	\$ 2	\$ -	\$ -	\$ -	\$ -
164300 Penalty Assessments	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues	\$ 8,226	\$ 8,013	\$ 8,046	\$ 8,046	\$ 8,046
Transfers from Other Funds					
F00001 Repayment Per Item 1250-011-0741, Budget Act of 2003	\$ 1,700	\$ -	\$ -	\$ -	\$ -
F00683 Teale Data Center (CS 15.00, Bud Act of 2005)	\$ -	\$ -	\$ -	\$ -	\$ -
Proposed GF Loan Repayment BA of 2011	\$ -	\$ -	\$ 2,700	\$ -	\$ -
Transfers to Other Funds					
T00001 GF loan per Item 1250-011-0741, BA of 2002	\$ -	\$ -	\$ -	\$ -	\$ -
T00001 GF loan per Item 1250-011-0741, BA of 2003	\$ -	\$ -	\$ -	\$ -	\$ -
T03039 Transfer to Dentally Underserved Account	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues and Transfers	\$ 9,926	\$ 8,013	\$ 10,746	\$ 8,046	\$ 8,046
Totals, Resources	\$ 16,086	\$ 14,193	\$ 13,453	\$ 9,621	\$ 5,605
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	\$ 12	\$ 14	\$ -	\$ -	\$ -
8880 Financial Information System of California (State Operations)	\$ 27	\$ 62	\$ 53	\$ -	\$ -
1110 Program Expenditures (State Operations)	\$ 9,867	\$ 11,410	\$ 11,825	\$ 12,062	\$ 12,303
Total Disbursements	\$ 9,906	\$ 11,486	\$ 11,878	\$ 12,062	\$ 12,303
FUND BALANCE					
Reserve for economic uncertainties	\$ 6,180	\$ 2,707	\$ 1,575	\$ -2,441	\$ -6,698
Months in Reserve	6.5	2.7	1.6	-2.4	-6.4

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2014-15 AND ON-GOING.
- B. ASSUMES INTEREST RATE AT .30%.
- C. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR.



**DENTAL BOARD - FUND 0741**  
**BUDGET REPORT**  
**FY 2012-13 EXPENDITURE PROJECTION**

May 1, 2013

OBJECT DESCRIPTION	FY 2011-12		FY 2012-13				
	ACTUAL	PRIOR YEAR	BUDGET	CURRENT YEAR	PERCENT	PROJECTIONS	UNENCUMBERED
	EXPENDITURES (MONTH 13)	EXPENDITURES 3/31/2012	STONE 2012-13	EXPENDITURES 3/31/2013	SPENT	TO YEAR END	BALANCE
<b>PERSONNEL SERVICES</b>							
Salary & Wages (Staff)	3,270,234	2,435,523	3,506,376	2,447,502	70%	3,300,000	206,376
Statutory Exempt (EO)	102,012	76,110	103,608	213,446	206%	236,291	(132,683)
Temp Help (Expert Examiners)	0	0	40,000	0	0%	0	40,000
Physical Fitness Incentive	5,330	3,965		4,160		5,400	(5,400)
Temp Help Reg (907)	185,150	128,876	222,403	110,045	49%	187,000	35,403
Temp Help (Exam Proctors)	0		45,447	0	0%	0	45,447
Board Member Per Diem (901, 920)	16,500	0	45,950	10,300	22%	16,500	29,450
Committee Members (911)	4,300	11,500	58,686	3,700	6%	5,000	53,686
Overtime	34,558	3,200	25,208	33,996	135%	45,000	(19,792)
Staff Benefits	1,443,263	21,114	1,759,409	1,140,006	65%	1,537,085	222,324
<b>TOTALS, PERSONNEL SVC</b>	<b>5,061,347</b>	<b>3,742,159</b>	<b>5,807,087</b>	<b>3,963,155</b>	<b>68%</b>	<b>5,332,276</b>	<b>474,811</b>
<b>OPERATING EXPENSE AND EQUIPMENT</b>							
General Expense	123,774	79,249	75,086	82,456	110%	134,000	(58,914)
Fingerprint Reports	24,978	11,828	25,777	14,911	58%	26,000	(223)
Minor Equipment	64,450	9,984	16,600	10,908	66%	20,000	(3,400)
Printing	40,384	29,664	42,502	33,554	79%	39,000	3,502
Communication	41,558	22,284	33,670	34,858	104%	59,000	(25,330)
Postage	69,066	53,844	59,791	57,053	95%	69,000	(9,209)
Insurance	2,027	2,027	2,100	2,775	132%	2,775	(675)
Travel In State	110,677	70,013	109,309	64,285	59%	120,000	(10,691)
Travel, Out-of-State	0		0	209		209	(209)
Training	6,434	4,060	7,148	4,348	61%	7,000	148
Facilities Operations	385,214	380,469	360,656	355,197	98%	386,000	(25,344)
C & P Services - Interdept.	50,623	167,088	102,086	45,863	45%	59,000	43,086
C & P Services - External	233,510	219,017	241,146	253,110	105%	264,000	(22,854)
<b>DEPARTMENTAL SERVICES:</b>							
OIS Pro Rata	436,830	318,419	511,106	382,287	75%	511,106	0
Admin/Exec	537,230	405,181	630,748	473,061	75%	630,748	0
Interagency Services	0	0	881	0	0%	0	881
IA w/ OER	0		0	23,330		23,330	(23,330)
DOI-ProRata Internal	18,178	16,766	25,531	19,148	75%	25,531	0
Public Affairs Office	36,306	28,460	36,456	27,342	75%	36,456	0
CCED	39,178	30,409	43,893	32,920	75%	43,893	0
<b>INTERAGENCY SERVICES:</b>							
Consolidated Data Center	26,960	17,966	17,517	14,099	80%	27,000	(9,483)
DP Maintenance & Supply	32,846	16,299	11,366	9,878	87%	20,000	(8,634)
Central Admin Svc-ProRata	413,261	309,946	506,464	379,848	75%	506,464	0
<b>EXAMS EXPENSES:</b>							
Exam Supplies	0	0	43,589	0	0%	0	43,589
Exam Freight	0	0	166	0	0%	0	166
Exam Site Rental	0	0	244,586	0	0%	0	244,586
C/P Svcs-External Expert Administration	231,504	180,524	6,709	121,509	1811%	203,000	(196,291)
C/P Svcs-External Expert Examiners	0	0	238,248	0	0%	0	238,248
C/P Svcs-External Subject Matter	76	210	0	0		0	0
<b>OTHER ITEMS OF EXPENSE:</b>	10,511	0	661	3,746	567%	11,000	(10,339)
Tort Pymts-Punitive	0	0	0	2,500		2,500	(2,500)
<b>ENFORCEMENT:</b>							
Attorney General	1,380,916	1,062,368	1,778,310	859,400	48%	1,160,000	618,310
Office Admin. Hearings	297,050	164,604	406,720	109,296	27%	200,000	206,720
Court Reporters	23,256	13,009	0	6,997		24,000	(24,000)
Evidence/Witness Fees	513,135	287,871	243,959	221,957	91%	514,000	(270,041)
Vehicle Operations	54,331	31,821	9,055	39,766	439%	54,000	(44,945)
Major Equipment	8,493	0	38,000	0	0%	100,000	(62,000)
<b>TOTALS, OE&amp;E</b>	<b>5,212,756</b>	<b>3,933,380</b>	<b>5,869,836</b>	<b>3,686,611</b>	<b>63%</b>	<b>5,279,012</b>	<b>590,824</b>
<b>TOTAL EXPENSE</b>	<b>10,274,103</b>	<b>7,675,539</b>	<b>11,676,923</b>	<b>7,649,766</b>	<b>131%</b>	<b>10,611,288</b>	<b>1,065,635</b>
Sched. Reimb. - Fingerprints	(24,483)	(14,601)	(53,000)	(13,720)	26%	(53,000)	0
Sched. Reimb. - Other	(12,255)	(8,670)	(214,000)	(7,180)	3%	(214,000)	0
Unsched. Reimb. - External/Private	(40,207)	(30,184)	0	(33,641)		0	0
Probation Monitoring Fee - Variable	(89,868)	(64,320)	0	(70,447)		0	0
Invest Cost Recover FTB Collection	(50)	0	0	(15,041)		0	0
Unsched. Reimb. - Other	(240,470)	(166,496)	0	(206,838)		0	0
<b>NET APPROPRIATION</b>	<b>9,866,770</b>	<b>7,391,269</b>	<b>11,409,923</b>	<b>7,302,899</b>	<b>64%</b>	<b>10,344,288</b>	<b>1,065,635</b>
<b>SURPLUS/(DEFICIT):</b>							<b>9.3%</b>

# **DENTAL ASSISTING**

# 36 - DENTAL ASSISTING PROGRAM

Item 1110-001-3142

## BUDGET SUMMARY

	<u>CY 2012/13</u>	<u>Governor's Budget BY 2013/14</u>		
2012 Governor's Budget	1,760,000			
Change Book / Governor's Veto:				
2012 Budget Act	1,760,000	1,760,000		
One-Time Costs:				
BCP 1111-01 (BreEZe)		-86,000		
Full-Year Costs:				
10-11 BCP 1110-1A (CPEI Adjustment)				
Baseline Adjustments:				
Retirement Rate Adjustment (BL 12-20)	12,352	12,000		
Employee Compensation (BL 12-21)	-32,205	0		
Health Benefit Adjustment (BL 12-24)	7,164	12,000		
Otech Rate Reduction	-864	-1,000		
Department Distributed Costs				
OIS		27,795		
Admin/Exec.		6,062		
DOI Internal		-292		
Public Affairs		-402		
CCED		-1,969		
DOI Investigative		0		
Statewide (Central Admin.) Prorata		-2,000		
Equipment Adjustment *		5,000		
Budget Change Proposals (BCPs):				
Board BCPs:				
Department-wide:				
BCP 1111-01 (BreEZe & Credit Card)		131,000		
BCP 1111-03 (Agency GRP)		5,000		
<b>REVISED APPROPRIATION</b>	<b>1,746,447</b>	<b>1,867,000</b>	<b>Net Change</b>	
Reimbursements	-16,000	-16,000	<b>120,553</b>	<b>6.9%</b>
<b>Revised Net Appropriation (from fund)</b>	<b>1,730,447</b>	<b>1,851,000</b>		
<b>PERSONNEL YEARS</b>	<b>9.1</b>	<b>9.1</b>	<b>0.0</b>	<b>0.0%</b>
Authorized Positions	9.0	9.0		
Blanket	0.1	0.1		

\* 12/13 major/minor equipment base = 0  
13/14 major/minor equipment base = 5,000  
difference = 5,000



# 3142 - Dental Assistant Program Analysis of Fund Condition

Prepared 5/3/13

(Dollars in Thousands)

## Governor's Budget 13-14

	Actual 2011-12	CY 2012-13	Governor's Budget BY 2013-14	BY + 1 2014-15	BY + 2 2015-16
<b>BEGINNING BALANCE</b>	\$ 2,263	\$ 2,445	\$ 2,245	\$ 2,050	\$ 1,824
Prior Year Adjustment	\$ 49	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 2,312	\$ 2,445	\$ 2,245	\$ 2,050	\$ 1,824
<b>REVENUES AND TRANSFERS</b>					
Revenues:					
125600 Other regulatory fees	\$ 16	\$ 16	\$ 16	\$ 16	\$ 16
125700 Other regulatory licenses and permits	\$ 306	\$ 327	\$ 343	\$ 343	\$ 343
125800 Renewal fees	\$ 1,224	\$ 1,227	\$ 1,228	\$ 1,228	\$ 1,228
125900 Delinquent fees	\$ 73	\$ 65	\$ 65	\$ 65	\$ 65
141200 Sales of documents	\$ -	\$ -	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 10	\$ 7	\$ 7	\$ 5	\$ 5
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1
161400 Miscellaneous revenues	\$ 4	\$ 4	\$ 4	\$ 4	\$ 4
164300 Penalty Assessments	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues	\$ 1,634	\$ 1,647	\$ 1,664	\$ 1,662	\$ 1,662
Totals, Revenues and Transfers	\$ 1,634	\$ 1,647	\$ 1,664	\$ 1,662	\$ 1,662
Totals, Resources	\$ 3,946	\$ 4,092	\$ 3,909	\$ 3,712	\$ 3,486
<b>EXPENDITURES</b>					
Disbursements:					
0840 State Controller (State Operations)	\$ 2	\$ 3	\$ -	\$ -	\$ -
8880 Financial Information System for CA (State Operations)	\$ 2	\$ 9	\$ 8		
1110 Program Expenditures (State Operations)	\$ 1,497	\$ 1,730	\$ 1,851	\$ 1,888	\$ 1,926
AG Augmentation	\$ -	\$ 105	\$ -	\$ -	\$ -
Total Disbursements	\$ 1,501	\$ 1,847	\$ 1,859	\$ 1,888	\$ 1,926
<b>FUND BALANCE</b>					
Reserve for economic uncertainties	\$ 2,445	\$ 2,245	\$ 2,050	\$ 1,824	\$ 1,560
<b>Months in Reserve</b>	15.9	14.5	13.0	11.4	9.5

### NOTES:

- ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2012-13 AND ONGOING.
- ASSUMES INTEREST RATE AT .30%.
- ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR.

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

May 1, 2013

OBJECT DESCRIPTION	FY 2011-12		FY 2012-13				
	ACTUAL	PRIOR YEAR	BUDGET	CURRENT YEAR	PERCENT	PROJECTIONS	UNENCUMBERED
	EXPENDITURES (MONTH 13)	EXPENDITURES 3/31/2012	STONE 2012-13	EXPENDITURES 3/31/2013	SPENT	TO YEAR END	BALANCE
<b>PERSONNEL SERVICES</b>							
Salary & Wages (Staff)	286,169	207,686	373,880	210,589	56%	300,771	73,109
Physical Fitness Incentive	0	0	158	0	0%	0	158
Temp Help (Exam Proctors)	196	196	0	0	0%	0	0
Board Member Per Diem (901, 920)	1,500		0	3,600	0%	4,000	(4,000)
Overtime	37,524	18,808	0	20,516	0%	30,000	(30,000)
Staff Benefits	152,711	108,620	200,224	145,506	73%	207,817	(7,593)
<b>TOTALS, PERSONNEL SVC</b>	<b>478,100</b>	<b>335,310</b>	<b>574,262</b>	<b>380,211</b>	<b>66%</b>	<b>542,588</b>	<b>31,674</b>
<b>OPERATING EXPENSE AND EQUIPMENT</b>							
General Expense	5,438	2,836	40,387	3,415	8%	6,548	33,839
Fingerprint Reports	0	0	7,780	20	0%	20	7,760
Minor Equipment	0	0	0	0	0%	0	0
Printing	23,470	14,758	19,001	9,088	48%	19,000	1
Communication	95	18	9,500	32	0%	100	9,400
Postage	21,004	15,232	35,991	16,854	47%	21,000	14,991
Insurance		0	0	0	0%	0	0
Travel In State	52,494	30,215	28,056	46,433	166%	50,625	(22,569)
Training	0	0	4,119	695	17%	695	3,424
Facilities Operations	35,866	35,301	63,950	31,806	50%	37,852	26,098
C & P Services - Interdept.	0	71,638	288,439	0	0%	0	288,439
C & P Services - External	0	15,000	12,532	14,825	118%	15,000	(2,468)
<b>DEPARTMENTAL SERVICES:</b>							
OIS ProRata	165,801	107,009	205,397	154,226	75%	205,397	0
Admin/Exec	74,232	55,987	76,639	57,442	75%	76,639	0
Interagency Services	0	0	72,554	0	0%	142,856	(70,302)
IA w/ OER	29,408		0	37,208	0%	37,208	(37,208)
DOI-ProRata Internal	2,500	29,408	3,105	2,329	75%	3,105	0
Public Affairs Office	4,993	2,305	4,391	3,290	75%	4,391	0
CCED	5,172	3,914	5,321	3,991	75%	5,321	0
<b>INTERAGENCY SERVICES:</b>	0	4,014	0	0	0%	0	0
Consolidated Data Center	0		1,576	0	0%	0	1,576
DP Maintenance & Supply	0	0	1,369	0	0%	0	1,369
Statewide ProRata	73,015	0	69,192	51,894	75%	69,192	0
<b>EXAMS EXPENSES:</b>		54,761					
Exam Supplies	9,853		3,946	9,636	244%	22,000	(18,054)
Exam Site Rental - State Owned	26,010	4,389		38,010	0%	45,510	(45,510)
Exam Site Rental - Non State Owned	46,495	17,210	69,939	35,665	51%	39,950	29,989
C/P Svcs-External Expert Administration	10,860	46,495	30,877	6,290	20%	11,000	19,877
C/P Svcs-External Expert Examiners	0	9,125	47,476	0	0%	0	47,476
C/P Svcs-External Expert Examiners	0	0	0	3,436	0%	2,516	(2,516)
C/P Svcs-External Subject Matter	177,084	141,706	0	83,608	0%	120,500	(120,500)
<b>OTHER ITEMS OF EXPENSE:</b>	0	0	285	0	0%	0	285
<b>ENFORCEMENT:</b>							
Attorney General	257,788	186,346	172,536	120,988	70%	212,000	(39,464)
Office Admin. Hearings	0	0	2,740	0	0%	0	2,740
Evidence/Witness Fees	0	0	87	2,890	3322%	888	(801)
<b>TOTALS, OE&amp;E</b>	<b>1,021,578</b>	<b>847,667</b>	<b>1,277,185</b>	<b>734,071</b>	<b>57%</b>	<b>1,149,313</b>	<b>127,872</b>
<b>TOTAL EXPENSE</b>	<b>1,499,678</b>	<b>1,182,977</b>	<b>1,851,447</b>	<b>1,114,282</b>	<b>124%</b>	<b>1,691,902</b>	<b>159,545</b>
Sched. Reimb. - Fingerprints	(1,690)	(612)	(13,000)	(1,519)	12%	(1,700)	(11,300)
Sched. Reimb. - Other	(1,205)	(960)	(3,000)	(705)	24%	(1,200)	(1,800)
<b>NET APPROPRIATION</b>	<b>1,496,783</b>	<b>1,181,405</b>	<b>1,835,447</b>	<b>1,112,058</b>	<b>61%</b>	<b>1,689,002</b>	<b>146,445</b>
<b>SURPLUS/(DEFICIT):</b>							<b>8.0%</b>



## **Agenda Item 8**

### **Update from Dental Hygiene Committee of California**

**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 www.dbc.ca.gov



## MEMORANDUM

DATE	May 16, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	<b>Agenda Item 8:</b> Update from the Dental Hygiene Committee of California

A representative from the Dental Hygiene Committee of California will give a verbal report.



## **Agenda Item 9**

**Update from the Department of  
Consumer Affairs**



**DENTAL BOARD OF CALIFORNIA**

2005 Evergreen Street, Suite 1550, Sacramento, CA 95815  
P (916) 263-2300 F (916) 263-2140 [www.dbc.ca.gov](http://www.dbc.ca.gov)



## MEMORANDUM

<b>DATE</b>	May 16, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 9:</b> Update from the Department of Consumer Affairs

Reichel Everhart, Deputy Director of Board Relations from the Department of Consumer Affairs, will give a verbal report.



## **Agenda Item 10**

### **Regulatory Process Overview**



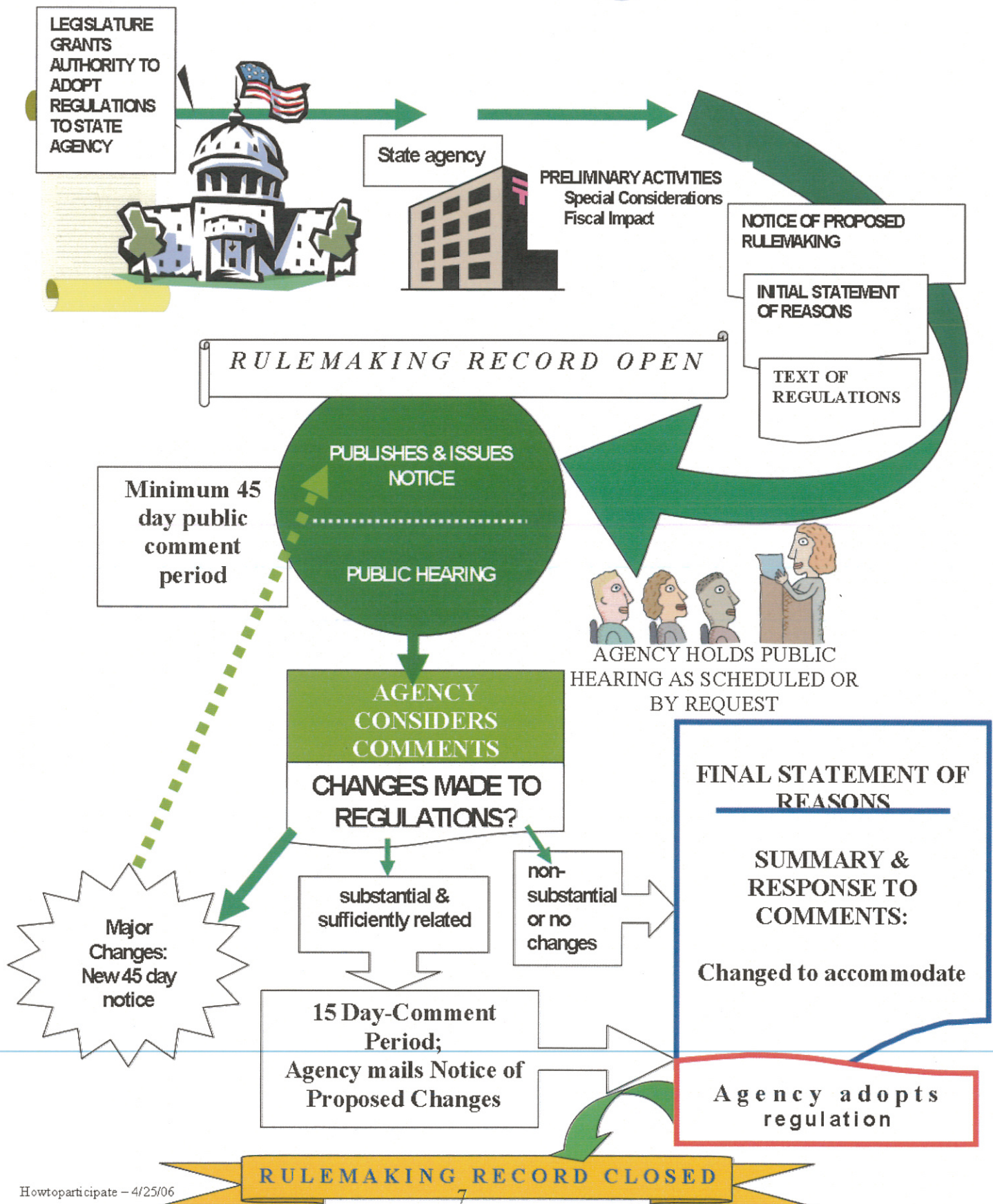
## MEMORANDUM

<b>DATE</b>	May 16, 2013
<b>TO</b>	Dental Board of California
<b>FROM</b>	Linda Byers, Executive Assistant Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 10:</b> Regulatory Process Overview

Ms. Donna Kantner, Regulatory Analyst for the Dental Hygiene Committee of California, will give an overview of the regulatory process.



# The Rulemaking Process



**THE 45 DAY COMMENT PERIOD** The APA requires, at minimum, a 45 day opportunity to comment in writing, by fax, or e-mail on the regulation changes as initially proposed by the agency. The notice of proposed rulemaking specifies where the comments must be directed and when this opportunity to comment in writing on the initial proposal closes.

**THE PUBLIC HEARING** Under the APA, an agency has an option as to whether it wishes to hold a public hearing on a proposed rulemaking action. (An agency's enabling statutes may eliminate this option by requiring a public hearing.) However, if an agency doesn't schedule a public hearing, and any interested person submits a written request for one within 15 days prior to the close of the written comment period, the agency must give notice of, and hold a public hearing. Because of this requirement, a rulemaking agency usually schedules a public hearing unless it is confident that one will not be requested.

**CONSIDERATION OF PUBLIC INPUT ON THE INITIAL PROPOSAL** The APA requires a rulemaking agency to consider all relevant matter presented to it during a comment period before adopting, amending, or repealing any regulation.

**ASSESSING THE NATURE OF MODIFICATIONS TO THE INITIAL PROPOSAL** After the initial public comment period, a rulemaking agency will often decide to change its initial proposal either in response to public comments or on its own. The agency must then decide whether a change is: (1) nonsubstantial, (2) substantial and sufficiently related, or (3) substantial and *not* sufficiently related.

**MAKING CHANGES AVAILABLE FOR PUBLIC COMMENT** The APA provides that a rulemaking agency must make each substantial, sufficiently related change to its initial proposal available for public comment for at least 15 days before adopting such a change. Thus, before a rulemaking agency adopts such a change, it must mail a notice of opportunity to comment on proposed changes along with a copy of the text of the proposed changes to each person who has submitted written comments on the proposal, testified at the public hearing, or asked to receive a notice of proposed modification. The agency must also post the notice on its website. No public hearing is required. The public may comment *on the proposed modifications* in writing. The agency must then consider comments received during the comment period, which are directed at the proposed changes. An agency may conduct more than one 15 day opportunity to comment on a large, complicated, or sensitive rulemaking action before the final version is adopted.



**OPPORTUNITY FOR PUBLIC COMMENT BASED UPON NEW MATERIAL RELIED UPON** A rulemaking agency must specifically identify in the initial statement of reasons and include in the rulemaking record the material it relies upon in proposing a rulemaking action. If during a rulemaking proceeding an agency decides to rely on material that it did not identify in the initial statement of reasons or otherwise identify or make available for public review prior to the close of the public comment period, the agency must make the document available for comment for 15 days.

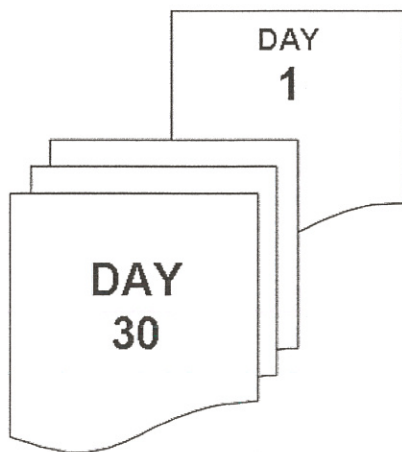
**SUMMARY AND RESPONSE TO COMMENTS** A rulemaking agency must summarize and respond on the record to timely comments that are directed at the rulemaking proposal or at the procedures followed. The summary and response to comment demonstrates that the agency has understood and considered all relevant material presented to it before adopting, amending, or repealing a regulation. An agency may respond to a comment in one of two ways. The agency must either (1) explain how it has amended the proposal to accommodate the comment, or (2) explain the reasons for making no change to the proposal. An agency's summary and response to comments is included as part of the final statement of reasons.

**SUBMISSION OF A RULEMAKING ACTION TO OAL FOR REVIEW** A rulemaking agency must transmit a rulemaking action to OAL for review within a year from the date that the notice of proposed rulemaking action was published in the California Regulatory Notice Register. OAL then has 30 working days in which to review the rulemaking record to determine whether it demonstrates that the rulemaking agency satisfied the procedural requirements of the APA, and to review regulations for compliance with the six standards: Authority, Reference, Consistency, Clarity, Nonduplication, and Necessity. OAL may not substitute its judgment for that of the rulemaking agency with regard to the substantive content of the regulations.

## OAL REVIEW

State agency must submit rulemaking record within 1 year of notice publication

OAL has 30 WORKING days to review a regulation

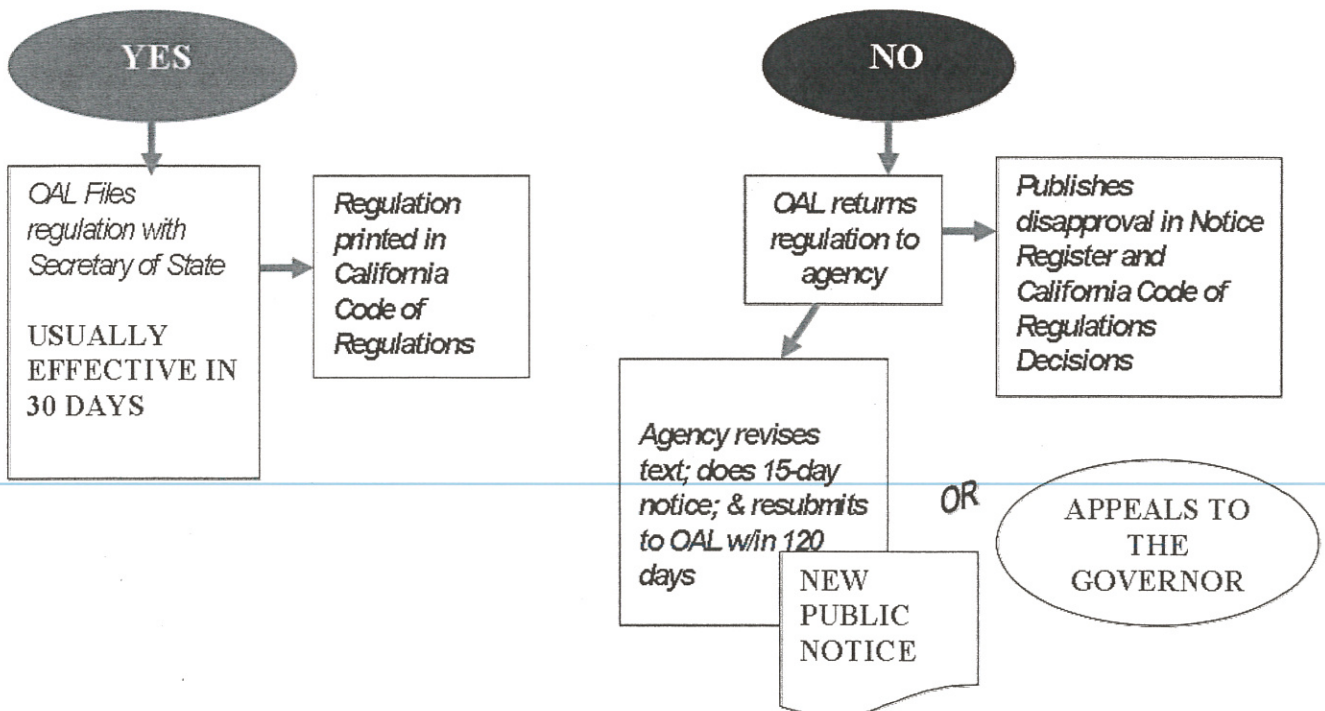


### APA STANDARDS:

**AUTHORITY  
REFERENCE  
CONSISTENCY  
CLARITY  
NON-DUPLICATION  
NECESSITY**

**& PROCEDURAL  
REQUIREMENTS**

DOES THE RULEMAKING SATISFY THE APA?





## **Agenda Item 11(A)**

**Discussion and Possible Action  
Regarding Comments Received  
During the 45-day Comment Period  
for the Board's Proposed Rulemaking  
to Amend §1018 and Add §1018.01 of  
Title 16 of the California Code of  
Regulations Relevant to Uniform  
Standards for Substance Abusing  
Licensees**





## MEMORANDUM

DATE	May 2, 2013
TO	Dental Board of California
FROM	Lori Reis, Manager Dental Board of California
SUBJECT	<b>Agenda Item 11(A):</b> Discussion and Possible Action Regarding Comments Received During the 45-day Comment Period for the Board's Proposed Rulemaking to Amend §1018 and Add §1018.01 of Title 16 of the California Code of Regulations Relevant to Uniform Standards for Substance Abusing Licensees

### **Background:**

On September 28, 2008, Senate Bill 1441 (Chapter 548, Statutes of 2008) was signed by Governor Arnold Schwarzenegger and established the Substance Abuse Coordination Committee (SACC) comprised of the executive officers of the Department of Consumer Affairs' (Department) healing arts boards, a representative of the California Department of Alcohol and Drug Programs, and chaired by the Director of the Department. The SACC was charged with the task of developing uniform standards in sixteen specific areas for use in dealing with substance abusing licensees, whether or not a healing arts board has a formal diversion program. In April 2010, the SACC developed a document named *Uniform Standards Regarding Substance-Abusing Healing Arts Licensees*, which contained the sixteen uniform standards as required by SB 1441. In April 2011, the SACC made revisions to the April 2010 version and finalized the document.

The Dental Board of California (Board) initiated its first rulemaking file to incorporate the uniform standards developed by the SACC into the Board's Disciplinary Guidelines in March 2011. As the Board moved through the formal rulemaking process during 2011 and early 2012, the Board was advised of varying agencies concerns regarding how the Board proposed the incorporation of the uniform standards. During that time, the Board received several legal opinions on its proposed incorporation of the uniform standards. The Board's first rulemaking file expired in March 2012 and the Board was required to initiate a new rulemaking. The Board worked closely with the Department and Board Legal Counsel to develop new proposed regulatory language to incorporate the uniform standards developed by the SACC. At its May 18, 2012 meeting, the Board approved new proposed regulatory language and directed staff to initiate a new rulemaking. As the rulemaking documents were being prepared, staff became aware of necessary substantive amendments to the proposed language.

At its February 28, 2013 meeting, the Board discussed and approved revised proposed regulatory language and directed staff to initiate a rulemaking. The initial rulemaking file was submitted to the Office of Administrative Law (OAL) on March 5, 2013. The proposed action was published on March 15, 2013 and was noticed on the Board's web site and mailed to interested parties. The 45-day public comment period began on March 15, 2013 and ended on April 29, 2013. A regulatory hearing was held on April 29, 2013 in Sacramento. The Board received written comments from the California Dental Association (CDA).

#### **COMMENTS RECEIVED DURING THE 45-DAY PUBLIC COMMENT PERIOD:**

##### ***Comments Received from the California Dental Association:***

The CDA provided the Board with written comments in response to the Board's proposed regulation. A copy of the letter is enclosed.

The CDA commented that they have been a participant in the Board's discussions that have led to the development of these proposed regulations, and that they appreciate the importance of making sure that dangerously impaired health care providers are not allowed to continue practicing and placing their patients' safety at risk. The CDA commented that the Uniform Standards are intended to provide that assurance when providers have been found through the Board's investigation and hearing process to be a substance-abusing provider. The CDA also commented that they support the continued functioning of the Board's Diversion Program, with the belief that an overly punitive approach could have the equally dangerous effect of discouraging providers from self-reporting to diversion before they begin to put patients at risk. The letter from CDA sought clarification regarding the role that the Board's Diversion Program will play in the process if these regulations are adopted as proposed. In particular, the CDA questioned if a licensee would be immediately subject to the Uniform Standards if the licensee self-reports to the Board's Diversion Program, or would the Uniform Standards be activated only in the event of formal disciplinary action.

##### **Staff Recommendation:**

Although the comments from the CDA are not considered adverse, staff has prepared the following recommended response in an effort to provide clarification to questions the CDA have regarding the Board's proposed regulation relating to uniform standards for substance abusing licensees:

The Board's Uniform Standards Related to Substance-Abusing Licensees would not apply to a licentiate who self-refers to the Board's Diversion Program, unless he or she tests positive for a banned substance, and the Board finds there is evidence that the licentiate is a substance-abusing licensee.

Pursuant to Business and Professions Code section 1695.5, subdivision (b), a licentiate who is not the subject of a current investigation may self-refer to the board's diversion program on a confidential basis, except as provided in subdivision (f). Subdivision (f) provides, in part, that "[i]f a licentiate in a diversion program tests positive for any

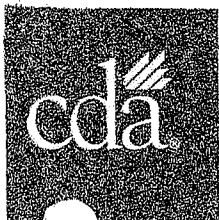
banned substance, the board's diversion program manager shall immediately notify the board's enforcement program and provide the documentation evidencing the positive test result to the enforcement program. This documentation may be used in a disciplinary proceeding." Once the board is notified of a positive test for a banned substance, the self-referring licentiate would, therefore, lose his or her confidential status, and the board would be allowed to initiate a disciplinary proceeding. Pursuant to the provisions of the proposed CCR section 1018.01, the uniform standards would apply to such a licentiate only after notice and a hearing has been conducted in accordance with Chapter 5, Part 1, Division 3, Title 2 of the Government Code (commencing with sections 11500 et seq.), and the Board finds that the evidence establishes that the licentiate is a substance-abusing licensee.

**Board Action Requested:**

The Board may vote to accept, reject, or modify staff's recommended response. If the Board votes to reject or modify staff's recommended response, staff requests the Board provide a rationale for inclusion in the rulemaking file.



# **CDA LETTER**



April 29, 2013

Ms. Lori Reis  
Complaint and Compliance Manager  
Dental Board of California  
2005 Evergreen Street, Ste. 1550  
Sacramento, CA 95815

SUBJECT: Proposed Regulations – Uniform Standards for Substance-Abusing Licensees

Dear Ms. Reis:

The California Dental Association appreciates the opportunity to comment on the Dental Board's proposed regulations relating to the state's Uniform Standards for Substance-Abusing Licensees.

CDA has been a participant in the board's discussions that have led to the development of these proposed regulations, and we appreciate the importance of making sure that dangerously impaired health care providers are not allowed to continue practicing and placing their patients' safety at risk. The Uniform Standards are intended to provide that assurance when providers have been found through the board's investigation and hearing process to be a substance-abusing provider. At the same time, however, CDA supports the continued functioning of the board's diversion program, believing that an overly punitive approach could have the equally dangerous effect of discouraging providers from self-reporting to diversion before they begin to put patients at risk.

To that end, since the Uniform Standards the board is adopting through these regulations are geared toward licensing boards that do not have diversion programs, CDA would appreciate clarification about the role that the board's diversion program will play in the process if these regulations are approved as drafted. In particular, when a licensee self-reports to the board's diversion program, will he/she be immediately subject to the Uniform Standards? Or will the Uniform Standards be activated only in the event of a formal disciplinary action resulting from a board investigation of that licensee?

Thank you for your consideration of our comments.

Sincerely,

Bill Lewis  
Manager, Regulatory Affairs



## **Agenda Item 11(B)**

**Discussion and Possible Action  
Regarding Adoption of the Proposed  
Amendment to §1018 and Addition of  
§1018.01 of Title 16 of the California  
Code of Regulations Relevant to  
Uniform Standards for Substance  
Abusing Licensees**



## MEMORANDUM

DATE	May 2, 2013
TO	Dental Board of California
FROM	Lori Reis, Manager Dental Board of California
SUBJECT	<b>Agenda Item 11(B):</b> Discussion and Possible Action Regarding Adoption of Proposed Amendment of §1018 and Addition of §1018.01 of Title 16 of the California Code of Regulations Relevant to Uniform Standards for Substance Abusing Licensees

### **Background:**

Following the Board's consideration of comments received during the required 45-day public comment period, the Board may hold discussion and take action to adopt the proposed amendment to Section 1018 and the proposed addition of Section 1018.01 of Title 16 of the California Code of Regulations regarding the Uniform Standards for Substance Abusing Licensees.

### **Action Requested:**

Staff requests the Board take the following action following consideration of the staff's recommended response to the comments received during the 45-day public comment period:

Adopt the final text as noticed and direct staff to take all steps necessary to complete the rulemaking process, including the filing of the final rulemaking package with the Office of Administrative Law and authorize the Executive Officer to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt the proposed amendment to Section 1018 and the proposed addition of Section 1018.01 of Title 16 of the California Code of Regulations.

# **PROPOSED LANGUAGE**

**TITLE 16. DENTAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS**

**PROPOSED LANGUAGE**

**Amend Section 1018 and Adopt Section 1018.01 of Article 4.5 of Chapter 1 of Division 10 of Title 16 of the California Code of Regulations to read as follows:**

**Article 4.5.  
Disciplinary Guidelines and  
Uniform Standards for Substance-Abusing Licensees**

§ 1018. Disciplinary Guidelines and Exceptions for Uniform Standards Related to Substance-Abusing Licensees.

(a) In reaching a decision on a disciplinary action under the Administrative Procedures Act (Government Code Section 11400 et seq.), the Dental Board of California shall consider the disciplinary guidelines entitled "Dental Board of California Disciplinary Guidelines With Model Language", revised 08/30/2010 which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Dental Board of California, in its sole discretion, determines that the facts of the particular case warrant such deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems.

(b) Notwithstanding subsection (a), the Board shall use the uniform standards for substance-abusing licensees as provided in Section 1018.01, without deviation, for each individual determined to be a substance-abusing licensee.

Note: Authority cited: Sections 315, 315.2, 315.4, and 1614, Business and Professions Code; and Sections 11400.20 and 11400.21, Government Code. Reference: Sections 315, 315.2, and 315.4 of the Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

§ 1018.01. Uniform Standards for Substance-Abusing Licensees.

(a) If after notice and hearing conducted in accordance with Chapter 5, Part 1, Division 3, Title 2 of the Government Code (commencing with sections 11500 et seq.), the Board finds that the evidence establishes that an individual is a substance-abusing licensee, then the terms and conditions contained in the document entitled "Uniform Standards Related to Substance-Abusing Licensees with Standard Language for Probationary Orders," New February 28, 2013, which are hereby incorporated by reference, shall be used in any probationary order of the Board affecting that licensee.

(b) Nothing in this Section shall prohibit the Board from imposing additional terms or conditions of probation that are specific to a particular case or that are derived from the

Board's guidelines referenced in Section 1018 in any order that the Board determines would provide greater public protection.

Note: Authority cited: Sections 315, 315.2, 315.4, and 1614, Business and Professions Code. Reference: Sections 315, 315.2, and 315.4 of the Business and Professions Code; and Sections 11400.20 and 11425.50(e), Government Code.

**UNIFORM STANDARDS RELATED TO  
SUBSTANCE-ABUSING LICENSEES WITH  
STANDARD LANGUAGE FOR PROBATIONARY ORDERS**

**New February 28, 2013**

Issued By:

The Dental Board of California  
2005 Evergreen Street, Suite 1550  
Sacramento, California 95815  
Telephone: (916) 263-2300  
Fax: (916) 263-2140





**STANDARD LANGUAGE TO BE INCLUDED IN EVERY PROBATIONARY ORDER  
FOR SUBSTANCE-ABUSING LICENSEES**

Pursuant to Section 315 of the Business and Professions Code, the Dental Board of California is directed to use the standards developed by the Substance Abuse Coordination Committee (SACC) for substance abusing licensees. On April 11, 2011, the SACC developed standards to be used by all healing arts boards. Administrative Law Judges, parties and staff are therefore required to use the language below, which is developed in accordance with those SACC standards.

To that end, the following probationary terms and conditions shall be used in every case where it has been determined that the individual is a substance-abusing licensee as provided in Section 1018.01 of Title 16 of the California Code of Regulations. For purposes of implementation of these conditions of probation, any reference to the Board also means staff working for the Dental Board of California or its designee. These conditions shall be used in lieu of any similar standard or optional term or condition proposed in the Board's Disciplinary Guidelines, incorporated by reference at Title 16, California Code of Regulations Section 1018. However, the Board's Disciplinary Guidelines should still be used in formulating the penalty and in considering additional terms or conditions of probation appropriate for greater public protection (e.g., other standard or optional terms of probation).

**ADDITIONAL PROBATIONARY TERMS AND CONDITIONS**

**(1) NOTIFICATION TO EMPLOYER:** Prior to engaging in the practice of dentistry, the Respondent shall provide a true copy of the Decision and Accusation to his or her employer, supervisor, or contractor, or prospective employer or contractor, and at any other facility where Respondent engages in the practice of dentistry before accepting or continuing employment. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in place of employment.

The Respondent shall provide to the Board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors, or contractors, and shall inform the Board in writing of the facility or facilities at which the person engages in the practice of dentistry.

Respondent shall give specific, written consent to the Board and its contractor to allow the Board or its designee to communicate with the employer and supervisor, or contractor regarding the licensee's work status, performance, and monitoring.

**Source:** (Uniform Standard #3 of "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," revised dated April 2011.)

**(2) SUPERVISED PRACTICE:** Within 60 days of the effective date of this decision, Respondent shall submit to the Board, for its prior approval, the name and qualifications of one or more proposed supervisors and a plan for each such supervisor by which Respondent's practice would be supervised. The Board will advise Respondent within two weeks whether or not the proposed supervisor and plan of supervision are approved. Respondent shall not practice until receiving notification of Board approval of Respondent's choice of a supervisor and plan of supervision. Respondent shall complete any required consent forms and sign an agreement with the supervisor and the Board regarding the Respondent and the supervisor's requirements and reporting responsibilities.

The plan of supervision shall be *(direct and require the physical presence of the supervising dentist in the dental office during the time dental procedures are performed.) (general and not require the physical presence of the supervising dentist during the time dental procedures are performed but does require an occasional random check of the work performed on the patient as well as quarterly monitoring visits at the office or place of practice)*. Additionally, the supervisor shall have full and random access to all patient records of Respondent. The supervisor may evaluate all aspects of Respondent's practice regardless of Respondent's areas of deficiencies.

Each proposed supervisor shall be a California licensed dentist who shall submit written reports to the Board on a quarterly basis verifying that supervision has taken place as required and include an evaluation of Respondent's performance. It shall be Respondent's responsibility to assure that the required reports are filed in a timely manner. Each supervisor shall have been licensed in California for at least five (5) years and not have ever been subject to any disciplinary action by the Board. An administrative citation and fine does not constitute discipline and therefore, in and of itself is not a reason to deny an individual as a supervisor.

The supervisor shall be independent, with no prior business or professional relationship with Respondent and the supervisor shall not be in a familial relationship with or be an employee, partner or associate of Respondent. If the supervisor terminates or is otherwise no longer available, Respondent shall not practice until a new supervisor has

been approved by the Board. All costs of the supervision shall be paid by the Respondent.

The supervisor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and agrees to supervise the licensee as set forth by the Board.

The supervisor shall have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board, but at least once per week. The supervisor shall interview other staff in the office regarding the licensee's behavior, if applicable. The supervisor shall review the licensee's work attendance and behavior.

The supervisor shall orally report any suspected substance abuse to the Board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the oral report must be within one (1) hour of the next business day. The supervisor shall submit a written report to the Board within 48 hours of occurrence.

The supervisor shall complete and submit a written report monthly or as directed by the board. The report shall include: the licensee's name; license number; supervisor's name and signature; supervisor's license number; worksite location(s); dates licensee had face-to-face contact with supervisor; worksite staff interviewed, if applicable; attendance report; any change in behavior and/or personal habits; any indicators that can lead to suspected substance abuse.

**Source:** (Uniform Standard #7 of "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," revised dated April 2011.)

**NOTE:** Orthodontic Assistants require, at a minimum, direct supervision to perform licensed functions (Business and Professions Code section 1750.3). Dental Sedation Assistants require, at a minimum, direct supervision to perform licensed functions (Business and Professions Code section 1750.5). Registered Dental Assistants in Extended Functions require, at a minimum, direct supervision to perform certain licensed functions (Business and Professions Code section 1753.5).

**(3) DRUG AND ALCOHOL TESTING:** Respondent shall submit to and pay for any random and directed biological fluid or hair sample, breath alcohol or any other mode of testing required by the Board. Though the frequency of testing will be determined by the board or its designee, and shall be designed so as to prevent Respondent from

anticipating testing dates (either randomized testing or unpredictable dates), the frequency of testing shall be at least the following: at least fifty-two (52) test dates during the first year of probation; at least thirty-six (36) test dates during the second, third, fourth, and fifth years of probation; and at least one (1) test per month in each year of probation after the fifth so long as there have been no positive test results during the previous five (5) years. The board or its designee may require less frequent testing if any of the following applies:

- Where Respondent has previously participated in a treatment or monitoring program requiring testing, the board or its designee may consider that prior testing record in applying the three-tier testing frequency schedule described above;
- Where the basis for probation or discipline is a single incident or conviction involving alcohol or drugs, or two incidents or convictions involving alcohol or drugs that were at least seven (7) years apart, that did not occur at work or on the way to or from work, the board or its designee may skip the first-year testing frequency requirement(s);
- Where Respondent is not employed in any health care field, frequency of testing may be reduced to a minimum of twelve (12) tests per year. If Respondent wishes to thereafter return to employment in a health care field, Respondent shall be required to test at least once a week for a period of sixty (60) days before commencing such employment, and shall thereafter be required to test at least once a week for a full year, before [he/she] may be reduced to a testing frequency of at least thirty-six (36) tests per year, and so forth;
- Respondent's testing requirement may be suspended during any period of tolling of the period of probation;
- Where Respondent has a demonstrated period of sobriety and/or non-use, the board or its designee may reduce the testing frequency to no less than twenty-four (24) tests per year.

Any detection through testing of alcohol, or of a controlled substance or dangerous drug absent documentation that the detected substance was taken pursuant to a legitimate prescription and a necessary treatment, may cause the board or its designee to increase the frequency of testing, in addition to any other action including but not limited to further disciplinary action.

Respondent shall have the test performed by a Board-approved laboratory certified and accredited by the U.S. Department of Health and Human Services on the same day that he or she is notified that a test is required. This shall ensure that the test results are sent immediately to the Board. Failure to comply within the time specified shall be considered an admission of a positive drug screen and constitutes a violation of probation. If a test results in a determination that the urine admission was too diluted for testing, the result shall be considered an admission of a positive urine screen and constitutes a violation of probation. If an “out of range result” is obtained, the Board may require Respondent to immediately undergo a physical examination and to complete laboratory or diagnostic testing to determine if any underlying physical condition has contributed to the diluted result and to cease practice. Any such examination or laboratory and testing costs shall be paid by Respondent. An “out of range result” is one in which, based on scientific principles, indicates the Respondent attempted to alter the test results in order to either render the test invalid or obtain a negative result when a positive result should have been the outcome. If it is determined that Respondent altered the test results, the result shall be considered an admission of a positive urine screen and constitutes a violation of probation and Respondent must cease practicing. Respondent shall not resume practice until notified by the board. If Respondent tests positive for a banned substance, Respondent shall be ordered by the Board to cease any practice, and may not practice unless and until notified by the Board. All alternative drug testing sites due to vacation or travel outside of California must be approved by the Board prior to the vacation or travel.

**Source:** (Uniform Standards #4, #8-10 of “Uniform Standards Regarding Substance-Abusing Healing Arts Licensees,” revised dated April 2011 and Section 315.2 of the Business and Professions Code.)

**(4) ABSTAIN FROM USE OF ALCOHOL, CONTROLLED SUBSTANCES AND DANGEROUS DRUGS:** Respondent shall abstain completely from the possession, injection, or consumption of any route, including inhalation, of all psychotropic (mood altering) drugs, including alcohol, and including controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drug as defined by Business and Professions Code Section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed by a physician and surgeon, dentist, or nurse practitioner for a bona fide illness or condition. Within fifteen (15) calendar days of receiving any lawful prescription medications, Respondent shall notify the Board in writing of the following: prescriber’s name, address, and telephone number; medication name and strength, issuing pharmacy name, address, and telephone number, and specific medical purpose for medication. Respondent shall also provide a current list of prescribed medication with the prescriber’s name, address, and

telephone number on each quarterly report submitted. Respondent shall provide the Board with a signed and dated medical release covering the entire probation period.

Respondent shall identify for the Board's approval a single coordinating physician and surgeon who shall be aware of Respondent's history of substance abuse and who will coordinate and monitor any prescriptions for Respondent for dangerous drugs, controlled substances, psychotropic or mood altering drugs. Once a Board-approved physician and surgeon has been identified Respondent shall provide a copy of the accusation and decision to the physician and surgeon. The coordinating physician and surgeon shall report to the Board on a quarterly basis Respondent's compliance with this condition. If any substances considered addictive have been prescribed, the report shall identify a program for the time limited use of such substances.

The Board may require that only a physician and surgeon who is a specialist in addictive medicine be approved as the coordinating physician and surgeon.

If Respondent has a positive drug screen for any substance not legally authorized, Respondent shall be ordered by the Board to cease any practice and may not practice unless and until notified by the Board. If the Board files a petition to revoke probation or an accusation based upon the positive drug screen, Respondent shall be automatically suspended from practice pending the final decision on the petition to revoke probation or accusation. This period of suspension will not apply to the reduction of this probationary period.

**Source:** (Uniform Standards #4, #8 of "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," revised dated April 2011, and Section 315.2 of the Business and Professions Code..)

**(5) FACILITATED GROUP SUPPORT MEETINGS:** Within fifteen (15) days from the effective date of the decision, Respondent shall submit to the Board or its designee for prior approval the name of one or more meeting facilitators. Respondent shall participate in facilitated group support meetings within fifteen (15) days after notification of the Board's approval of the meeting facilitator. When determining the type and frequency of required facilitated group support meeting attendance, the Board shall give consideration to the following:

- The licensee's history;
- The documented length of sobriety/time that has elapsed since substance abuse;
- The recommendation of the clinical evaluator;

- The scope and pattern of use;
- The licensee's treatment history; and ,
- The nature, duration, and severity of substance abuse.

Verified documentation of attendance shall be submitted by Respondent with each quarterly report. Respondent shall continue attendance in such a group for the duration of probation unless notified by the Board that attendance is no longer required. All costs associated with facilitated group support meetings shall be paid by the Respondent.

The group facilitator shall meet the following qualifications and requirements:

1. The group meeting facilitator shall have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
2. The group meeting facilitator shall not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years.
3. The group facilitator shall provide to the Board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
4. The group meeting facilitator shall report any unexcused absence to the Board within twenty-four (24) hours.

**Source:** (Uniform Standard #5 of "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," revised dated April 2011,

**(6) CLINICAL DIAGNOSTIC EVALUATION:** Upon order of the Board, Respondent shall undergo a clinical diagnostic evaluation. The board or its designee shall select or approve evaluator(s) holding a valid, unrestricted license to practice, with a scope of practice that includes the conduct of clinical diagnostic evaluations and at least three (3) years' experience conducting such evaluations of health professionals with alcohol or substance abuse problems. The evaluator(s) shall not have a financial relationship, personal relationship, or business relationship with Respondent within the last five (5) years. The evaluator(s) shall provide an objective/ unbiased, and independent evaluation of Respondent. Respondent shall provide the evaluator with a copy of the Board's Decision prior to the clinical diagnostic evaluation being performed.

Any time the Respondent is ordered to undergo a clinical diagnostic evaluation,

Respondent shall cease practice for a minimum of 30 days pending the results of a clinical diagnostic evaluation and review by the Board. During such time, the Respondent shall submit to random drug testing at least 2 times per week.

Respondent shall cause the evaluator to submit to the Board a written clinical diagnostic evaluation report within 10 days from the date the evaluation was completed, unless an extension, not to exceed 30 days, is granted to the evaluator by the Board. The cost of such evaluation shall be paid by the Respondent. The evaluation(s) shall be conducted in accordance with acceptable professional standards for alcohol or substance abuse clinical diagnostic evaluations. The written report(s) shall set forth, at least, the opinions of the evaluator as to: whether Respondent has an alcohol or substance abuse problem; whether Respondent is a threat to him/herself or others; and recommendations for alcohol or substance abuse treatment, practice restrictions, or other steps related to Respondent's rehabilitation and safe practice. If the evaluator determines during the evaluation process that Respondent is a threat to him/herself or others, the evaluator shall notify the board within twenty-four (24) hours.

Respondent shall cease practice until the Board determines that he or she is able to safely practice either full-time or part-time and has had at least 30 days of negative drug test results. Respondent shall comply with any restrictions or recommendations made as a result of the clinical diagnostic evaluation.

**Source:** (Uniform Standards #1, 2 of "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," revised dated April 2011, and Business and Professions Code section 315.4,)

**(7) DRUG OR ALCOHOL ABUSE TREATMENT PROGRAM:** Upon order of the Board, Respondent shall successfully complete an inpatient, outpatient or any other type of recovery and relapse prevention treatment program as directed by the Board. When determining if Respondent should be required to participate in inpatient, outpatient or any other type of treatment, the Board shall take into consideration the recommendation of the clinical diagnostic evaluation, license type, licensee's history, length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse and whether the licensee is a threat to himself or herself or others. All costs associated with completion of a drug or alcohol abuse treatment program shall be paid by the Respondent.

**Source:** (Uniform Standard #6 of "Uniform Standards Regarding Substance-Abusing Healing Arts Licensees," revised dated April 2011.





## **Agenda Item 12(A)**

### **Dental and Dental Assisting Program Licensure & Permit Statistics**



## MEMORANDUM

<b>DATE</b>	May 6, 2013
<b>TO</b>	Licensing, Certification and Permits Committee Dental Board of California
<b>FROM</b>	Dawn Dill, Manager, Licensing and Examination Unit
<b>SUBJECT</b>	<b>Agenda Item 12A – Dental and Dental Assisting Program Licensure &amp; Permit Statistics</b>

Following are statistics of current license/permits by type as of May 5, 2013

	Dental License (DDS)	Registered Dental Assistant (RDA)	Registered Dental Assistant in Extended Functions (RDAEF)	Total Licenses
Active	35,993	34,225	1,295	71,513
Inactive	3,753	8,653	122	12,528
Retired	1,756	10	0	1,766
Disabled Non practice	114	N/A	N/A	114
Renewal in Process	259	589	12	860
Fingerprinting Hold	153	524	524	695
Delinquent	3,318	9,154	183	12,655
Suspended No Coronal Polish/X-ray	N/A	1,347	0	1,347
Total Current Population	45,346	54,502	1,630	101,478
Total Cancelled Since Implementation	12,232	34,745	156	47,133

New RDAEF licenses issued since January 1, 2010 = 131.

Existing RDAEF licenses enhanced since January 1, 2010 = 141.

Dental Licenses Issued via Pathway	Total Issued in 2013	Total Issued in 2012	Total Issued to Date	Date Pathway Implemented
California Exam	0	0	53,977	Prior to 1929
WREB Exam	138	697	4,931	January 1, 2006
Licensure by Residency	36	163	915	January 1, 2007
Licensure by Credential	50	148	2,460	July 1, 2002
LBC Clinic Contract	1	1	25	July 1, 2002
LBC Faculty Contract	0	0	3	July 1, 2002

License/Permit /Certification/Registration Type	Current Active Permits	Delinquent	Total Cancelled Since Implemented
Additional Office Permit	2,042	387	5,265
Conscious Sedation Permit	483	24	319
Continuing Education Registered Provider Permit	1,257	668	1,177
Elective Facial Cosmetic Surgery Permit	24	0	0
Extramural Facility Registration*	142	n/a	n/a
Fictitious Name Permit	5,254	1,022	3,735
General Anesthesia Permit	813	22	760
Mobile Dental Clinic Permit	23	11	25
Medical General Anesthesia Permit	67	27	131
Oral Conscious Sedation Certification (Adult Only 1,110; Adult & Minors 1,201)	2,311	468	128
Oral & Maxillofacial Surgery Permit	83	4	12
Referral Service Registration*	289	n/a	n/a
Special Permits	30	14	152
Dental Sedation Assistant Permit	20	0	0
Orthodontic Assistant Permit	79	1	0

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

### Active Licensed Dentists by County

County	Licensed Dentists (DDS)	Population
Alameda	1,445	1,554,720
Alpine	0	1,129
Amador	27	37,035
Butte	165	221,539
Calaveras	23	44,742
Colusa	3	21,411
Contra Costa	1,046	1,079,597
Del Norte	16	28,290
El Dorado	164	180,561
Fresno	567	947,895
Glenn	7	27,992
Humboldt	92	134,827
Imperial	43	176,948

County	Licensed Dentists (DDS)	Population
Inyo	13	18,495
Kern	349	856,158
Kings	62	151,364
Lake	26	63,983
Lassen	31	33,658
Los Angeles	8,417	9,962,789
Madera	49	152,218
Marin	346	256,069
Mariposa	7	17,905
Mendocino	62	87,428
Merced	91	262,305
Modoc	5	9,327
Mono	2	14,348
Monterey	294	426,762
Napa	121	139,045
Nevada	94	98,292
Orange	3,683	3,090,132
Placer	443	361,682
Plumas	16	19,399
Riverside	1,080	2,268,783
Sacramento	1,098	1,450,121
San Benito	22	56,884
San Bernardino	1,312	2,081,313
San Diego	2,679	3,177,063
San Francisco	1,211	825,863
San Joaquin	378	702,612
San Luis Obispo	236	274,804
San Mateo	862	739,311
Santa Barbara	340	431,249
Santa Clara	2,194	1,837,504
Santa Cruz	197	266,776
Shasta	126	178,586
Sierra	3	3,086
Siskiyou	32	44,154
Solano	299	420,757
Sonoma	397	491,829
Stanislaus	281	521,726
Sutter	59	95,022
Tehama	29	63,406
Trinity	5	13,526
Tulare	203	451,977
Tuolumne	54	54,008
Ventura	631	835,981
Yolo	119	204,118
Yuba	11	72,926

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



## **Agenda Item 12(B)**

**General Anesthesia/Conscious  
Sedation/Medical General Anesthesia  
Evaluation Statistics**



## MEMORANDUM

DATE	May 16, 2013
TO	Licensing, Certification and Permits Committee Dental Board of California
FROM	Jessica Olney, Associate Governmental Program Analyst Dental Board of California
SUBJECT	<b>Agenda Item: 12(B):</b> General Anesthesia/Conscious Sedation/Medical General Anesthesia Evaluation Statistics

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

#### General Anesthesia Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
April	14	0	2	3	3	0
May	14	0	0	2	2	0
June	9	0	0	2	2	0
July	10	0	0	1	1	1
August	10	0	0	1	0	4
September	10	0	3	2	4	2
October	18	0	0	0	5	1
November	13	0	0	3	3	0
December	5	0	0	3	1	2
January	12	0	0	1	5	2
February	9	0	0	1	4	0
March	13	0	3	4	1	1
April*	11	1	2	2	1	2
May*	18	0	0	1	1	0
<b>Total</b>	<b>166</b>	<b>1</b>	<b>10</b>	<b>26</b>	<b>33</b>	<b>15</b>

\*Approximate schedule for April/May

## Conscious Sedation Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
<b>April</b>	7	0	1	1	1	2
<b>May</b>	5	0	0	0	2	1
<b>June</b>	4	0	2	2	1	1
<b>July</b>	0	0	0	3	2	1
<b>August</b>	2	0	0	3	1	2
<b>September</b>	4	0	1	2	4	1
<b>October</b>	1	0	1	2	1	4
<b>November</b>	5	1	2	1	0	0
<b>December</b>	1	0	0	0	2	5
<b>January</b>	5	0	0	3	1	1
<b>February</b>	5	0	1	2	0	1
<b>March</b>	4	0	3	0	2	0
<b>April*</b>	8	0	1	1	1	4
<b>May*</b>	6	0	0	0	0	2
<b>Total</b>	<b>57</b>	<b>1</b>	<b>12</b>	<b>20</b>	<b>18</b>	<b>25</b>

\*Approximate schedule for April/May

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

## Medical General Anesthesia Evaluations

	Pass Eval	Fail Eval	Permit Cancelled / Non Compliance	Postpone no evaluators	Postpone by request	Permit Canc by Request
<b>April</b>	1	0	0	1	0	0
<b>May</b>	1	0	0	1	0	0
<b>June</b>	0	0	0	1	0	0
<b>July</b>	1	0	0	0	0	0
<b>August</b>	1	0	0	0	0	0
<b>September</b>	0	0	1	1	0	0
<b>October</b>	0	0	0	1	1	0
<b>November</b>	0	0	0	1	1	0
<b>December</b>	0	0	0	1	0	0
<b>January</b>	0	0	0	0	1	0
<b>February</b>	0	0	0	2	0	0
<b>March</b>	0	0	0	1	0	0
<b>April*</b>	1	0	0	0	0	0
<b>May*</b>	2	0	0	0	0	0
<b>Total</b>	<b>7</b>		<b>1</b>	<b>10</b>	<b>3</b>	<b>0</b>

\*Approximate schedule for April/May



### **Evaluators Approved after November 2012**

<b>Region</b>	<b>GA</b>	<b>CS</b>	<b>MGA</b>
Northern California	0	0	0
Southern California	0	1	0

### **Pending Evaluator Applications\***

<b>Region</b>	<b>GA</b>	<b>CS</b>	<b>MGA</b>
Northern California	0	2	0
Southern California	6	2	0

\*Deficient, or do not meet 3 year requirement.

### **Current Evaluators per Region**

<b>Region</b>	<b>GA</b>	<b>CS</b>	<b>MGA</b>
Northern California	155	67	15
Southern California	202	91	14



## **Agenda Item 12(C)**

**Licensing, Certification and Permits  
Closed Session Results –  
Reissuance of License to Replace  
Cancelled License**



## MEMORANDUM

DATE	May 16, 2013
TO	Dental Board of California
FROM	Linda Byers, Executive Assistant Dental Board of California
SUBJECT	<b>Agenda Item 12(C):</b> Licensing, Certification and Permits (LCP) Closed Session results – Reissuance of License to Replace Cancelled License

Dr. Bruce Whitcher, Chair of the Licensing, Certification and Permits Committee will give a verbal report regarding the actions that occurred during the LCP Committee Closed Session.



## **Agenda Item 13(A)**

### **Enforcement Program Status**



## MEMORANDUM

<b>DATE</b>	May 1, 2013
<b>TO</b>	Enforcement Committee Dental Board of California
<b>FROM</b>	Kim A. Trefry, Enforcement Chief Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 13(A):</b> Program Status

### **Enforcement Efforts**

On March 12, 2013 Investigator Stephen Nicas assisted the Secret Service with a warrant service on the dental office and residence of Dr. Edward Joseph Bodek. Bodek and his wife are alleged to have committed elder financial abuse, identity theft and conspiracy to commit fraud at his Encinitas dental practice amounting to more than \$260,000. Bodek was taken into custody and has been charged with multiple felonies. The board was granted a suspension of practice order pending the completion of the criminal or administrative proceeding.

In another enforcement action, Investigator Nicas joined with Drug Enforcement Administration (DEA) investigators on a search warrant involving drug diversion allegations. In this instance, administrative and/or criminal charges have not been filed, so the subject dentist has not been named.

On April 10, 2013, the Southern Region office conducted a search warrant at a residential location as a result of an unlicensed activity investigation conducted by Investigator Carlos Alvarez. The action resulted in the felony arrest of Carlos Presca, who was being held on a \$20,000 warrant.

### **Outreach**

On April 2, 2013, Southern California Supervising Investigator Teri Lane provided a speech at the Angel City Dental Society's monthly meeting in Los Angeles. Ms. Lane discussed the board's enforcement role, the disciplinary process, and compliance with the Dental Practice Act. Dr. Katrina Eagilin described the presentation as "the best presentation that I have ever heard on the topic of Dental Law." Audience members asked great questions and participated in a discussion about the use of digital record keeping.

On April 23, 2013, Ms. Lane spoke before the ASDA (Associated Student Dental Association) at Loma Linda University School of Dentistry during their Legislative week lunch hour presentation. There were approximately 80 people in attendance.

On April 26, 2013, Ms. Lane and Supervising Deputy Attorney General Greg Salute spoke before the graduating class of the UC San Francisco, School of Dentistry. The two hour presentation provided an overview of the Board, the Board's enforcement program including Complaint intake, Investigative Analysis, Inspection and Investigation units. In addition, they covered the Top 15 violations we see occurring in the complaints we receive, investigate and prosecute. About 80 graduating students attended.

### **Staffing**

In April, Investigator Carlos Alvarez resigned from the board's enforcement program to pursue a fulltime police officer position with the City of Placentia. Alvarez's bilingual abilities and previous experience investigating abuse cases were great assets to the Orange office. During his tenure, Alvarez assisted in 16 unlicensed investigations and will be missed.

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



## **Agenda Item 13(B)**

### **Enforcement Program Statistics**



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

## MEMORANDUM

<b>DATE</b>	May 1, 2013
<b>TO</b>	Enforcement Committee Dental Board of California
<b>FROM</b>	Kim A. Trefry, Enforcement Chief Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 13(B):</b> Enforcement Statistics (Complaints and Investigations)

Attached please find Complaint Intake and Investigation statistics for the previous four fiscal years, and the current fiscal year to date. Below is a summary of some of the program's trends:

### Complaint & Compliance Unit

**Complaints Received:** The total number of complaint files received during the previous 9 months was **2109**, averaging **234** per month (a 7% decrease from the previous 4-year average).

**Pending Cases** (as of 3/30/2013): **1005**

Average caseload per Consumer Services Analyst (CSA) = **143**complaint cases

**Case Aging** (as of 3/30/2013)

0–3 Months	585	58%
4–6 Months	253	26%
7–9 Months	100	10%
10–12 Months	52	5%
1-3 Years	15	1%

**Cases Closed:** The total number of complaint files closed between July 1, 2012 and March 30, 2013 was **2092**, averaging **232** per month. The previous 4-year average is 240 closures per month.

The average number of days a complaint took to close within the last 9 months was **69** days (comparable to last year's average of 72 days). Chart 2 displays the average complaint closure age over the previous four fiscal years.



## **Investigations**

### **Current Open Caseload** (As of 3/30/13)

There are currently approximately **810** open investigative cases, **319** probation cases, and **62** open inspection cases.

Average caseload per full time Investigator = 41 (28.5 in North, 48.2 in South)

Average caseload per Special Investigator/Analyst = 34.25

### **Case Aging**(As of 3/30/13)

0 – 3 Months	97	12%
3 – 6 Months	99	12%
6 – 12 Months	198	25%
1 – 2 Years	291	37%
2 – 3 Years	90	11%
3+ Years	20	3%

Since our last report (February 2013), the number of cases over 1 year old has increased from 45% - 51%. The number of cases in the oldest category (3 years and older) has increased from 14 to 20.

**Case Closures** The total number of investigation cases closed, filed with the Attorney General's Office or filed with the District/City Attorney during the last nine months is **596**, an average of **66** per month. The previous 4-year average was 74 per month. Chart 2 displays the average closure age over the previous four fiscal years.

Of the closures, approximately 12% were referred to the AGO for discipline.

The average number of days an investigation took to complete within the last 12 months was **395** days. The 4-year average number of days to close a case is 445 days.

**Cases Referred for Discipline** The total number of cases referred to the Attorney General's Office during the past 9 months was **50** (approximately 5 referrals per month). The 9-month average for a disciplinary case to be completed was **863** days. Chart 2 displays the average closure age over the previous four fiscal years for cases referred for discipline.

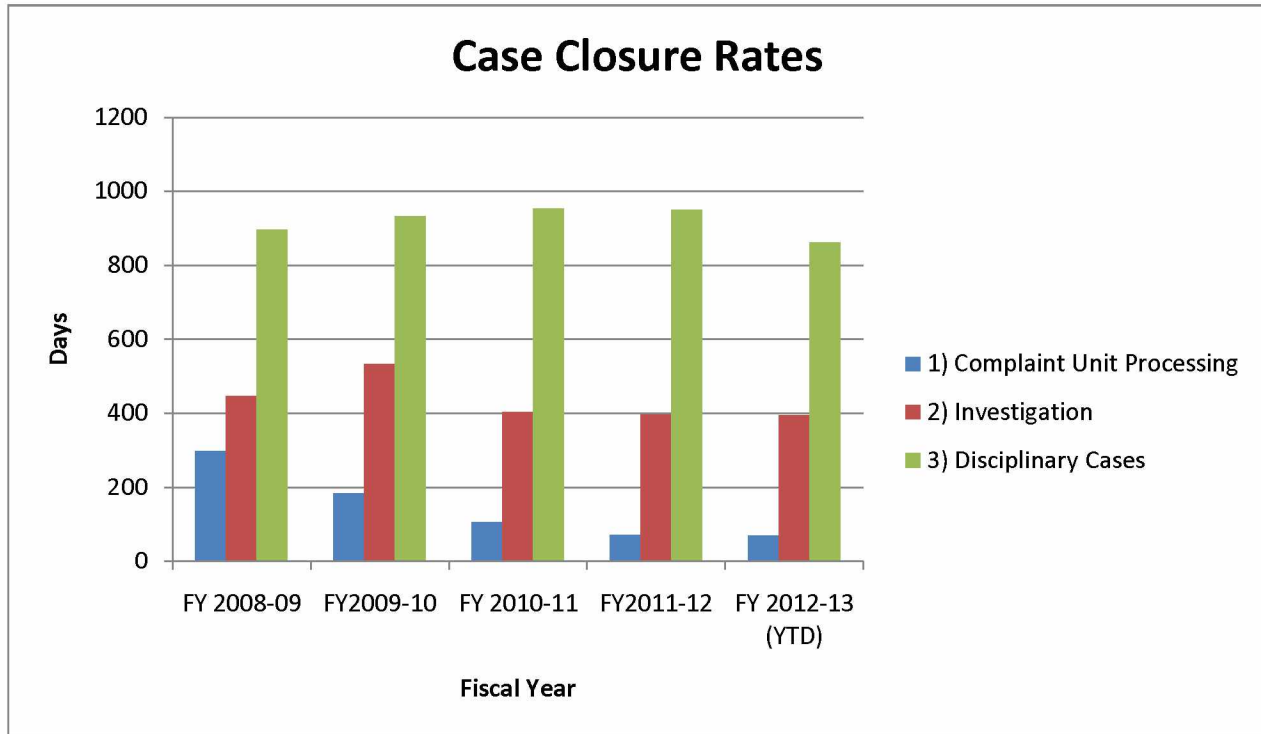
I will be available during the Board meeting to answer any questions or concerns you may have.

# Dental Board of California Enforcement Statistics

STATISTICAL DESCRIPTION	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13 (Year to Date)				
COMPLAINT UNIT					Jul-Sep	Oct - Dec	Jan - Mar	Apr - Jun	YTD
Complaints Received	3254	3013	3056	2813	659	668	782		2109
Complaints Closed	2915	3246	2987	2409	642	686	764		2092
Convictions/Arrests	290	177	678	750	220	345	222		787
Pending at end of period	1678	1078	491	734	777	919	1005		
INVESTIGATIONS									
Cases Opened	755	769	1241	916	182	168	173		523
Cases Closed	831	651	997	1094	231	162	203		596
Referred to AG	195	138	144	174	19	35	18		72
Referred for Criminal	20	11	8	12	11	0	4		15
Pending at end of period	661	779	995	1025	799	805	780		
Citations Issued	11	48	42	15	6	3	7		16
ATTORNEY GENERAL'S OFFICE									
Cases Pending at AG	232	191	199	229	210	216	189		
Administrative Actions:									
Accusation	98	97	90	99	25	5	11		41
Statement of Issues	36	27	23	41	5	0	1		6
Petition to Revoke Probation	6	5	5	9	1	2	0		3
Licensee Disciplinary Actions:									
Revocation	23	39	24	30	12	4	6		22
Probation	41	66	65	68	14	8	18		40
Suspension/Probation	1	0	0	2	0	0	0		0
License Surrendered	6	9	10	6	3	2	4		9
Public Reprimand	1	8	9	13	4	4	1		9
Other Action (e.g. exam required, education course, etc.)	6	10	11	8	3	2	1		6
Accusation Withdrawn	3	8	9	8	2	2	5		9
Accusation Declined	8	6	6	1	0	0	2		2
Accusation Dismissed	0	5	0	0	0	1	1		2
Total, Licensee Discipline	75	136	106	114	29	19	30		78
Other Legal Actions:									
Interim Suspension Order Issued	1	1	1	6	1	1	2		4
PC 23 Order Issued	2	0	0	0	1	1	0		2

## Dental Board of California Enforcement Program Chart 2- Case Closure Rates

Case Stages:	FY 2008-09	FY2009-10	FY 2010-11	FY2011-12	FY 2012-13 (YTD)
1) Complaint Unit Processing	298	183	106	72	69
2) Investigation	446	534	404	397	395
3) Disciplinary Cases	897	933	954	950	863



## Licensee Population by County

County	Licensees		County	Licensees	
	DDS	RDA		DDS	RDA
Alameda	1,445	1366	Orange	3,683	2234
Alpine	0	0	Placer	443	613
Amador	27	60	Plumas	16	20
Butte	165	296	Riverside	1,080	1,993
Calaveras	23	67	Sacramento	1,098	1,778
Colusa	3	20	San Benito	22	95
Contra Costa	1,046	1532	San Bernardino	1,312	1,707
Del Norte	16	43	San Diego	2,679	2,895
El Dorado	164	280	San Francisco	1,211	490
Fresno	567	786	San Joaquin	378	786
Glenn	7	53	San Luis Obispo	236	303
Humboldt	92	218	San Mateo	862	859
Imperial	43	82	Santa Barbara	340	328
Inyo	13	13	Santa Clara	2,194	1,893
Kern	349	624	Santa Cruz	197	255
Kings	62	129	Shasta	126	300
Lake	26	77	Sierra	3	3
Lassen	31	61	Siskiyou	32	44
Los Angeles	8,417	5258	Solano	299	618
Madera	49	156	Sonoma	397	795
Marin	346	229	Stanislaus	281	677
Mariposa	7	13	Sutter	59	139
Mendocino	62	97	Tehama	29	64
Merced	91	193	Trinity	5	8
Modoc	5	10	Tulare	203	396
Mono	2	9	Tuolumne	54	91
Monterey	294	408	Ventura	631	636
Napa	121	151	Yolo	119	252
Nevada	94	132	Yuba	11	85

			DDS and RDA	% of Total
Southern Region	18,770	16,060	34,830	53%
Northern Region	12,797	17,725	30,522	47%
<b>Combined Total*</b>	<b>31,567</b>	<b>33,785</b>	65,352	100%

\*Totals do not include Out of State Licensees

# Dental Board of California Complaint Volume by Allegation Type

Allegations	Fiscal Years				2012-13 (Year to Date)				
	2008-09	2009-10	2010-11	2011-12	Jul-Sep	Oct - Dec	Jan - Mar	Apr - Jun	YTD
Substance Abuse, Mental/Physical Impairment	21	10	12	4	1	1	4		6
Drug Related Offenses	29	29	29	38	7	5	15		27
Unsafe/Unsanitary Conditions	81	76	70	79	23	22	19		64
Fraud	102	188	299	123	36	22	32		90
Non-Jurisdictional	374	438	393	251	44	43	60		147
Incompetence / Negligence	2211	2123	2076	1540	361	317	358		1036
Other	315	336	181	266	64	86	86		236
Unprofessional Conduct	330	385	352	205	48	29	50		127
Sexual Misconduct	10	21	15	13	3	6	2		11
Discipline by Another State	15	15	31	25	13	1	2		16
Unlicensed / Unregistered	126	119	127	111	29	16	36		81
Criminal Charges	405	206	456	854	243	299	172		714
Total	4019	3946	4041	3509	872	847	836		2555



## **Agenda Item 13(C)**

### **Enforcement Program Performance Measures - Third Quarter**



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

## MEMORANDUM

<b>DATE</b>	May 1, 2013
<b>TO</b>	Enforcement Committee Dental Board of California
<b>FROM</b>	Kimberly Trefry, Enforcement Chief Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 13(C): Q3 Performance Measures</b>

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

**Q3** (January through March 2013)

**Volume: 818** Total (724 Consumer complaints, 94 Conviction reports)  
Number of complaints and convictions received per quarter

### Cycle Time:

- **Intake – Target: 10 Days** **Q2 Average: 8 Days**  
Average cycle time from complaint receipt, to the date the complaint was acknowledged and assigned to an analyst in the Complaint Unit for processing (This 10 day time frame is mandated by Business and Professions Code section 129 (b)) ;
- **Intake & Investigation – Target: 270 Days** **Q2 Average: 163 Days**  
Average time from complaint receipt to closure of the investigation process (does not include cases sent to the Attorney General (AG) or other forms of formal discipline);
- **Formal Discipline – Target: 540 Days** **Q2 Average: 779 Days**  
Average number of days to complete the entire enforcement process for cases resulting in formal discipline (Includes intake and investigation by the Board, and prosecution by the AG);

A number of factors (both internally and externally) can contribute to case aging at the Attorney General's office. Board actions which may extend case aging include when additional investigations are combined with a pending accusation and can set back the

overall time to resolve. Amending an accusation or requesting additional expert opinions can also cause delays in case adjudication. Other matters are outside the control of the Board and include: availability of hearing dates, continuance of hearing dates, changes to opposing party counsel, and requests for a change of venue.

- **Probation Intake – Target: 10 Days**

**Q2 Average: 25 Days**

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

Probation Intake measures the time between when the probation monitor is assigned the case file and the date they meet with their assigned probationer to review monitoring terms and conditions. The Board's probation monitors are assigned a case file within a few days of the probationary order being signed. Monitors attempt to schedule their initial meeting on or soon after the effective date of the decision; thereby resulting in a 10 – 20 day intake average. We believe this Q2 average of 23 days is reasonable. It should also be noted that in some cases, probation monitoring may not take place until an applicant has completed all their licensing requirements, or returned to California (if the applicant is out-of-state). These exceptions may skew this average.

- **Probation Violation Response – Target: 10 Days**

**Q2 Average: 17 Days**

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

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

- **Consumer Satisfaction Survey**

Data was not provided during this reporting period.



# Dental Board of California

## Performance Measures

### Q3 Report (January - March 2013)

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

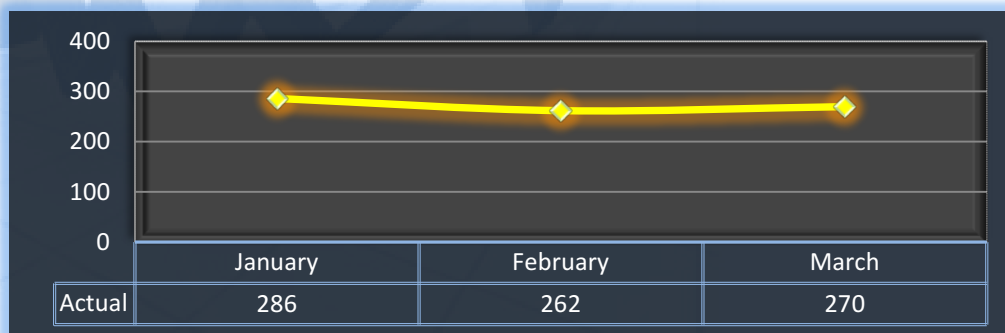
#### Volume

Number of complaints and convictions received.

**Q3 Total: 818**

*Complaints: 724 Convictions: 94*

**Q3 Monthly Average: 273**

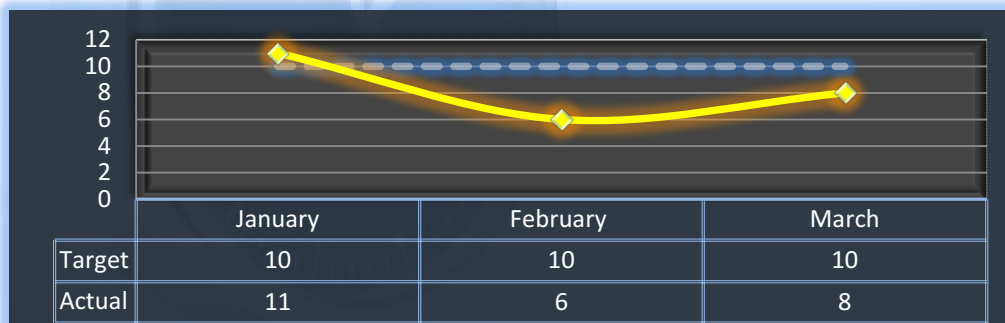


#### Intake

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

**Target: 10 Days**

**Q3 Average: 8 Days**

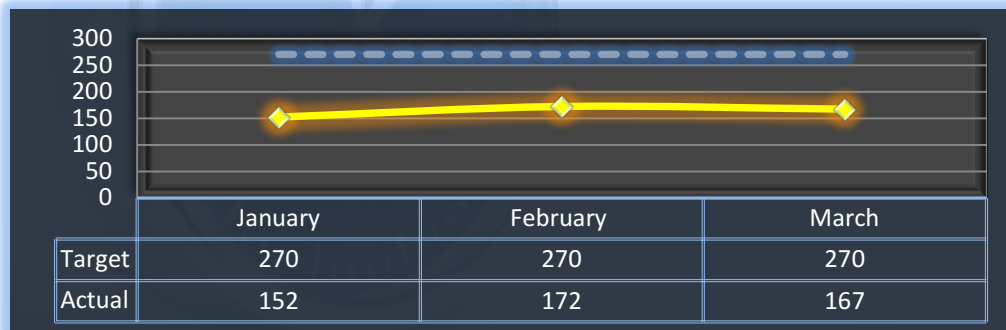


## Intake & Investigation

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

**Target: 270 Days**

**Q3 Average: 163 Days**

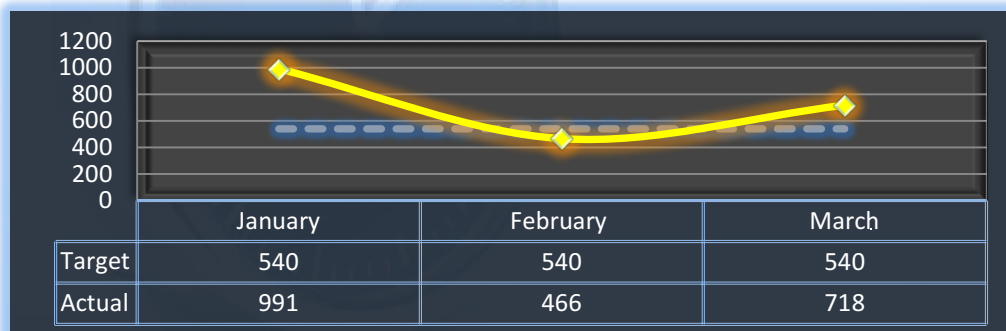


## Formal Discipline

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

**Target: 540 Days**

**Q3 Average: 779 Days**

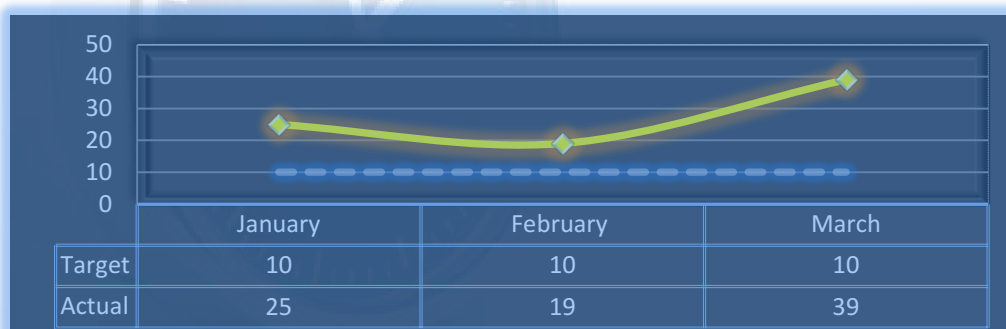


## Probation Intake

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

**Target: 10 Days**

**Q3 Average: 25 Days**

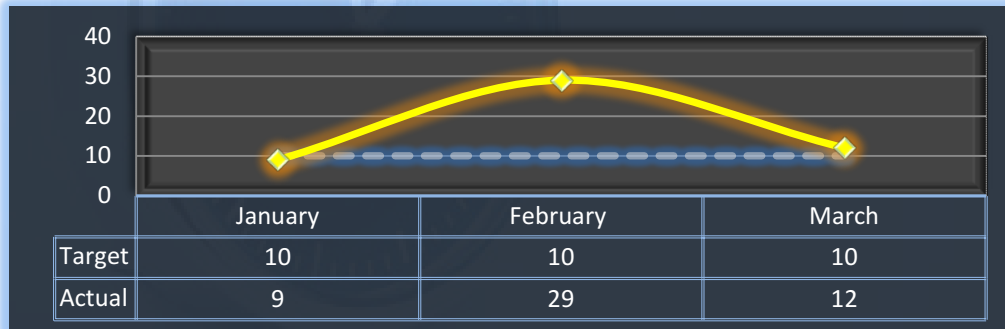


## Probation Violation Response

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

**Target: 10 Days**

**Q3 Average: 17 Days**





## **Agenda Item 13(D)**

### **Diversion Program Statistics**



## MEMORANDUM

<b>DATE</b>	May 1, 2013
<b>TO</b>	Dental Board Members
<b>FROM</b>	Lori Reis, Manager Dental Board of California
<b>SUBJECT</b>	<b>Agenda Item 13(D):</b> Diversion Program Statistics

Diversion Evaluation Committee (DEC) program statistics for quarter ending 03/31/13 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.

Month	Intakes	Closures
January	0	2 Successful Completions
February	1-Investigative 2-Self Referrals	1 Withdrawn Pre DEC
March	0	1 Successful Completion 1 Terminated Non-Compliant

There are currently 34 participants in the program, 17 in the Northern DEC and 17 in the Southern DEC.

On April 3, 2013, at the Southern DEC meeting, interviews were conducted for the vacant dental assistant/hygienist position. No candidates were chosen, therefore, recruitment continues for a dentist in the Northern DEC and a dental assistant/hygienist position in the Southern DEC.

The next DEC meeting is scheduled for June 6, 2013 at the Board's Sacramento Office.



## **Agenda Item 14**

**Report on the April 17, 2013 Meeting  
of the Elective Facial Cosmetic  
Surgery Permit Credentialing  
Committee; and Discussion and  
Possible Action to Accept Committee  
Recommendations for Issuance of  
Permits**



## MEMORANDUM

DATE	May 1, 2013
TO	Dental Board Members
FROM	Nellie Forgét, Program Coordinator Elective Facial Cosmetic Surgery (EFCS) Permit Program
SUBJECT	<b>Agenda Item 14:</b> Report on the April 17, 2013 Meeting of the Elective Facial Cosmetic Surgery Permit Credentialing Committee; and Discussion and Possible Action to Accept Committee Recommendations for Issuance of Permits.

### Background

The Elective Facial Cosmetic Surgery (EFCS) Permit Credentialing Committee met on April 17, 2013 by teleconference.

In closed session, the Credentialing Committee reviewed two (2) applications. According to statute, the Committee shall make a recommendation to the Dental Board on whether to issue a permit to the applicant. The permit may be unqualified, entitling the permit holder to perform any facial cosmetic surgical procedure authorized by the statute, or it may contain limitations if the Credentialing Committee is not satisfied that the applicant has the training or competence to perform certain classes of procedures, or if the applicant has not requested to be permitted for all procedures authorized in statute.

The Committee's Recommendations to the Board are as follows:

1. Applicant: Dr. Kurt G. Hummeldorf - Requested unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty) & Category II (cosmetic soft tissue contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

***The Committee recommends the Board issue Dr. Kurt G. Hummeldorf a permit for unlimited Category I & Category II procedures.***

2. Applicant: Dr. Eric M. Scharf - Requested unlimited privileges for Category I (cosmetic contouring of the osteocartilaginous facial structure, which may include, but is not limited to, rhinoplasty and otoplasty) & Category II (cosmetic soft tissue

contouring or rejuvenation, which may include, but not limited to, facelift, blepharoplasty, facial skin resurfacing, or lip augmentation).

***The Committee recommends the Board issue Dr. Eric M. Scharf a permit for unlimited Category I & Category II procedures.***

Action Requested:

1. Staff requests a motion from the Board to accept the EFCS Permit Credentialing Committee Report.
2. Staff requests the Board to issue Dr. Kurt G. Hummeldorf an EFCS Permit for unlimited Category I & Category II procedures. Staff also requests the Board to issue Dr. Eric M. Scharf an EFCS Permit for unlimited Category I & Category II procedures.