STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1350 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhbc.ca.gov

Notice is hereby given that a public meeting of the
Dental Hygiene Board of California (DHBC) will be held as follows:

DHBC Public Teleconference Meeting Agenda

Saturday, October 8, 2022
9:00 a.m. - Adjournment

Pursuant to the provisions of Government Code section 11133, neither a public nor teleconference location is provided. Members of the public may observe or participate using the link below. Due to potential technical difficulties, please consider submitting written comments via email at least five business days prior to the meeting to dhbcinfo@dca.ca.gov for consideration.

Instructions for Meeting Participation

The DHBC will conduct the meeting via WebEx computer program. The preferred audio connection is via telephone conference and not the microphone and speakers on your computer. The phone number and access code will be provided as part of your connection to the meeting. Please see the instructions attached hereto to observe and participate in the meeting using WebEx from a Microsoft Windows-based PC.

For all those who wish to participate or observe the meeting, please log on to the website below. If the hyperlink does not work when clicked on, you may need to place the cursor on the hyperlink, then right click. When the popup window opens, click on "Open Hyperlink" to activate it and join the meeting.

https://dca-meetings.webex.com/dca-meetings/j.php?MTID=mf8901f1cac0a18ef19cad128ed1af9ee

Event Number ID: 2485 775 4372 Password: DHBC1082022

Audio conference: US Toll Number: +1-415-655-0001
Access code: 248 577 54372
Passcode: 34221082

Members of the Board

President – Dr. Carmen Dones, RDH Educator Member
Vice President – Noel Kelsch, RDHAP Member
Secretary – Denise Davis, Public Member
RDH Member – Sonia "Pat" Hansen
RDH Member – Nicolette Moultrie
Public Health Dentist Member - Dr. Timothy Martinez
Public Member – Susan Good
Public Member – Sherman King
Public Member – Erin Yee

Meeting Materials 1 of 271

The DHBC welcomes and encourages public participation in its meetings. Please see public comment specifics at the end of this agenda.

The DHBC may act 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.

Agenda

1. Roll Call & Establishment of Quorum.

2. Public Comment for Items Not on the Agenda.
   [The DHBC may not discuss or act 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 sections 11125 & 11125.7).]

3. President's Welcome.

4. Discussion and Possible Action to Approve the July 23, 2022, Full Board Meeting Minutes.

5. Licensing and Examination Committee Report.

6. Discussion and Possible Action on the Recommendations of the Alternative Pathway to Licensure Taskforce.

7. Discussion and Possible Action to Amend California Code of Regulations, Title 16, Section 1119 (formerly 1115): Retired License.

8. Discussion and Possible Action on Draft 2023 Sunset Review Report.

9. Future Agenda Items.

<<Recess to Reconvene the Full Board for Closed Session>>

10. ***Closed Session – Full Board***

The Board may meet in Closed Session to deliberate on disciplinary matters pursuant to Government Code section 11126, subdivision (c)(3). If there is no closed session at this meeting, it will be announced.

<<Return to Open Session>>

11. Adjournment.

Due to technological limitations, adjournment will not be broadcast via WebEx. Adjournment will immediately follow Closed Session, and there will be no other items of business discussed.

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

A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting DHBC at 916-263-1978, via email at dhbcinfo@dca.ca.gov, or by sending a written request to 2005 Evergreen Street, Suite 1350, Sacramento, CA 95815. Providing your request at least five business days prior to the meeting will help to ensure availability of the requested accommodation.

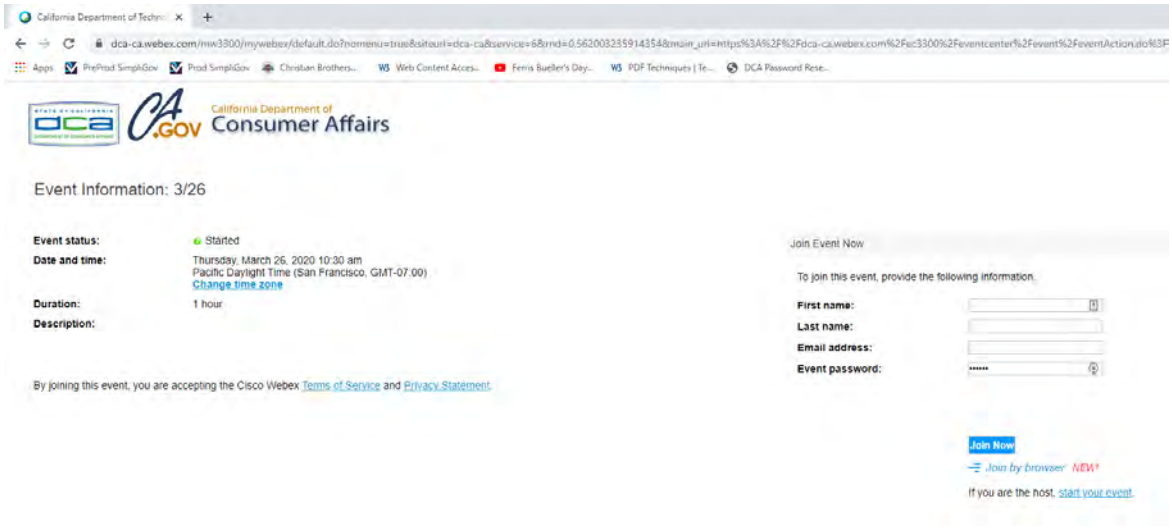
HOW TO – Join – DCA WebEx Event

The following contains instructions to join a WebEx event hosted by the Department of Consumer Affairs (DCA).

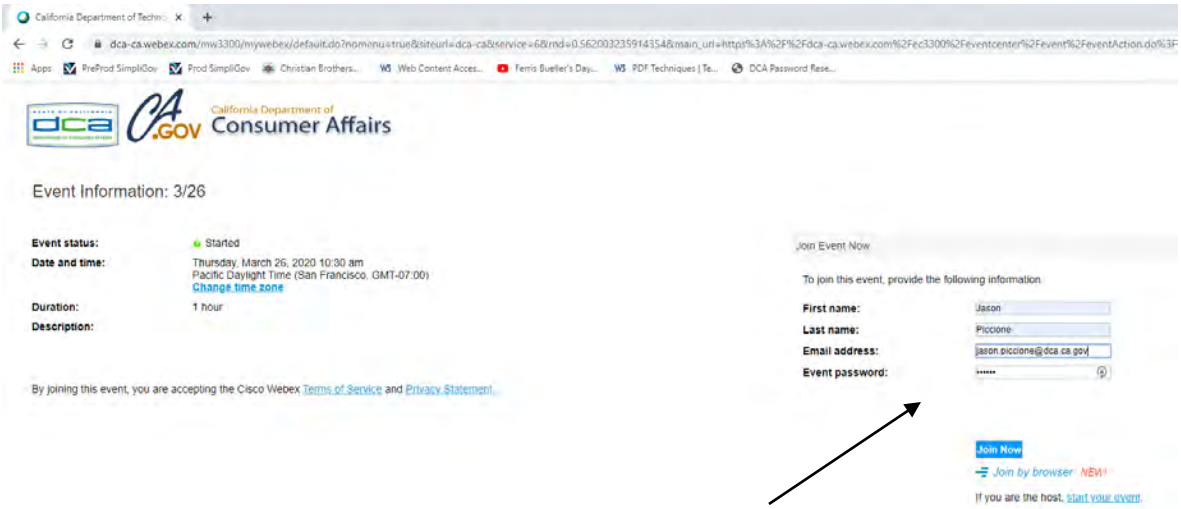
NOTE: The preferred audio connection to our event is via telephone conference and not the microphone and speakers on your computer. Further guidance relevant to the audio connection will be outlined below.

1. Navigate to the WebEx event link provided by the DCA entity (an example link is provided below for reference) via an internet browser.

   Example link:
   https://dca-ca.webex.com/dca-ca/onstage/g.php?MTID=eb0a73a251f0201d9d5ef3aaa9e978bb5



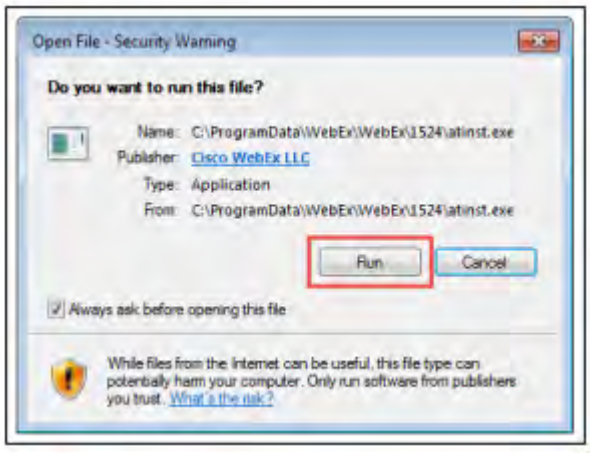
2. The details of the event are presented on the left of the screen and the required information for you to complete is on the right.
   NOTE: If there is a potential that you will participate in this event during a Public Comment period, you must identify yourself in a manner that the event Host can then identify your line and unmute it so the event participants can hear your public comment. The 'First name', 'Last name' and 'Email address' fields do not need to reflect your identity. The department will use the name or moniker you provide here to identify your communication line should you participate during public comment.



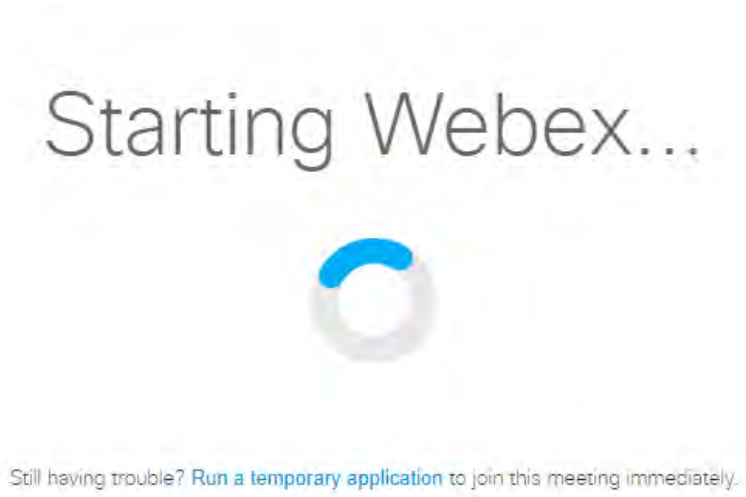
3. Click the 'Join Now' button.

   NOTE: The event password will be entered automatically. If you alter the password by accident, close the browser and click the event link provided again.

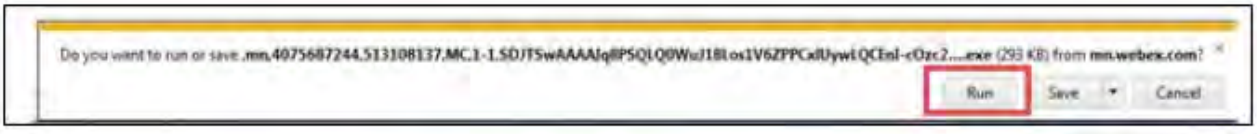
4. If you do not have the WebEx applet installed for your browser, a new window may open, so make sure your pop-up blocker is disabled. You may see a window asking you to open or run new software. Click 'Run'.



   Depending on your computer's settings, you may be blocked from running the necessary software. If this is the case, click 'Cancel' and return to the browser tab that looks like the window below. You can bypass the above process.



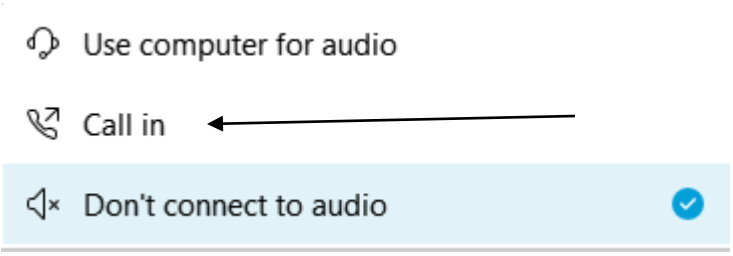
5. To bypass step 4, click ‘Run a temporary application’.
6. A dialog box will appear at the bottom of the page, click ‘Run’.



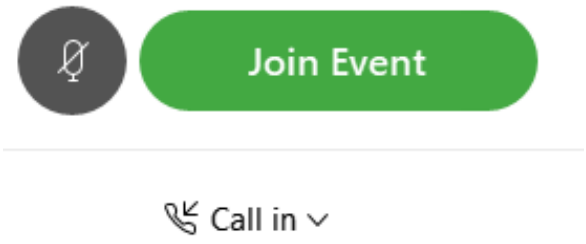
The temporary software will run, and the meeting window will open.

7. Click the audio menu below the green ‘Join Event’ button.

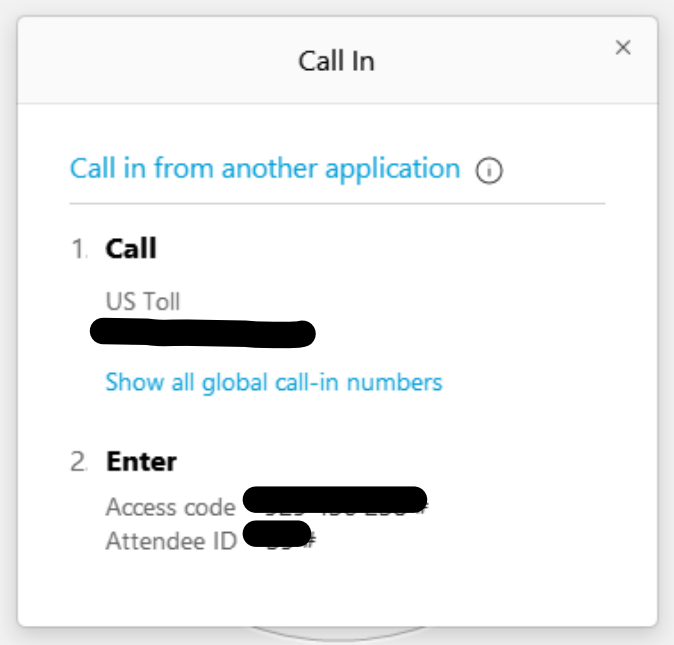
8. When the audio menu appears click ‘Call in’.



9. Click ‘Join Event’. The audio conference call in information will be available after you join the Event.



10. Call into the audio conference with the details provided.



NOTE: The audio conference is the preferred method. Using your computer's microphone and speakers is not recommended.

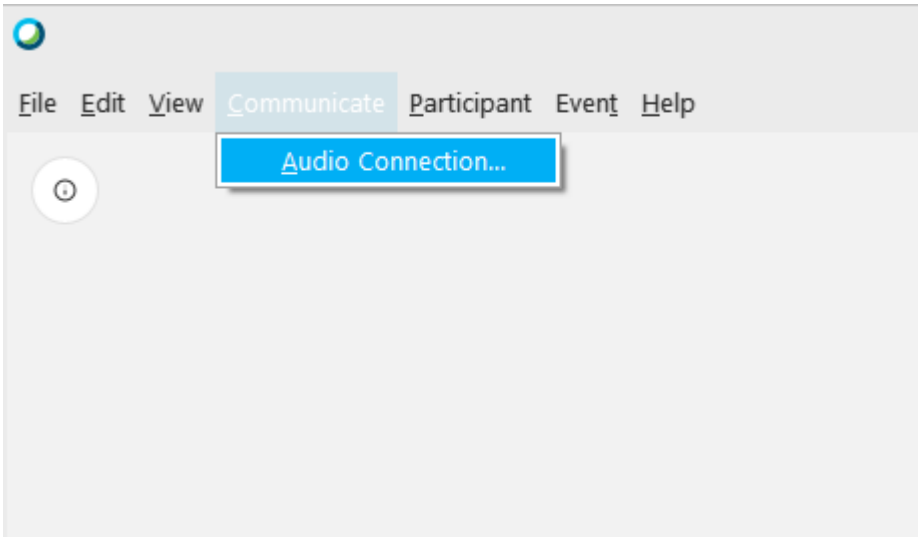
Once you successfully call into the audio conference with the information provided, your screen will look like the screen below and you have joined the event.

Congratulations!

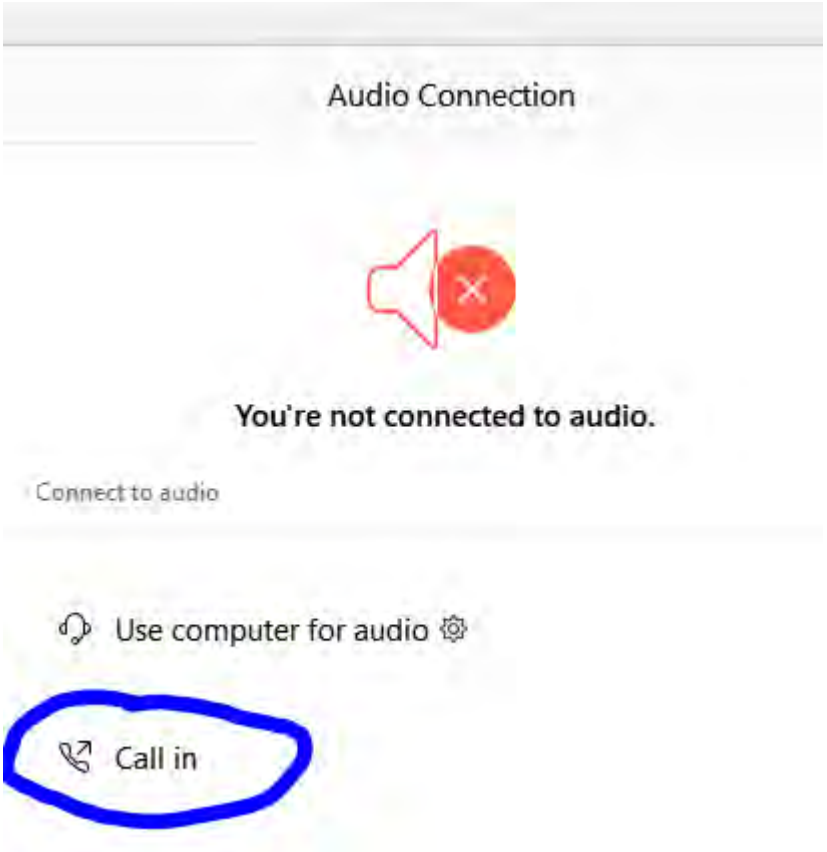
NOTE: Your audio line is muted and can only be unmuted by the event host.

If you join the meeting using your computer's microphone and audio, or you didn't connect audio at all, you can still set that up while you are in the meeting.

Select 'Communicate' and 'Audio Connection' from top left of your screen.



The ‘Call In’ information can be displayed by selecting ‘Call in’ then ‘View’



You will then be presented the dial in information for you to call in from any phone.

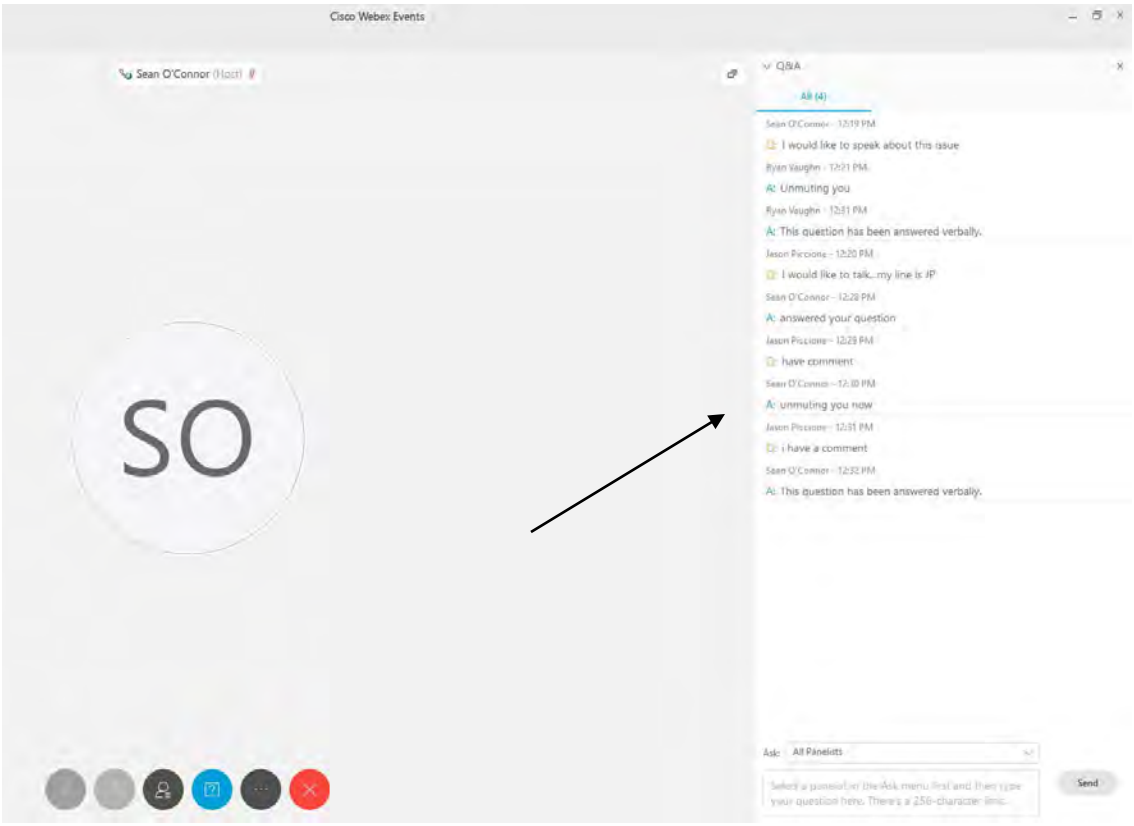
Participating During a Public Comment Period

At certain times during the event, the facilitator may call for public comment. If you would like to make a public comment, click on the 'Q and A' button near the bottom, center of your WebEx session.

This will bring up the 'Q and A' chat box.

NOTE: The 'Q and A' button will only be available when the event host opens it during a public comment period.

HOW TO – Join – DCA WebEx Event



To request time to speak during a public comment period, make sure the 'Ask' menu is set to 'All panelists' and type 'I would like to make a public comment'.

Attendee lines will be unmuted in the order the requests were received, and you will be allowed to present public comment.

NOTE: Your line will be muted at the end of the allotted public comment duration. You will be notified when you have 10 seconds remaining.

DHBC
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Board of California

Member	Present	Absent
Denise Davis		
Carmen Dones		
Susan Good		
Sonia “Pat” Hansen		
Noel Kelsch		
Sherman King		
Timothy Martinez		
Nicolette Moultrie		
Erin Yee		

Saturday, October 8, 2022

Dental Hygiene Board of California

Agenda Item 1

Roll Call & Establishment of Quorum

Board Secretary to call the Roll.

DHBC
Dental Hygiene
Board of California

Saturday, October 8, 2022

Dental Hygiene Board of California

Agenda Item 2

Public Comment for Items Not on the Agenda.

[The DHBC may not discuss or act 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 Sections 11125 & 11125.7(a)]

Saturday, October 8, 2022

Dental Hygiene Board of California

Agenda Item 3

President's Welcome.

Dental Hygiene Board of California
Meeting Minutes

DRAFT

Saturday, July 23, 2022

Embassy Suites Hotel – South San Francisco
Northrop Stanley Ballroom
250 Gateway Boulevard
South San Francisco, CA 94080

DHBC Members Present:

President – Dr. Carmen Dones, Registered Dental Hygienist (RDH) Educator Member
Secretary – Denise Davis, Public Member
RDH Member – Sonia "Pat" Hansen
Public Health Dentist Member – Dr. Timothy Martinez
Public Member – Susan Good
Public Member – Sherman King
Public Member – Erin Yee

DHBC Member Absent:

Vice President – Noel Kelsch, Registered Dental Hygienist in Alternative Practice (RDHAP) Member
RDH Member – Nicolette Moultrie

DHBC Staff Present:

Anthony Lum, Executive Officer
Sabra D'Ambrosio, Continuing Education Analyst
Brittany Elliott, Enforcement Analyst
Adina Pineschi-Petty, Doctor of Dental Surgery (DDS), Education, Legislative, and Regulatory Specialist (via "Teams" teleconference)
Michael Kanotz, Department of Consumer Affairs (DCA) Legal Counsel for the DHBC
Danielle Rogers, DCA Regulatory Unit Legal Counsel for the DHBC (via "Teams" teleconference)

1. Roll Call and Establishment of a Quorum

Dr. Carmen Dones, President of the Dental Hygiene Board of California (DHBC, Board), reviewed meeting guidelines and called the meeting to order at **9:03 a.m.** Secretary Denise Davis completed the roll call, and a quorum was established with seven members present. Board members Noel Kelsch and Nicolette Moultrie were absent and excused.

2. Public Comment for Items Not on the Agenda.

There was no public comment.

3. President's Report (Informational Only).

President Dones welcomed all in attendance for the meeting and said that even with the recent increase in the number of Coronavirus Pandemic (COVID-19) cases, she welcomed to conduct the meeting in person. She stated this year for the Board is one of transition as the tenured members are gradually terming out and replaced with new members. She welcomed Mr. Sherman King and Ms. Sonia "Pat" Hansen to the Board and added that she looks forward to working with them. Additionally, she thanked Evangeline Ward and Garry Shay for their contributions to the Board over the years and that certificates of appreciation will be sent to them in recognition of their efforts.

President Dones provided an update as to her current activities:

1. Attended the Dental Board's May 12-13, 2022, Board meeting and provided an update on DHBC activities.
    a. In the process of drafting the 2023 Sunset Review Report for the Board's approval.
    b. Implemented the RDHAP dental relationship reporting requirement for referral, consultation, and emergencies so they (Dental Board) are aware of this requirement should they receive questions from their dentist licensees.
    c. Reported that several regulations are continuing through the regulatory process, with many regulations experiencing successful approvals.
    d. Created a taskforce (Alternative Pathway to Licensure – APL) to research alternative pathways to licensure (APL) other than the clinical examination to prepare a recommendation to the Board for approval.
    e. Updated the status of reviewing all California dental hygiene educational programs to establish a baseline and that the Board has conducted site visits to almost all of them within the projected timeline even with the pandemic.

2. On July 14, 2022, the APL Taskforce met for the sixth time and believes there is a viable recommendation to present to the Licensing and Examination Committee at the next board meeting.

3. President Dones continues to meet with Executive Officer (EO) Anthony Lum on a regular basis every other week. She stated staff continues to complete the Board's work and that she's frequently updated on project statuses, Board issues, and upcoming deadlines.

President Dones reminded the Board that 2022 is the Board's Sunset year, as the sunset date was delayed by the Legislature a year due to the pandemic. She stated staff will complete the draft report for the Board's review which requires an additional meeting where revisions can be made for finalization at the November 2022 meeting.

President Dones stated that with the continued lingering effects of COVID-19, and due the passage of a new bill that modifies the Open Meetings Act, the Board can conduct Webex

teleconference meetings going forward without having to notice each Board member's location. She added the Board experienced a huge increase in the number of meeting participants and a substantial cost savings by hosting the meetings through Webex.

President Dones added that due the state's recent increase in COVID-19 infections, the Board reminds everyone to be safe and to follow standard protocols.

Board member comment: None.

Public comment: None.

4. **Update from the Department of Consumer Affairs (DCA) Executive Staff.**

EO Anthony Lum reported that due to DCA staffing shortages, no live DCA report will be provided. He stated that a DCA representative will provide a report at the next scheduled DHBC meeting.

DCA provided a written report handout regarding public meetings, new DCA initiatives, personnel changes, and upcoming meetings and trainings. EO Lum stated that if are any questions on these issues, the public may contact DCA Member Relations via email or by calling the DCA Director's Office directly for assistance.

5. **Discussion and Possible Action to Approve the March 19, 2022, Full Board WebEx Teleconference Meeting Minutes.**

Motion: Susan Good moved to approve the March 19, 2022, Full Board WebEx Teleconference Meeting Minutes with the amendments: 1) Removing the "e" in "Newsome" in Agenda Item 4, section 2; and 2) Clarifying the motion in Agenda Item 5 "Meeting Minutes" for the "January 22, 2022, Teleconference Meeting Minutes".

Second: Timothy Martinez.

Member discussion: None.

Public comment: None.

Vote: Motion for the Board to approve the March 19, 2022, Full Board WebEx Teleconference Meeting Minutes with the amendments: 1) Removing the "e" in "Newsome" in Agenda Item 4, section 2; and 2) Clarifying the motion in Agenda Item 5 "Meeting Minutes" for the "January 22, 2022, Teleconference Meeting Minutes". Passed 6:0:3.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King			X (Abstain)
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

6. Executive Officer's Report (Informational Only).

Executive Officer (EO) Anthony Lum reported on the following:

1) Office Operations:
Board staff continue to use a hybrid telework schedule where they rotate 3 days in the office and 2 teleworking days, except for the Board receptionist who is required to be in the office every day to maintain the public counter. COVID-19 has intermittently affected Board staff over the past few months, and COVID 19 precautions are followed according to the guidelines to limit exposure, especially during the current spike in cases.

2) Personnel:
As of July 1, 2022, the Board obtained 2 additional staff positions to address the Board's workload. Once filled those staff positions will be dedicated to the CE Audits and Citation and Fine Unit and to implement the mobile dental hygiene clinic review program.

Additionally, at the end of June, DHBC Assistant Executive Officer (AEO) Elizabeth Elias obtained a promotional position at another DCA program. Ms. Elias was key in reshaping the Board's enforcement operations and thanked her for the excellent work she completed for the Board.

In total, the Board has 5 vacant positions because our hiring efforts went unfulfilled for the administration position; however, the Board filled the Enforcement Analyst position.

3) Budget:

EO Lum provided the latest Budget Expenditure and Revenue Reports to the Board and reported the DHBC's current year budget along with a forecast of the anticipated amount to be spent for the rest of the year. He stated that the revenue amount will fluctuate throughout the year depending on the number of license renewals and applications the Board receives in a given month.

Additionally, EO Lum reported on the Board's Fund Condition (FC) which shows a point-in-time of how much the Board has in its reserve fund by fiscal year. He stated that the FC is projected to be in the black for several years thanks to the additional revenue coming from the new fee increases approved last year and effective July 1, 2022.

4) Administration:

Since the Board's March 19, 2022 meeting, EO Lum has participated in the following activities: several Executive level meetings with the department, attended the Dental Board's May meetings in Anaheim, participated in two educational program site visits, onboarded a new board member, reviewed draft regulatory language, and completed many reports, risk assessment, and legislative impact reports for the department, agency, and Department of Finance while continuing to oversee board operations and absorbing many functions the AEO performed.

EO Lum provided the following 2022 Board Meeting Schedule:

- Tentative: Saturday, October 8, 2022 (for Sunset Review Report)
- Saturday, November 19, 2022.

Many of these dates can change to two-day meetings if committees are needed and the amount of board business to be conducted.

5) Update on Exemption Position Request (EPR):

At the November 20, 2021, Board meeting, the Board voted to submit an exempt position request (EPR) through the Department of Consumer Affairs to upgrade the EO's exempt level and salary. Over the past 6 months, the request was reviewed by DCA, Agency, the Governor's Office, and CalHR, and determined that the EO's exempt level is commensurate and appropriate for this size of Board. They encouraged the Board to resubmit another EPR for the exempt level increase upon significant programmatic changes that alter the Board's staffing level and budget size beyond the current exempt level. EO Lum will continue to pursue the upgrade to ensure the structure of the Board is established at position levels appropriate to oversee board operations now and into the future as the program grows.

Member comment: Discussion took place regarding the EO report.

Susan Good requested information as to what additional duties could be shown to the governing bodies to support an increase to the EO's exempt level and salary and requested as to how the Board would be able to submit an additional request for the increase.

Dr. Timothy Martinez requested clarification as to what bodies considered the proposals and how the ultimate decision was made to deny the request.

Public comment: None.

7. Discussion and Possible Action to Schedule Additional Board Meeting Date to Review Draft 2022 Sunset Review Report (Saturday, October 8, 2022).

EO Lum reported every four to five years, the Legislature conducts a review of selected state programs called "Sunset Review". The Board was supposed to complete its "Sunset Review" in 2022, since its sunset date was January 1, 2023. He stated with the continuing effects of the pandemic, the Legislature extended the Board's sunset date a year until January 1, 2024. EO Lum explained the extensive process of preparing for sunset and requested the Board to consider an additional Board meeting date of Saturday, October 8, 2022, to review the draft 2022 Sunset Review Report to ensure there is adequate time to complete the draft report for finalization at the November board meeting prior to submitting it to the Legislature.

Motion: Sonya "Pat" Hansen moved for the Board to schedule an additional Board meeting date to review the draft 2022 Sunset Review Report on Saturday, October 8, 2022.

Second: Susan Good.

Member discussion: Discussion took place regarding meeting accommodations (WebEx teleconference option).

Public comment: None.

Vote: Motion to for the Board to schedule an additional Board meeting date to review the draft 2022 Sunset Review Report on Saturday, October 8, 2022. Passed 7:0:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

8. Update to the Full Board from the Alternative Pathways to Licensure Taskforce (Informational Only).

President Dones stated that at the March 20, 2021, Board meeting, the Board voted to reconstitute the Alternative Pathways to Licensure (APL) Taskforce that had previously been assembled years before to research other pathways to licensure than the patient-based clinical examination. Additionally, the APL taskforce met four times in 2021 and twice in 2022; most recently on July 14, 2022, to discuss alternative options and ideas for the clinical exam. Some issues discussed were:

- Prior research from the group including the review of other DCA allied health professional licensing boards to determine their licensing methods without requiring a patient-based clinical examination. Currently, the Dental Board, Dental Hygiene Board, and Hearing Aid Dispensers are the only licensing boards identified using a patient-based clinical examination for licensure. Additionally, to be clear, the Dental Board has a portfolio option for licensure, as well as noting the Hearing Aid Dispensers exam is non-invasive.
- Ethics behind the clinical and manikin exam, for example, in patient care: incomplete treatment after exam, HIPAA violations of sharing patient information with other students who may not be treating the patient, unsupervised patient treatment during examinations of unlicensed students, and the high pass rate and cost of the examination.
- Subjectivity of the clinical exams, along with the report from the Office of Professional Examination Services provided at the March 20, 2021, WebEx Teleconference Board meeting in which they recommended for the Board to consider whether a skills-based examination is necessary given the level of structured training and assessments the candidates undergo during their educational program clinical training.
- Alternative methods to replace the patient-based clinical examination in the interest of consumer protection, if determined by the Board.
- Discussion regarding the ADEX, CRDTS, WREB clinical exam, and the report from ADEX that 47 states accept their manikin exam. Additionally, it was determined that 35 states are accepting the exam permanently.

President Dones reported the APL taskforce determined the following:

- Determined legislative changes to the current law needs to occur prior to implementing the APL taskforce's recommendation.
- To move language forward to the Licensing committee to eliminate the clinical and manikin exam and only require clinical type exams by potential licenses from other states. License portability with other states was taken into consideration for students who choose to move out of state but was justified by knowing colleges can still offer exams for students who intend to move out of state.
- The APL taskforce anticipates providing statutory language recommendations to the Board's Licensing Committee for possible inclusion in the Board's Sunset report at a future meeting.

Member comment: Discussion took place regarding APL taskforce report. Susan Good requested reports reviewed by the taskforce to be provided to Board members prior to discussion of the agenda item.

Public comment: None.

9. Update from the from the Dental Board of California (DBC) (Informational Only).

Dr. Alan Felsenfeld, MA, DDS, DBC President, updated the Board on DBC activities.

Dr. Felsenfeld reported that currently James Yu, DDS, MA, is serving as vice president and Sonia Molina, DMD, MPH, is serving as secretary. He added that DBC EO Karen Fischer retired at the end of 2021 and DBC is currently in the process of finding a new permanent EO.

Dr. Felsenfeld stated the DBC has a Dental Assisting Council (DAC) and unfortunately lost two of their members last year. After a search for replacements, they appointed De'Andra Epps-Robbins, RDA, and Kandice Pliss, RDA, to the DAC.

Dr. Felsenfeld reported the DBC made changes to the Registered Dental Assistant in Extended Functions (RDAEF) examination. He stated that with the assistance of the Office of Professional Examination Services (OPES), the DBC reviewed the viability of the RDAEF examination and determined to eliminate the RDAEF clinical examination. On September 28, 2021, Governor Newsom signed Senate Bill 607, eliminating the clinical examination for RDAEF licensure. The DBC and OPES developed a written RDAEF examination and launched on January 24, 2022, as a requirement for RDAEF licensure.

Dr. Felsenfeld stated that for the past few years the DBC has been working on SB 501 (Glazer, Chapter 929, Stats. of 2018), relating to minimal, moderate, and general anesthesia in dental offices. He explained the significance of the bill and its genesis. He stated they are now in the process of writing regulations to enact the changes brought about by SB 501.

Dr. Felsenfeld shared the current status for dentists providing vaccinations to the public. He stated that early in 2021, the DCA Director issued a public health emergency waiver allowing dentists, after training, to provide COVID-19 vaccinations. The DBC then requested an emergency bill to amend the Dental Practice Act to allow dentists to provide vaccinations to patients over 3-years old. He stated regulations are currently in development for this duty.

Member comment: Discussion took place regarding the RDAEF category.

Public comment: None.

10. Discussion and Possible Action to Extend the Temporary Acceptance of the Manikin-Based Dental Hygiene Clinical Examinations Administered by ADEX/WREB and CRDTS.

EO Lum reported at the August 29, 2020, DHBC meeting, the Board voted to temporarily accept the manikin-based clinical examinations administered by ADEX/WREB and CRDTS due to the COVID-19 environment. The temporary acceptance of this exam was extended three times at Board meetings (March 6, 2021, July 17, 2021, and March 19, 2022) and now is set to expire on December 31, 2022. He stated information received from dental hygiene programs administering the exams require advanced notice of exam acceptance to enable them to arrange and schedule it in the future for students. The manikin-based clinical exam is an alternative method to the acceptance of the in-person, patient-based clinical examinations administered by WREB and CRDTS.

EO Lum stated that due to the continued COVID-19 environment, continued hesitation for unnecessary large gatherings, advanced notice to arrange and schedule the exam, and some ethical issues associated with the live patient-based clinical examinations like payment for patient participation and possible extortion of payment for participating, staff recommends extension of the deadline to temporarily accept the alternative manikin-based dental hygiene clinical examination until July 31, 2023.

Motion: Sonia "Pat" Hansen moved for the Board to extend the temporary acceptance of the alternative manikin-based clinical examinations administered by ADEX/WREB and CRDTS, as well as the patient-based examinations by the same exam administrators, until July 31, 2023, based upon the current COVID-19 environment.

Second: Erin Yee

Member discussion: Discussion took place regarding the extension of the temporary acceptance of manikin-based dental hygiene clinical examinations administered by ADEX/WREB and CRDTS.

Public comment: Ruth Kern, Chabot College and Diablo Valley College, stated that educators give their students an education on how to provide excellent care to their patients post-graduation. She stated she is aware of clinical limitations and stated live patient examinations during COVID-19 is not safe due to the many variants. She stated she is in favor of the manikin examinations.

Vote: Motion for the Board to extend the temporary acceptance of the alternative manikin-based clinical examinations administered by ADEX/WREB and CRDTS, as well as the patient-based examinations by the same exam administrators, until July 31, 2023, based upon the current COVID-19 environment. Passed 6:1:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good		X	
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

11. Discussion and Possible Action on Request by Concord Career College – San Bernardino to Increase Enrollment.

Dr. Adina Petty reported that on April 2, 2021, the Concorde Career College – San Bernardino Dental Hygiene Educational Program (CCC-SB) requested the Board to review and approve a permanent increase in the maximum enrollment capacity from 24 students to 32 students for the CCC-SB dental hygiene educational program. She stated that on July 17, 2021, the Board, based on 1105.3 (b)(2), approved the expansion of the program's physical facilities for the CCC-SB program.

Dr. Petty added that on June 28, 2022, EO Anthony Lum and Subject Matter Expert (SME) JoAnn Galliano completed a site visit of the program ensuring the completed expansion and sufficient supplies were present to support the enrollment expansion of CCC-SB. She stated staff recommends to the Board to consider and approve the permanent increase in the maximum enrollment capacity from 24 students to 32 students for the CCC-SB program.

Motion: Susan Good moved for the Board to approve the permanent increase in the maximum enrollment capacity from 24 students to 32 students for the Concorde Career College – San Bernardino dental hygiene educational program.

Second: Erin Yee.

Member comment: None.

Public comment: None.

Vote: Motion to for the Board to approve the permanent increase in the maximum enrollment capacity from 24 students to 32 students for the Concorde Career College – San Bernardino dental hygiene educational program. Passed 7:0:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

12. Discussion and Possible Action on Request by Concord Career College - Garden Grove to Increase Enrollment.

Dr. Adina Petty reported that on June 1, 2021, the Concorde Career College – Garden Grove Dental Hygiene Educational Program (CCC-GG) requested the Board to review and approve a permanent increase in the maximum enrollment capacity from 24 students to 34 students for the CCC-GG program. She stated that on July 17, 2021, the Board, based on 1105.3 (b)(2), approved the expansion of the program's physical facilities for the CCC-GG program.

Dr. Petty added that On June 29, 2022, EO Anthony Lum and SME JoAnn Galliano completed a site visit ensuring the completed expansion and sufficient supplies were present to support the enrollment expansion of CCC-GG. She stated that staff recommends to the Board to consider and approve the permanent increase in the maximum enrollment capacity from 24 students to 34 students for the CCC-GG program.

Motion: Susan Good moved for the Board to approve the permanent increase in the maximum enrollment capacity from 24 students to 34 students for the Concorde Career College – Garden Grove dental hygiene educational program.

Second: Dr. Timothy Martinez.

Member comment: None.

Public comment: None.

Vote: Motion to for the Board to approve the permanent increase in the maximum enrollment capacity from 24 students to 34 students for the Concorde Career College – Garden Grove dental hygiene educational program. Passed 7:0:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

13. Regulatory Update: Status of Dental Hygiene Board of California Regulatory Packages (Informational Only).

Dr. Adina Petty reported the current status as to DHBC proposed regulatory packages completed and in process for the Board.

Member discussion: None

Public comment: None.

14. Discussion and Possible Action to Initiate a Rulemaking and Possibly Amend Title 16, California Code of Regulations (CCR) Section 1104.1: Process for Approval of a New RDH Educational Program.

Dr. Adina Petty reported that at the March 19, 2022, Web Ex Teleconference Board meeting, the proposed language and the associated form incorporated by reference was presented to the Board to address the statutory changes implemented by SB 534 into California Code of Regulations (CCR), title 16, section 1104.1. She stated that the Board approved the proposed amended language and associated form and directed DHBC staff to begin the Office of Administrative Law (OAL) rulemaking process for 16 CCR section 1104.1.

Dr. Petty stated that after consulting with the Board's Regulatory Legal Counsel at the Department of Consumer Affairs (DCA), it was determined 16 CCR section 1104.1 would benefit from a two-stage process of 1) submitting non-substantive changes under 1 CCR

section 100; and 2) submitting substantive changes under the regular OAL rulemaking process. She added that the 1 CCR section 100 (non-substantive) rulemaking process was completed on June 6, 2022.

Dr. Petty requested for the Board review the proposed amended language and associated form, determine whether additional information or language is required, complete the draft of the proposed regulatory language and associated form, and authorize the Executive Officer to take all steps necessary to initiate the rulemaking process.

Motion: Erin Yee moved for the Board to approve the proposed amended language and associated form for section 1104.1 and direct staff to submit the language to the Director of the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency for review, and if no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the package, and set the matter for a hearing if requested. If no adverse comments are received during the 45-day comment period and no hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking and adopt the proposed regulation at Section 1104.1 as noticed.

Second: Susan Good.

Member discussion: Discussion took place regarding proposed regulatory package 16 CCR section 1104.1.

Public comment: None.

Vote: Motion for the Board to approve the proposed amended language and associated form for section 1104.1 and direct staff to submit the language to the Director of the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency for review, and if no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the package, and set the matter for a hearing if requested. If no adverse comments are received during the 45-day comment period and no hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking and adopt the proposed regulation at Section 1104.1 as noticed. Passed 7:0:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)

Name	Aye	Nay	Abstain/Absent
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

15. Discussion and Possible Action to Amend 16 CCR Section 1104.3: Reviews, Site Visits, Citation and Fine, and Probationary Status for Dental Hygiene Educational Programs.

Dr. Adina Petty reported that at the November 20, 2021, WebEx Teleconference Board meeting, the Board approved the proposed regulatory language to implement the mandates in Business and Professions Code (BPC) section 1941.5. However, during the rulemaking process, substantive changes were made to the Board-approved draft regulatory language for 16 CCR section 1104.3 to include specific factors to contest citations and regarding compliance with citations or orders of abatement. She added that in response to recommendations from DCA Director Kimberly Kirchmeyer, Board staff developed the attached amended draft regulatory language for 16 CCR section 1104.3 to implement the provisions of BPC section 1941.5.

Dr. Petty requested for the Board to re-review the proposed language in the attached document, determine whether additional information or language is required, complete the draft of the proposed regulatory language, and authorize the Executive Officer to take all steps necessary to initiate the rulemaking process.

Motion: President Dones moved to approve the proposed amended language and associated form for section 1104.3 and direct staff to submit the language to the Director of the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency for review, and if no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the package, and set the matter for a hearing if requested. If no adverse comments are received during the 45-day comment period and no hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking and adopt the proposed regulation at Section 1104.3 as noticed.

Second: Susan Good.

Member discussion: Discussion took place regarding the proposed amended language for 16 CCR section 1104.3.

Public comment: None.

Vote: Motion for the Board to approve the proposed amended language and associated form for section 1104.3 and direct staff to submit the language to the Director of the Department of Consumer Affairs and the Business, Consumer Services, and Housing Agency for review, and if no adverse comments are received, authorize the Executive Officer to take all steps necessary to initiate the rulemaking process, make any non-substantive changes to the package, and set the matter for a hearing if requested. If no adverse comments are received during the 45-day comment period and no hearing is requested, authorize the Executive Officer to take all steps necessary to complete the rulemaking and adopt the proposed regulation at Section 1104.3 as noticed. Passed 7:0:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

16. Discussion and Possible Action to Initiate a Rulemaking and Possibly Adopt Title 16, California Code of Regulations (CCR) Section 1114: Temporary Licensure.

Dr. Adina Petty stated that Assembly Bill (AB) 107 (Salas, Chapter 693, Statutes of 2021) enacted BPC section 115.6 requiring the Board, on and after January 1, 2023, and after appropriate investigation, to issue temporary licenses to military spouse applicants if the applicant meets specified requirements. She reported that during the review of the proposed language for 16 CCR section 1114 Temporary Licensure, the statutory provisions established by AB 107 do not support the requirements for dental hygiene licensure established by the Board.

EO Lum explained further regarding AB 107. He explained that the Board sent a letter to the author about requirements for RDH licensure in the Board's statutes and regulations that were not addressed within the bill and of concerns the DHBC has in the interest of consumer protection. EO Lum recommended to the Board to table the discussion until further discussions take place regarding the regulation to address the concerns expressed by the DHBC.

Motion: Susan Good moved to table the discussion on 16 CCR section 1114 Retired Licensure.

Second: Sherman King.

Member discussion: Discussion took place regarding the concerns regarding consumer protection and acknowledged the importance of providing temporary licensure to military spouse applicants.

Public comment: JoAnn Galliano, Board Educational Consultant, requested for the Board to ensure applicants are completing accredited programs as some out-of-state programs are not accredited. She stated the issues that need to be addressed are of preceptorship as well as of the Board's Soft Tissue Curettage, Local Anesthesia, and Nitrous Oxide-Oxygen Analgesia requirement for licensure.

Vote: Motion for the Board to table the discussion on 16 CCR section 1114 Retired Licensure. Passed 7:0:2.

Name	Aye	Nay	Abstain/Absent
Denise Davis	X		
Carmen Dones	X		
Susan Good	X		
Sonia "Pat" Hansen	X		
Noel Kelsch			X (Absent)
Sherman King	X		
Timothy Martinez	X		
Nicolette Moultrie			X (Absent)
Erin Yee	X		

17. Update on the Following Legislation (Informational Only).

Dr. Adina Petty updated the Board on proposed legislative packages currently in progress of concern for the Board which included:

Legislation	DHBC Position as 7.23.22
Assembly Bill (AB) 646 (Low): Department of Consumer Affairs: boards: expunged convictions.	Watch.
AB 858 (Jones-Sawyer): Employment: health information technology: clinical practice guidelines: worker right	Watch.

Legislation	DHBC Position as 7.23.22
AB 1604 (Holden): The Upward Mobility Act of 2022: boards and commissions: civil service: examinations: classifications.	Watch.
AB 1636 (Akilah Weber): Physician's and surgeon's certificate: registered sex offenders.	Watch.
AB 1662 (Gipson): Licensing boards: disqualification from licensure: criminal conviction.	Oppose.
AB 1733 (Quirk): State bodies: Open meetings.	Support.
AB 1982 (Santiago): Telehealth: dental care.	Watch.
AB 2104 (Flora): Professions and vocations.	Oppose.
AB 2145 (Davies): Dental services: skilled nursing facilities and intermediate care facilities/developmentally disabled.	Support.
AB 2600 (Megan Dahle): State agencies: letters and notices: requirements.	Watch.
AB 2276 (Carrillo): Dental Assistants.	Watch.
Senate Bill (SB) 189 (Committee on Budget and Fiscal Review): State Government.	Informational only. Chaptered before brought to Board.
SB 652 (Bates): Dentistry: use of sedation: training.	Watch.
SB 889 (Ochoa Bogh): Nurse anesthetists.	Watch.
SB 1031 (Ochoa Bogh): Healing arts boards: inactive license fees.	Oppose.
SB 1237 (Newman): Licenses: military service.	Watch.
SB 1365 (Jones): Licensing boards: procedures.	Oppose.
SB 1443 (Roth): The Department of Consumer Affairs.	Watch.
SB 1471 (Archuleta): Dentistry: foreign dental schools.	Watch.

18. Education Update (Informational Only).

Dr. Adina Petty reported the current status of Dental Hygiene Educational Program (DHEP) compliance at Chabot College, Southwestern College, Concorde Career College – San Bernardino, and Concorde Career College – Garden Grove. Additionally, she provided the Board the current Site Visit schedule for upcoming program reviews.

Member discussion: None.

Public comment: None.

19. Enforcement Update: Statistical Report (Informational Only).

Brittany Elliott, DHBC Probation Monitor, provided the following:

1) Enforcement Staff Update:

As of September 10, 2022, the Enforcement Analyst position will no longer be vacant, as Brittany Elliot was selected to fill that position. Consequently, effective September 10, 2022, the Probation Monitor position will become vacant. The job posting for the Probation Monitor position was posted on the CalCareers website in preparation for this vacancy and will close on August 18, 2022.

2) Enforcement Program Update:

Enforcement staff continue to work on several major projects including revising disciplinary guidelines, updates to desk manuals, and creating content for an enforcement section to the Board's website. Recently, staff finalized identifying additional BreEZe codes that will help with monitoring cases and workload. The updates have been processed and staff is now using the additional BreEZe codes.

Additionally, Ms. Elliot provided detailed enforcement statistics for the Board to review that were included in the meeting materials. EO Lum commended the Enforcement Program staff for their efficiency and proactive approach to clearing the prior backlog the program experienced in the past.

Member discussion: Discussion took place regarding the enforcement data provided.

Public comment: None.

20. Licensing, Continuing Education Audits and Examination Update: Statistical Reports (Informational Only).

a. Licensing Update

EO Anthony Lum reported the Licensing Unit continues to receive a steady flow of applications for licensure because of the recent graduations that occurred at multiple California dental hygiene educational programs. He stated that pursuant to 16 CCR section 1069, the Board has up to 90 days to notify an applicant of whether their application is complete or deficient and notify them of what specific information is still required.

EO Lum provided the current average processing times applicants are experiencing and stated the times are well below the 90 days allowed by the law. EO Lum added that the application processing time will fluctuate due to the amount of workflow received by the Board and the timely submission of required documentation from the applicant. He added that the Licensing staff have been doing an excellent job of maintaining the application processing times well below the allowable time as stated in law.

b. Continuing Education Update

Sabra D'Ambrosio, Continuing Education (CE) Audit Analyst, presented current CE Audit data which included detailed audit failure rates and reasons for failures. She reviewed the CE audit process for the Board and reported that through the audit process, the licensee has many opportunities to show compliance before further administrative action is taken.

Ms. D'Ambrosio reminded licensees to maintain their CE certificates of completion for 3 license renewal cycles in case they are chosen for a random audit as well as to verify that the CE provider of the selected courses are appropriately approved and acceptable for license renewal credit.

Member discussion: Discussion took place regarding the CE audit statistics and reasons for non-compliance of the requirement.

Public comment: Alison Yochim, California Dental Hygienists' Association, questioned how licensees should check CE providers to ensure they are acceptable to the Board for CE credit.

21. Future Agenda Items.

1. Board Member Comments:
    a. Susan Good: Set a Board policy regarding alternating between in person and WebEx teleconference meetings. Additionally, if agenda items requires a two day meeting, to ensure that meeting is scheduled in person.

    b. President Dones: A request was placed by a participant at the last Board meeting in regard to addressing Direct Supervision of Local Anesthesia as a future agenda item.

2. Public Comments:
    a. Edward Cramp, Attorney and Educator, echoed Susan Good's comments that in-person meetings are beneficial and important to democratic rule of the Boards that govern our licensure.

22. Closed Session – None.

23. Adjournment

Meeting was adjourned at **11:55 a.m.**

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
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MEMORANDUM

DATE	October 8, 2022
TO	Dental Hygiene Board of California
FROM	Anthony Lum Executive Officer
SUBJECT	**FULL 5: Licensing and Examination Committee Report.**

BACKGROUND

The Licensing and Examination Committee met on October 7, 2022 to discuss the results of the Alternative Pathway to Licensure Taskforce's research and recommendation for consideration to the Full Board.

A verbal report will be provided.

Requested Sunset Amendments to the Business and Professions Code

Section 1917

The dental hygiene board shall grant initial licensure as a registered dental hygienist (RDH) to a person who satisfies all of the following requirements:

~~(a) Completion of an educational program for registered dental hygienists, approved by the dental hygiene board, accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution.~~

~~(b) Within the preceding three years, satisfactory completion of the dental hygiene examination given by the Western Regional Examining Board or any other clinical or dental hygiene examination approved by the dental hygiene board.~~

(a) Completion of either of the following:

(1) Satisfactory completion of a California educational program for RDHs, approved by the dental hygiene board, accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution. If an applicant fails to apply for licensure within three years of completion of a dental hygiene board-approved California educational program for RDHs, the applicant shall be required to satisfactorily complete a dental hygiene licensure examination approved by the dental hygiene board; or

(2) Satisfactory completion of a non-California educational program for RDHs, accredited by the Commission on Dental Accreditation, recognized by the dental hygiene board, and conducted by a degree-granting, postsecondary institution within the United States or Canada, and within three years of the application date satisfactory completion of a dental hygiene licensure examination approved by the dental hygiene board.

~~(c)~~(b) Satisfactory completion of the National Board Dental Hygiene Examination.

~~(d)~~(c) Satisfactory completion of the examination in California law and ethics as prescribed by the dental hygiene board.

~~(e)~~(d) Submission of a completed application form and all fees required by the dental hygiene board.

~~(f)~~(e) Satisfactory completion of dental hygiene board-approved instruction in gingival soft-tissue curettage, nitrous oxide-oxygen analgesia, and local anesthesia.

MEMORANDUM

DATE	March 20, 2021
TO	Dental Hygiene Board of California
FROM	Anthony Lum Executive Officer
SUBJECT	**FULL 8: Discussion and Possible Action on Analysis from the DCA Office of Professional Examination Services (OPES) Regarding the Temporary Acceptance of Mannequin-based Dental Hygiene Clinical Examinations.**

BACKGROUND

Due to the COVID-19 pandemic and associated safety precautions implemented by Governor Newsom and multiple Federal, State, and Local public health agencies to deter the spread of the virus in 2020, registered dental hygienist clinical examination administrators suspended all current patient-based clinical examinations and rescheduled them to future dates. As a result, the dental hygiene class of 2020 were left with no options to complete the clinical examination requirement to apply to obtain a dental hygiene license. At the May 29, 2020 WebEx Teleconference Board meeting, the Board requested and authorized the Department of Consumer Affairs (DCA) Office of Professional Examination Services (OPES) to review all nonpatient-based clinical examinations presented to the Board as an alternative to the live, patient-based clinical examinations. The Western Regional Examination Board (WREB), the Central Regional Dental Testing Services (CRDTS), and the American Board of Dental Examiners, Inc. (ADEX) submitted clinical examination information and data for OPES's review.

At the August 29, 2020 WebEx Teleconference Board meeting and upon conclusion of the review of these alternative examinations, OPES opined that the non-patient-based alternative exams were not a viable option to replace the live, patient-based clinical examinations at that time. Despite OPES's recommendation and due to the class of 2020's predicament, the Board moved to temporarily accept the mannequin-based alternative licensure examinations administered by CRDTS, ADEX, and WREB, when available, in addition to the current patient-based clinical examinations to apply toward Board licensure requirements. The temporary acceptance of these alternative examinations is from August 29, 2020 until March 31, 2021, unless extended.

The original plan was to have a report ready for the Board at the November 21, 2020 WebEx Teleconference Board meeting, but with only two and a half months of exam administrations, there wasn't enough data to report and additional time was needed to provide the Board ample statistics. OPES submitted a memo to the Board that affirmed the lack of statistical data at the time and maintained their original position from the August 29, 2020 Board meeting that the mannequin-based clinical exam is a non-viable

alternative to the patient-based clinical examinations in measuring the skills required for competent dental hygiene practice. The issue was deferred for presentation until the March 20, 2021 Board meeting. Since the November 2020 meeting, staff has been working to request additional mannequin-based data from CRDTS, ADEX, and WREB for OPES to conduct an analysis of the exams.

OPES has obtained additional information from the clinical exam administrators and will provide a presentation and exam analysis for the Board. Because the Board has already extended the temporary acceptance of the alternative mannequin-based clinical exams until August 31, 2021 at the March 6, 2021 meeting, please consider the information and analysis presented for any future decisions on the alternative examinations.

DHBC
Dental Hygiene
Board of California

REVIEW OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS NATIONAL BOARD DENTAL HYGIENE EXAMINATION

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

DENTAL HYGIENE BOARD OF CALIFORNIA

REVIEW OF THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS NATIONAL BOARD DENTAL HYGIENE EXAMINATION

February 2021

Ruxandra Nunn, M.A., Research Data Specialist II

Karen Okicich, M.A., Research Data Supervisor II

Heidi Lincer, Ph.D., Chief

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

This report is mandated by California Business and Professions (B&P) Code § 139 and by DCA Licensure Examination Validation Policy OPES 18-02.

EXECUTIVE SUMMARY

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs used in California licensure comply with psychometric and legal standards. To become a licensed dental hygienist in California, a candidate must have the requisite education and experience and pass three examinations:

1. The National Board Dental Hygiene Examination (NBDHE)
2. The Western Regional Examining Board (WREB) Dental Hygiene Examination or the Central Regional Dental Testing Service (CRDTS) Dental Hygiene Examination
3. The California Registered Dental Hygienist Law and Ethics Examination

The Dental Hygiene Board of California (Board) requested that DCA's Office of Professional Examination Services (OPES) complete a comprehensive review of its examination program. This report is a review of the NBDHE, which is developed by the Joint Commission on National Dental Examinations (JCNDE). OPES performed this review in order to evaluate the suitability of the NBDHE for continued use in California licensure of dental hygienists.

The JCNDE is an independent agency associated with the American Dental Association (ADA). JCNDE develops and administers the NBDHE, a national examination that measures knowledge related to the competencies required for safe, entry-level dental hygiene practice. This examination is required by all dental hygiene licensing agencies in the United States.

OPES, in collaboration with the Board, received and reviewed a report provided by JCNDE that included information regarding an occupational analysis (OA) conducted in 2014–2016. In addition, OPES also reviewed other reports and documents provided by JCNDE regarding practices and procedures used to develop and validate the NBDHE. OPES performed a comprehensive evaluation of the documents to determine whether the following NBDHE components met professional guidelines and technical standards: (a) OA, (b) examination development, (c) passing scores and passing rates, (d) test administration, (e) examination scoring and performance, and (f) test security procedures. Follow-up emails were also exchanged with JCNDE representatives to clarify processes.

OPES found that the procedures used to establish and support the validity and defensibility of the components listed above meet professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* (2014) (*Standards*) and in California Business and Professions (B&P) Code § 139. However, to fully comply with B&P Code § 139 and related policy, OPES 20-01, OPES recommends phasing out the service of board members and educators in examination development processes.

In addition to reviewing documents provided by JCNDE, OPES convened a workshop of California registered dental hygienists in May 2020. The dental hygienists served as subject matter experts (SMEs) to review the content of the NBDHE. The SMEs were selected to represent the profession in terms of geographic location and experience. The purpose of the

review was to compare the content of the NBDHE test specifications with the California registered dental hygienist description of practice that resulted from the OPES 2019 California OA of the Registered Dental Hygienist Profession (California RDH OA, 2019). During this workshop, the SMEs compared the task and knowledge statements from the California description of practice to the examination content of the NBDHE. The linkage study was performed to identify whether there were areas of California dental hygiene practice that are not measured by the NBDHE.

The results of the linkage study indicated that competencies associated with all practice areas included in the California registered dental hygienist description of practice were adequately linked to the content of the NBDHE, except California laws, regulations, and ethics. The SMEs indicated that California laws, regulations, and ethics should continue to be measured by the California-specific Registered Dental Hygienist Law and Ethics Examination.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1 | INTRODUCTION

PURPOSE OF THE COMPREHENSIVE REVIEW

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) must ensure that examination programs used in California licensure comply with psychometric and legal standards. The public must be reasonably confident that an individual passing a licensure examination has the requisite knowledge and skills to competently and safely practice in the profession.

The Dental Hygiene Board of California (Board) requested that DCA's Office of Professional Examination Services (OPES) complete a comprehensive review of the National Board Dental Hygiene Examination (NBDHE) developed by the Joint Commission on National Dental Examinations (JCNDE). The NBDHE is a multiple-choice examination that measures a candidate's knowledge of essential competencies associated with dental hygiene practice.

The OPES review had three purposes:

1. To evaluate the suitability of the NBDHE for continued use in California.

2. To determine whether the NBDHE meets the professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* (2014) (*Standards*[1]) and in California Business and Professions (B&P) Code § 139.

3. To identify any areas of California registered dental hygiene practice that the NBDHE does not assess.

In relation to the *Standards*, evaluating the acceptability of an examination does not involve determining whether the examination satisfies each individual standard interpreted literally. The importance of each standard varies according to circumstances. Page 7 of the *Standards* states:

> Individual standards should not be considered in isolation. Therefore, evaluating acceptability depends on (a) professional judgment that is based on a knowledge of behavioral science, psychometrics, and the relevant standards in the professional field to which the test applies; (b) the degree to which the intent of the standard has been satisfied by the test developer and user; (c) the alternative measurement devices that are readily available; (d) research and experiential evidence regarding the feasibility of meeting the standard; and (e) applicable laws and regulations.

[1] See Chapter 10 for the complete reference to the *Standards*.

OPES, in collaboration with the Board, requested documentation from JCNDE to determine whether the following NBDHE program components met professional guidelines and technical standards outlined in the *Standards* and B&P Code § 139: (a) occupational analysis (OA),[2] (b) examination development, (c) passing scores and passing rates,[3] (d) test administration, (e) examination scoring and performance, and (f) test security procedures.

CALIFORNIA LAW AND POLICY

Section 139 (a) of the California B&P Code states:

> The Legislature finds and declares that occupational analyses and examination validation studies are fundamental components of licensure programs.

It further requires that DCA develop a policy to address the minimum requirements for psychometrically sound examination validation, examination development, and occupational analyses, including standards for the review of state and national examinations.

DCA Licensure Examination Validation Policy OPES 18-02 (OPES 18-02) specifies the *Standards* as the most relevant technical and professional standards to be followed to ensure that examinations used for licensure in California are psychometrically sound, job-related, and legally defensible.

FORMAT OF THE REPORT

The chapters of this report provide the relevant standards related to psychometric aspects of the NBDHE and describe the findings and recommendations that OPES identified during its review.

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[2] An occupational analysis is also known as a job analysis, practice analysis, or task analysis.
[3] A passing score is also known as a pass point or cut score.

CHAPTER 2 | OCCUPATIONAL ANALYSIS

STANDARDS

The following standard is most relevant to conducting OAs for licensure examinations, as referenced in the *Standards*:

> **Standard 11.13**
>
> 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 and evidence should be provided to support the claim that the knowledge or skills being assessed are required for credential-worthy performance in that occupation and are consistent with the purpose for which the credentialing program was instituted (pp. 181-182).

The comment following Standard 11.13 emphasizes its relevance:

> **Comment**: Typically, some form of job or practice analysis provides the primary basis for defining the content domain. If the same examination is used in the credentialing of people employed in a variety of settings and specialties, a number of different job settings may need to be analyzed. Although the job analysis techniques may be similar to those used in employment testing, the emphasis for credentialing is limited appropriately to knowledge and skills necessary for effective practice (p. 182).
>
> In tests used for licensure, knowledge and skills that may be important to success but are not directly related to the purpose of licensure (i.e., protecting the public) should not be included (p. 182).

California B&P Code § 139 requires that each California licensing board, bureau, commission, and program report annually on the frequency of its occupational analysis and the validation and development of its examinations. OPES 18-02 states:

> Generally, an occupational analysis and examination outline should be updated every five years to be considered current; however, many factors are taken into consideration when determining the need for a different interval. For instance, an occupational analysis and examination outline must be updated whenever there are significant changes in a profession's job tasks and/or demands, scope of practice, equipment, technology, required knowledge, skills and abilities, or law and regulations governing the profession (p. 4).

FINDINGS

In 2014–2016, JCNDE conducted an OA of the dental hygiene profession. This OA was conducted at the national level, and the results were documented in the Dental Hygiene Practice Analysis and Revision of the NBDHE (JCNDE OA, 2016). Additional information regarding this study was obtained through other technical reports and documentation provided by JCNDE, from JCNDE's website, and through email communication with JCNDE representatives.

Occupational Analysis – Methodology and Time Frame

The purpose of the OA was to help establish evidence of validity to support the use of the NBDHE by state boards in determining the qualifications of candidates seeking licensure to practice dental hygiene (JCNDE OA, 2016). The methodology used to conduct the OA study was an online survey. The survey described the competencies performed by registered dental hygienists, which had been developed and reviewed by the JCNDE and stakeholders in the dental community. The final survey was sent to 43,743 dental hygienists whose information was obtained from the JCNDE's NBDHE administration application files. The survey recipients had been licensed between 2006 and 2015 (JCNDE OA, 2016). In addition, members of the American Dental Hygienists' Association (ADHA) were invited to complete the survey.

> Finding 1: The OA began in 2014 and was completed in 2016. The OA was conducted within a time frame considered to be current and legally defensible.
>
> Finding 2: JCNDE attempts to conduct an OA every 5 years. This interval complies with the DCA policy established under B&P Code § 139, which specifies that, generally, an OA should be conducted every 5 years.

Occupational Analysis – Development of Survey and Sampling Plan

In 2014, the JCNDE initiated an OA of the dental hygiene profession. This OA was conducted at the national level and focused on identifying the competencies required for practice in a majority of states, according to the NBDHE 2020 Candidate Guide.

JCNDE began by reviewing several sources of information regarding the competencies required for dental hygiene practice. These sources included:

1. 56 competencies included on an OA previously conducted by JCNDE in 2009.
2. American Dental Education Association (ADEA) Competencies for Entry into the Profession of Dental Hygiene (ADEA Competencies, 2010).
3. The Commission on Dental Accreditation (CODA) Accreditation Standards for Dental Hygiene Education Programs (CODA Standards, 2012).
4. The ADHA's Standards for Clinical Dental Hygiene Practice (ADHA Standards, 2016).

From these sources, JCNDE consolidated similar competencies and standards into a list of 43 proposed competencies thought to underly dental hygiene practice (JCNDE OA, 2016).[4] These 43 consolidated competencies were incorporated into a preliminary survey that was administered to stakeholders in the dental community: the 2014 NBDHE Competency Survey. These stakeholders were asked to provide feedback regarding the relevance and comprehensiveness of the competencies for dental hygiene practice. In addition, this survey also asked stakeholders to review 17 additional statements that represented skills or activities performed by dental hygienists, and their relationship to the proposed 43 competencies.

In 2015, JCNDE's Committee on Research and Development requested JCNDE staff to group the competencies into one of three clinical component sections or a mixed clinical component section. The grouping was documented in the JCNDE Dental Hygiene Competencies Crosswalk (JCNDE Crosswalk, 2015) and in the 2016 JCNDE OA.

The JCNDE Committee on Dental Hygiene—comprising four joint commissioners, three dental hygienists, and a student representative—then reviewed the competencies and clinical components for redundancy and for adequacy in measuring minimum competence for practice. The resulting list was then also reviewed by representatives from the ADHA. As a result of these reviews, a final list of 30 competency content areas was organized into three clinical component sections: (1) Diagnosis and Treatment Planning, (2) Oral Health Management, and (3) Practice and Profession.

A second preliminary survey comprising this final list of 30 competency content areas within the three clinical component sections was then administered to 6,000 stakeholders in the dental community. This survey was titled the NBDHE Clinical Content Area Survey (NBDHE Content Area Survey, 2015). The purpose of the survey was to confirm that the competency content areas were comprehensive and relevant to current dental hygiene practice and to determine the final set of clinical content areas that would be incorporated into the OA survey.

The 30 competency content areas were then used to develop the final 2016 NBDHE Practice Analysis Survey (JCNDE OA, 2016). The final survey included two sections and was administered to dental hygienists located predominantly in the United States. The first section of the survey comprised demographic questions designed to gather information about the survey respondents and their practice setting. The second section of the survey comprised the 30 competency content areas that were distributed across the three clinical component sections related to dental hygiene practice. In this section, respondents were asked to rate each competency content area on two rating scales: frequency of use in patient care, and importance to patient care. After completing the second section of the survey, respondents were invited to make comments or suggestions.

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[4] The resulting language of the proposed competency statements predominantly reflects the ADEA Competencies.

In rating the frequency of the competency content areas, respondents were asked to consider their work over the past 12 months and to rate how frequently they performed each competency. The response options for this scale included: More than 5 times per day, 3–5 times per day, 1–2 times per day, 1–4 times per week, Less than once per week, Never, and Not applicable (JCNDE OA, 2016).

In rating the importance of the competency content areas, respondents were asked to consider the risk of adverse consequences for the patient if the competency area was neglected. They were then asked to rate each competency area on how important it is to patient care. The responses for this scale included: Extremely important, Very important, Important, Somewhat important, Not important, and Not applicable (JCNDE communication, 2020).

Finding 3: During the development phase, two preliminary surveys were administered to stakeholders for input: the 2014 NBDHE Competency Survey and the 2015 NBDHE Content Area Survey. Of the 137 stakeholders who responded to the first preliminary survey to confirm the relevance and comprehensiveness of competencies, 127 indicated they were dental hygiene program directors or faculty (NBDHE Competency Survey, 2014). Other stakeholders who responded included current and former NBDHE Test Construction Committee members, and the president of a dental hygiene association. Six respondents indicated they were dental hygiene practitioners. Half of the stakeholder respondents indicated they did not spend any hours per week practicing as a dental hygienist. The majority of respondents had been licensed more than 20 years; none had been licensed less than 10 years (NBDHE Competency Survey, 2014). Three stakeholders were from California.

Of the 203 stakeholders who responded to the 2015 NBDHE Content Area Survey, 170 indicated they were practicing dentists (NBDHE Content Area Survey, 2015). It appears that the intended recipients of this survey were dentists; however, nine responses were received from dental hygienists. Nine of these stakeholders were from California.

Finding 4: The predominant stakeholders involved in the 2014 NBDHE Competency Survey were program directors or faculty, approximately half of whom had been licensed more than 20 years. The procedures used by JCNDE to develop the OA survey generally comply with professional guidelines and technical standards; however, the input of newly-licensed practitioners should be included to ensure that knowledge and skills are appropriately defined for entry-level practice.

Occupational Analysis – Sampling Plan and Response Rate

As indicated above, the sampling plan for the OA study included a total of 43,743 dental hygienists (JCNDE sample) (JCNDE OA, 2016). Survey recipients included only those hygienists licensed between 2006 and 2015 in order to maintain an entry-level perspective in identifying the competencies required for safe and effective practice at the time of initial licensure.

An email containing an invitation to complete the online survey was first sent to 21,234 dental hygienists from the JCNDE sample. This group was stratified by year of graduation and state of residence (JCNDE OA, 2016). Due to a low initial response rate, email invitations were then sent to the remaining 22,509 dental hygienists in the JCNDE sample. In addition, the survey was also sent to ADHA members who had been licensed 10 years or less (ADHA sample).

A total of 3,863 respondents from the JCNDE sample and 260 from the ADHA sample opened the online survey. Data from all responses for opened surveys were included in analyses of demographics; however, only data from respondents who rated at least one competency content area were included in further analyses. As a result, data from a total of 2,853 responses from the JCNDE sample were used in analyses of competency area ratings, for a response rate of 6.5%. The total number of dental hygienists in the ADHA sample who received an invitation to complete the survey was not reported.

> Finding 5: The intent of the sampling plan generally complies with professional standards and technical guidelines; the intent was to obtain an entry-level perspective regarding the competencies included on the survey.
>
> Finding 6: The overall response rate for the OA was low. However, the response rate of dental hygienists licensed 5 years or less appears sufficient to ensure that an entry-level perspective was reflected. Approximately 11% of respondents from the JCNDE sample and 6% of the respondents from the ADHA sample who opened the survey were from California (JCNDE OA, 2016). The percentage of dental hygienists from California who provided ratings on competency content areas was not provided. However, based on response rates of those who opened the survey, it appears that ratings of competency content areas likely included a sufficient number of California practitioners to ensure representation of dental hygiene practice in California.

Occupational Analysis – Survey Results

After administering the survey, JCNDE collected the data and analyzed the survey results. Results of analyses from the JCNDE and ADHA were analyzed separately. Results indicated that responses from both samples yielded similar results (JCNDE OA, 2016).

Analyses of mean frequency and importance rating were conducted for competencies within each of the clinical component sections. Ratings obtained on the frequency and importance scales for each competency were then combined using a weighted multiplicative model proposed by Kane, Kingsbury, Colton, & Estes (1989). Using this model, mean frequency ratings were multiplied by weighted mean importance ratings to obtain an overall criticality index for each competency content area (JCNDE OA, 2016).

Based on the criticality indices for all competency content areas, a preliminary determination was made about the number of items that would be allocated (or reallocated) to each of the existing content areas included on the NBDHE (JCNDE OA, 2016).

> Finding 7: Survey respondents were licensed dental hygienists located throughout the United States, all of whom had been practicing for 10 years or less. Approximately 76% of the respondents from the JCNDE sample and 60% of those from the ADHA sample reported that they had been practicing for less than 5 years (JCNDE OA, 2016). The majority of respondents (61% from both samples) reported that they worked 31–40 hours a week as a dental hygienist, while 35% of the JCNDE sample and 26% (approximately) of the ADHA sample indicated that they worked 11–30 hours per week (JCNDE OA, 2016). In addition, the majority of respondents from both the JCNDE and ADHA samples (79% and 75%, respectively) categorized their primary work setting as a private general practice. The demographic data indicate that ratings provided by respondents licensed 5 years or less appear to be sufficient to ensure that an entry-level perspective was achieved, and the respondents appear representative of general dental hygiene practice.

Occupational Analysis – Development of Test Specifications

In October 2016, a Test Specifications Practice Analysis Review Panel (Panel) reviewed the results of the OA survey. The Panel included 11 members, including: 5 joint commissioners, 4 practicing dental hygienists, and 2 dental hygiene educators from accredited dental hygiene programs (JCNDE OA, 2016). Panelists reviewed the mean frequency ratings, mean importance ratings, and the overall criticality of ratings for each of the competency content areas. In addition, they reviewed the list of 30 competency content areas in conjunction with the content assessed on the NBDHE.

The Panel then linked the results of the OA with the disciplines assessed on the NBDHE (JCNDE OA, 2016). The Panel also ensured that the distribution of items in each of the disciplines reflected the relative importance and frequency of each of the competency content areas, as identified in the OA. The Panel reviewed the results of ratings on competency content

areas from both the JCNDE sample and the ADHA sample and reached a consensus about the number of items that should be devoted to each of the disciplines and subdisciplines on the NBDHE. The results of this review resulted in a recommendation for the new test specification for the NBDHE.

In 2017, the Committee on Research and Development and the Committee on Dental Hygiene reviewed the practice analysis survey results and approved the Panel's recommended test specifications. The new test specification was subsequently adopted by JCNDE and was reflected in NBDHE forms beginning in 2019.

> Finding 8: The processes used to establish a link between competencies identified by the OA as required for entry-level practice and the disciplines of the NBDHE demonstrate a sufficient level of validity, thereby meeting professional guidelines and technical standards.

RECOMMENDATIONS

> Recommendation 1: OPES recommends that JCNDE increase the participation of dental hygiene practitioners in the development of future OAs. In addition, SMEs involved in the development process should represent the profession in terms of geographic location and level of experience. OPES further recommends that JCNDE include practitioners licensed 5 years or less in subsequent OA development processes.

CONCLUSIONS

Given the findings, the OA conducted by JCNDE appears to meet professional guidelines and technical standards. Additionally, the development of the test specifications for the NBDHE is based on the results of the most recent OA and appears consistent with professional guidelines and technical standards. OPES recommends that JCNDE modify future OA development processes to include actively practicing dental hygienists and to include SMEs who represent the practice in terms of experience level. Because the results of the OA form the basis of the NBDHE, entry-level practitioners (licensed 5 years or less) should be involved in these processes.

CHAPTER 3 | EXAMINATION DEVELOPMENT

STANDARDS AND REGULATIONS

Examination development includes many steps within an examination program, from the development of an examination content outline to scoring and analyzing items after the administration of an examination. Several specific activities involved in the examination development process are evaluated in this section. The activities include development of examination content, linkage of examination content to the examination outline, and development of the scoring criteria and the examination forms.

The following standards are most relevant to examination development for licensure examinations, as referenced in the *Standards.*

Standard 4.7

The procedures used to develop, review, and try out items and to select items from the item pool should be documented (p. 87).

Standard 4.12

Test developers should document the extent to which the content domain of a test represents the domain defined in the test specifications (p. 89).

The following regulations are relevant to the integrity of the examination development process:

California B&P Code § 139 requires DCA to develop a policy on examination validation which includes minimum requirements for psychometrically sound examination development.

DCA Policy Participation in Examination Development OPES 20-01 (OPES 20-01), as mandated by B&P Code § 139, specifies that board members, committee members, and instructors should not serve as expert consultants in the licensure examination development process. This is due to potential conflict of interest, undue influence, and security considerations.

FINDINGS

The information below about the NBDHE is included in the 2018–2019 Technical Report on the NBDHE (NBDHE Technical Report, 2020).

The NBDHE consists of 350 multiple-choice items and comprises two components (NBDHE Candidate Guide, 2020). The first component is discipline-based. This component consists of 200 items across three major areas related to dental hygiene practice. These disciplines include: Scientific Basis for Dental Hygiene Practice (organized into six subdisciplines),

Provision of Clinical Dental Hygiene Services (organized into seven subdisciplines), and Community Health/Research Principles (organized into three subdisciplines).

The second component is case-based. It consists of 150 items involving 12–15 dental hygiene patient cases. Cases in this section include at least one case (or scenario) involving geriatric, adult-periodontal, pediatric, special needs, and medically compromised patients. Case-based items involve the presentation of patient histories, dental charts, radiographs, and clinical photographs. These questions are designed to evaluate a candidate's ability to assess patient characteristics, interpret clinical information, plan dental hygiene care, perform periodontal procedures and use preventative agents, and provide supportive treatments.

The NBDHE also uses testlet items, which present a case study or problem and a set of 4–5 associated questions.

In July 2020, JCNDE began administering a short-form version of the NBDHE on a temporary basis to address testing backlogs associated with COVID-19 (JCNDE website, https://www.ada.org/en/jcnde). This shortened version comprises 155 multiple choice items: 85 discipline-based items, and 70 case-based items. JCNDE has stated that reliability and validity of the short form have been thoroughly investigated. "The shortened version of the NBDHE has undergone thorough psychometric investigation within the Department of Testing Services; there is strong validity and reliability evidence to support usage of the short-form NBDHE" (JCNDE website).

> Finding 9: JCNDE has provided results of reliability estimates for the short form. JCNDE provided estimates of classification consistency (.95), classification accuracy (.92–.95), and Kuder-Richardson 20 (KR20) reliability among short-form versions of the NBDHE. These estimates indicated an acceptable level of these indices (NBDHE Quick Facts, 2020). Further, the short form is a proportional representation of the test specifications resulting from the most recent OA for the long-form NBDHE. The passing score for the short form appears to be based on the passing standard set in 2015 for the long-form NBDHE.
>
> JCNDE has indicated on its website that it intends to maintain the short-form NBDHE until the backlog of candidates is resolved. Once this happens, JCNDE will make a determination about future testing (JCNDE website).

Examination Development – Subject Matter Experts (SMEs)

Examination development for the NBDHE is performed by SMEs who serve as test constructors, according to the 2019 JCNDE Test Construction Teams and Selection Criteria (JCNDE Construction Teams Manual, 2019). Potential test construction SMEs must provide evidence that specific qualification criteria have been met, including credentials demonstrating subject matter expertise (JCNDE Construction Teams Manual, 2019). Potential test construction

SMEs must have graduated from an accredited program and must possess the following expertise in one of eight areas:

1. Biomedical Sciences – doctoral degree, dentist or dental hygienist with advanced biomedical education beyond entry-level dental hygiene education, and a minimum of three years' teaching experience in the past 5 years.
2. Radiology – dentist or dental hygienist with baccalaureate degree from accredited program, oral and maxiofacial radiologist or dental hygienist with education beyond entry-level dental hygiene education, and a minimum of 3 years' teaching experience in the past 5 years.
3. Periodontics (Periodontist) – graduate from an accredited dental program with advanced education in periodontics, and a minimum of 3 years' teaching periodontics in the past 5 years.
4. Periodontics (Dental Hygienist) – graduate from an accredited dental hygiene program, and a minimum of 3 years' teaching periodontics in the past 5 years.
5. Oral Medicine/Oral Diagnosis/Oral Pathology – dentist or dental hygienist with advanced education or experience, and 3 years' experience teaching in oral medicine/oral diagnosis/oral pathology in the past 5 years.
6. Special Needs Professional – dentist or dental hygienist with advanced clinical experience or education with special needs populations, and 3 years' experience teaching in a relevant subject area in the past 5 years.
7. Dental Hygiene Curriculum – dental hygienist with advanced degree in dental hygiene, experience in curriculum design, program director, curriculum committee, or consultant, and 3 years' teaching experience or clinical experience in dental hygiene in a private or faculty practice setting.
8. Clinical Dental Hygiene – dental hygienist with a baccalaureate degree in dental hygiene, education, or biomedical science, and a minimum of 3 years of teaching or practicing dental hygiene in the past 5 years.
9. Community Dental Health – dentist or dental hygienist with advanced education in public health or community dental health (JCNDE Construction Teams Manual, 2019).

Once approved, each test constructor SME receives the following materials: Test Item Development Guide, Orientation Manual for Test Constructors, Dental Hygiene Examination Specifications, and Acceptance Form. New test constructors also receive a style manual for producing items for the NBDHE and are mentored by returning test constructors.

> Finding 10: The criteria used to select test construction SMEs appear relatively consistent with professional guidelines and technical standards. However, the use of educators in examination development processes is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Examination Development – Linkage to Examination Blueprint

In October 2016, the Panel convened to link the competency content areas derived from the 2016 JCNDE OA with the disciplines and subdisciplines covered on the NBDHE (JCNDE OA, 2016). The Panel provided a recommendation regarding the number of examination items that should be devoted to each of the OA competency content areas and the number of items devoted to each discipline and subdiscipline. In 2017, the Committee on Research and Development and the Committee on Dental Hygiene approved the Panel's recommendation for the new NBDHE test specifications. Subsequently, JCNDE adopted the updated test specifications for the NBDHE.

> Finding 11: The methods used to establish a link between examination content and the competencies necessary for practice appear consistent with professional guidelines and technical standards.

Examination Development – Item Development and Pilot Testing

Each year, JCNDE appoints test construction SMEs to Test Construction Teams (TCTs) (NBDHE Technical Report, 2020). Six TCTs work together to develop the content of the NBDHE. Test construction SMEs are responsible for reviewing test specifications to ensure that they reflect current practice, for submitting new examination items, and for constructing examination forms.

The TCTs are divided into two groups: Component A teams are responsible for developing and reviewing discipline-based items, and Component B teams develop and review case-based items.

New items are reviewed by test construction SMEs during TCT meetings. In addition, new items are included on NBDHE forms as experimental items (pretest items) and are not counted toward a candidate's score. Item analyses are then performed, and the statistical performance of these items is reviewed by SMEs at TCT meetings to determine whether the items meet criteria for inclusion on future examination forms (NBDHE Technical Report, 2020). In evaluating item performance, SMEs consider indices of both item difficulty and item discrimination. Items that do not meet defined performance criteria are returned for revision or are eliminated.

> Finding 12: The procedures used to develop, review, and field test new items appear consistent with professional guidelines and technical standards. However, the service of educators in examination development processes is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Examination Development – Examination Forms

Examination forms for the NBDHE are constructed by TCTs based on the examination specifications. Throughout the construction process, test constructor SMEs ensure that examination content reflects current practice (NBDHE Technical Report, 2020). In addition, all examination forms are constructed using the same criteria to ensure that forms are comparable in terms of content and item difficulty. Examination forms also include anchor items to equate alternate forms of the NBDHE.

Final forms of the NBDHE are reviewed by a Consultant Review Team consisting of four test constructor SMEs. This team reviews examinations to ensure consistency and coherence of both the Component A and Component B sections of each examination form (NBDHE Technical Report, 2020).

> Finding 13: The procedures used to construct NBDHE forms appear consistent with professional guidelines and technical standards. However, the use of educators in examination development processes is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

RECOMMENDATIONS

> Recommendation 2: In addition to ensuring that examinations are valid, California boards are required to ensure that they are fair to candidates and do not create artificial barriers to practice. If sufficient evidence of reliability and validity exists to support the use of the short-form NBDHE as a measure of competence for dental hygiene practice, OPES recommends that this form be maintained or that a strong psychometric justification be provided for returning to the full-length form.

> Recommendation 3: OPES recognizes that JCNDE includes educators in examination development processes in order to obtain information regarding the education that dental hygienists receive. In order to be fully compliant with OPES 20-01, OPES recommends phasing out or limiting the service of educators during examination development processes.

CONCLUSIONS

Given the findings, the examination development procedures conducted by JCNDE appear consistent with professional guidelines and technical standards. To reduce the potential for conflict of interest during examination development processes, OPES recommends phasing out the service of educators and increasing the service of dental hygienists who are providing clinical services.

The COVID-19 pandemic has created profound challenges to test administration, and OPES commends JCNDE's efforts to improve the efficiency of test administration. JCNDE stated that it thoroughly investigated reliability and validity evidence before making changes to the length of

the NBDHE. Provided reliability and validity evidence support the use of the short-form NBDHE, OPES recommends that JCNDE continue the use of this form once testing backlogs have resolved. Alternately, a compelling psychometric justification for returning to the full-length form should be provided. In the absence of such justification, a return to the full-length form would be unfair to candidates and potentially create an artificial barrier to practice.

CHAPTER 4 | PASSING SCORES AND PASSING RATES

STANDARDS

The passing score of an examination is the score that represents the level of performance that divides those candidates for licensure who are minimally competent from those who are not competent.

The following standards are most relevant to passing scores, cut points, or cut scores for licensure examinations, as referenced in the *Standards.*

> **Standard 5.21**
>
> When proposed score interpretations involve one or more cut scores, the rationale and procedures used for establishing cut scores should be documented clearly (p. 107).
>
> **Standard 11.16**
>
> The level of performance required for passing a credentialing test should depend on the knowledge and skills necessary for credential-worthy performance in the occupation or profession and should not be adjusted to control the number or proportion of persons passing the test (p. 182).

The supporting commentary on passing or cut scores in Chapter 5 of the *Standards*, "Scores, Scales, Norms, Score Linking, and Cut Scores" states that the standard setting process used should be clearly documented and defensible. The qualifications and the process of selection of the judges involved should be part of the documentation. A sufficiently large and representative group of judges should be involved, and care must be taken to ensure that judges understand the process and procedures they are to follow (p.101).

In addition, the supporting commentary in Chapter 11 of the *Standards*, "Workplace Testing and Credentialing" states that the focus of tests used in credentialing is on "the standards of competence needed for effective performance (e.g., in licensure this refers to safe and effective performance in practice)" (p. 175). It further states, "Standards must be high enough to ensure that the public, employers, and government agencies are well served, but not so high as to be unreasonably limiting" (p. 176).

OPES 20-01, as mandated by B&P Code § 139, specifies that board members, committee members, and instructors should not serve as expert consultants in the licensure examination development process. This is due to potential conflict of interest, undue influence, and security considerations.

FINDINGS

Passing Scores – The NBDHE Process, Participation of SMEs, and Methodology

The NBDHE uses a criterion-referenced passing standard that is set on a base form of the examination. A bookmark procedure was used to establish the passing standard, which relies on the expert judgment of SMEs to determine the knowledge a candidate should possess in order to be "just qualified" (minimally qualified) for safe and effective dental hygiene practice.

To determine the passing standard, a panel with SMEs was held in 2015, according to the 2015 Report on Standard Setting for the NBDHE (Standard Setting Report, 2015). Twelve SMEs participated in this panel, comprising five dental hygienists, four dentists, and three educators. The panel was facilitated by a psychometrician.

SMEs were first provided with information about the NBDHE OA, test specifications, and examination development processes (Standard Setting Report, 2015). SMEs were also provided with information about passing standards and the bookmark standard setting process. The SMEs then self-administered an abbreviated form of the NBDHE that was representative of the NBDHE full form. The intent of this activity was to have SMEs experience the item formats, level of challenge, and test-taking conditions experienced by candidates. After this activity, the SMEs participated in another activity aimed at understanding the concept of the "Just Qualified Candidate" (minimally competent candidate), followed by a session of practice ratings and subsequent discussion.

After the practice session and discussion, the SMEs worked collectively during three rounds to provide bookmark judgments/placements for operational items (Standard Setting Report, 2015). At the end of each round, analyses were conducted on the recommended bookmark placements. The passing standard was derived from the median of the SMEs' bookmark placements. The criterion-referenced passing standard was then used to adjust the scale used to score the NBDHE to a consistent passing score (NBDHE Candidate Guide, 2020).

Item Response Theory (IRT) was used to statistically produce equivalent scores on alternate forms of the NBDHE based on this score scale and criterion-referenced passing standard. Scaled scores on the NBDHE can range from 49–99, and candidates must achieve a score of 75 or higher to pass the NBDHE.

The passing standard from the 2015 bookmark procedure was approved by JCNDE in 2016 and implemented in 2017. Passing standards are periodically reviewed by SMEs and by JCNDE to ensure that they continue to reflect the knowledge required for safe, entry-level practice. When passing standards are updated, modifications are made to the score scale so that a score of 75 continues to reflect the minimum passing score (NBDHE Candidate Guide, 2020).

Finding 14: The number of SMEs used in setting the passing standard meets professional guidelines and technical standards. However, the use of educators in the process is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Finding 15: The methods used to set the passing standard for the NBDHE and scale scores on alternate forms generally appear consistent with professional guidelines and technical standards.

PASSING RATES

JCNDE tracks annual passing rates for the NBDHE. This data is provided for first-time and repeat test takers who attended accredited and non-accredited dental hygiene programs. OPES reviewed the pass rates for 2017–2019, which correspond with the implementation of the current passing standard. Passing rates for 2020 administrations were not available at the time of this report.

Finding 16: The overall passing rate for first-time test takers from accredited programs for the period analyzed was 92–94% (approximately), while pass rates for repeat test takers was 50–54% (approximately). The pass rates for first-time test takers coming from non-accredited programs during the period ranged from 65–67% (approximately), while the pass rate for repeat test takers ranged from 49–56% (approximately). The overall pass rate across all candidates was 86–89%.

Data were not provided regarding the pass rates for California candidates.

RECOMMENDATIONS

Recommendation 4: In order to be fully compliant with OPES 20-01, OPES recommends phasing out or limiting the service of board members and educators during examination development processes.

Recommendation 5: OPES recommends that JCNDE provide data regarding pass rates for California candidates so that specific evaluations can be made of the performance of candidates in California.

CONCLUSIONS

Given the findings, the passing score methodologies used by JCNDE to set the passing standard and scale scores on the NBDHE demonstrate a sufficient degree of validity, thereby meeting professional guidelines and technical standards.

The pass rates for the NBDHE indicate that, overall, candidates tend to perform very well. First-time test takers who come from accredited programs tend to perform better than those who come from non-accredited programs. In addition, first-time test takers tend to perform better than repeat test takers. This is consistent with pass rate patterns observed in other high-stakes licensure programs. OPES recommends that the NBDHE provide data for California candidates so that an evaluation of state-specific performance can be made.

CHAPTER 5 | TEST ADMINISTRATION

STANDARDS

The following standards are most relevant to the test administration process for licensure examinations, as referenced in the *Standards.*

Standard 3.4

Test takers should receive comparable treatment during the test administration and scoring process (p. 65).

Standard 4.15

The directions for test administration should be presented with sufficient clarity so that it is possible for others to replicate the administration conditions under which the data on reliability, validity, and (where appropriate) norms were obtained. Allowable variations in administration procedures should be clearly described. The process for reviewing requests for additional testing variations should also be documented (p. 90).

Standard 4.16

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 materials, practice or sample questions, criteria for scoring, and a representative item identified with each item format or major area in the test's classification or domain should be provided to the test takers prior to the administration of the test or should be included in the testing material as part of the standard administration instructions (p. 90).

Standard 6.1

Test administrators should follow carefully the standardized procedures for administration and scoring specified by the test developer and any instructions from the test user (p. 114).

Standard 6.2

When formal procedures have been established for requesting and receiving accommodations, test takers should be informed of these procedures in advance of testing (p. 115).

Standard 6.3

Changes or disruptions to standardized test administration procedures or scoring should be documented and reported to the test user (p. 115).

Standard 6.4

The testing environment should furnish reasonable comfort with minimal distractions to avoid construct-irrelevant variance (p. 116).

Standard 6.5

Test takers should be provided appropriate instructions, practice, and other support necessary to reduce construct-irrelevant variance (p. 116).

Standard 8.1

Information about test content and purposes that is available to any test taker prior to testing should be available to all test takers. Shared information should be available free of charge and in accessible formats (p. 133).

Standard 8.2

Test takers should be provided in advance with as much information about the test, the testing process, the intended test use, test scoring criteria, testing policy, availability of accommodations, and confidentiality protection as is consistent with obtaining valid responses and making appropriate interpretations of test scores (p. 134).

FINDINGS

JCNDE contracts with Pearson VUE, a national test administration vendor, to administer the NBDHE (NBDHE Candidate Guide, 2020). The NBDHE is administered throughout the calendar year via computer at over 280 Pearson VUE testing centers and thousands of Pearson VUE authorized testing centers in the U.S., U.S. territories, and Canada. A brief optional tutorial is provided before the examination begins. The tutorial familiarizes candidates with computer operation and the steps involved in proceeding through the examination.

JCNDE provides information about the NBDHE and test administration to candidates and prospective candidates through its website at https://www.ada.org/en/jcnde.

Test Administration – Candidate Registration

Candidates register to take the NBDHE by first obtaining a Dental Personal Identification Number (DENTPIN) and submitting an application through the ADA Department of Testing Services (DTS) website at https://dts.ada.org/login/login__ADA.aspx. After applications have been processed, candidates receive an email with scheduling instructions.

The JCNDE website and the NBDHE 2020 Candidate Guide provide detailed instructions and information regarding the application and registration process, including:

- Application procedures
- Examination fees
- Examination schedule
- Rescheduling or canceling a test appointment
- Policies regarding re-application and eligibility for re-examination

Finding 17: The NBDHE registration process appears straightforward. The information available to candidates is detailed and comprehensive. The candidate registration process appears to meet professional guidelines and technical standards.

Finding 18: JCNDE implements a re-administration policy that requires candidates to wait 90 days before reapplying for the examination. JCNDE also implements a Five Year/Five Attempts Eligibility Rule. This rule specifies that candidates must pass the examination within 5 years of their first attempt or within five attempts, whichever comes first. This policy is consistent with industry standards for high-stakes licensure programs and is clearly specified on the JCNDE website and in the NBDHE 2020 Candidate Guide.

Test Administration – Accommodation Requests

JCNDE complies with the Americans with Disabilities Act and provides reasonable accommodations to candidates with documented disabilities or medical conditions. In addition to an application to test, candidates who require testing accommodations must submit a Testing Accommodations Request Form that indicates the accommodation requested to address functional limitations (NBDHE Candidate Guide, 2020). In addition, candidates are also required to submit an evaluation report completed by a qualified health care professional within the past 5 years that includes information regarding the candidate's disability or diagnosis and recommendations for accommodation.

In considering requests for accommodation, JCNDE maintains a focus on the validity of the examination and on providing candidates with the "opportunity to demonstrate their knowledge and [cognitive] skills, as opposed to having the measurement of their knowledge and [cognitive] skills inappropriately reflect a disability" (NBDHE Candidate Guide, 2020, p. 19).

Finding 19: JCNDE's accommodation procedures appear consistent with professional guidelines and technical standards.

Test Administration – Test Centers

The full-length NBDHE is administered over a nine-hour time period at Pearson VUE testing centers or Pearson VUE authorized testing centers. The short-form NBDHE (beginning in July 2020) is administered over 3 hours and 35 minutes at these same locations. Pearson VUE testing centers and authorized testing centers are located throughout the U.S and its territories, and in Canada (JCNDE website).

> Finding 20: Candidates have access to thousands of authorized testing centers that administer the NBDHE. These centers have trained proctors and controlled testing conditions.

Test Administration – Directions and Instructions to Candidates

The JCNDE website provides detailed information about the NBDHE. In addition, the NBDHE 2020 Candidate Guide provides detailed information to candidates regarding:

- Purpose of the examination and dental hygiene licensure
- Examination specifications
- Examination preparation and resources
- Practice tests
- Examination scoring and results
- Eligibility requirements
- Examination fees, scheduling, and application procedures
- Testing center procedures and administration
- Testing accommodations
- Examination regulations and testing center rules of conduct
- Examination privacy and security
- Examination irregularities and appeals

Through the Pearson VUE examination software link, candidates are able to download an online tutorial to become familiar with the examination software used to administer the NBDHE.

In addition, through the JCNDE website, candidates can purchase practice tests comprised of retired NBDHE items (JCNDE website). These practice tests are designed to assist candidates in identifying their strengths and weaknesses when preparing for the NBDHE and to familiarize them with the content and format of the examination.

> Finding 21: The directions and instructions provided to candidates appear straightforward. The information available to candidates is detailed and comprehensive.

Test Administration – Standardized Procedures and Testing Environment

Candidates are tested in similar testing centers, using the same equipment, under the same conditions. All candidates are assessed on the same examination content. In addition, all candidates are provided two note boards and two low-odor fine tip markers during the examination (NBDHE Candidate Guide, 2020).

> Finding 22: The procedures established for the test administration process and testing environment appear to be consistent with professional guidelines and technical standards.

CONCLUSIONS

Given the findings, the test administration protocols put in place by JCNDE appear consistent with professional guidelines and technical standards.

CHAPTER 6 | EXAMINATION SCORING AND PERFORMANCE

STANDARDS

The following standards are most relevant to scoring and performance for licensure examinations, as listed in the *Standards*.

> **Standard 2.3**
>
> For each total score, subscore, or combination of scores that is to be interpreted, estimates of relevant indices of reliability/precision should be reported (p. 43).
>
> **Standard 4.10**
>
> When a test developer evaluates the psychometric properties of items, the model used for that purpose (e.g., classical test theory, item response theory, or another model) should be documented. The sample used for estimating item properties should be described and should be of adequate size and diversity for the procedure. The process by which items are screened and the data used for screening, such as item difficulty, item discrimination, or differential item functioning (DIF) for major examinee groups, should also be documented. When model-based methods (e.g., IRT) are used to estimate item parameters in test development, the item response model, estimation procedures, and evidence of model fit should be documented (pp. 88-89).

FINDINGS

Examination Scoring

The NBDHE consists of multiple-choice items that are scored dichotomously (correct or incorrect). There is no penalty for selecting an incorrect response—a candidate's score is based on the number of correct responses (NBDHE Technical Report, 2020). In calculating a candidate's score, a raw score is first obtained by computing the number of items answered correctly (NBDHE Candidate Guide, 2020). The raw score is then statistically converted to a scale score, which can range from 49–99. A minimum score of 75 is required to pass the NBDHE.

As part of the validation process, candidate examination responses are routinely audited for accuracy before results are distributed. In addition, candidates can request to have their examination responses audited or rechecked for accuracy (NBDHE Technical Report, 2020).

Results for candidates who achieve a scaled score of 75 or higher are reported as "pass." Candidates who fail the examination receive information about their performance in each of the major disciplines assessed on the examination (NBDHE Candidate Guide, 2020). The discipline subscores are placed on a common measurement scale so that comparisons can be made and are presented graphically (NBDHE Technical Report, 2020). This allows candidates to identify areas of weakness and to compare scores across administration attempts.

Examination results are typically available 3–4 weeks after the examination date (NBDHE Candidate Guide, 2020). Candidates' pass/fail status is reported to the Board, and candidates can view their results by logging into their account on JCNDE's website. Candidates' pass/fail status may also be reported to accredited dental hygiene programs. In addition, accredited programs receive periodic reports that describe how their students perform on the examination relative to students from other programs.

> Finding 23: The scoring criteria is applied equitably, and the examination scoring process appears consistent with professional guidelines and technical standards.

Examination Performance

After administration of NBDHE forms, JCNDE performs item analyses and evaluates overall examination statistics. In addition, JCNDE also evaluates indices of examination consistency using a reference group comprising first-time test takers who attended accredited programs. These indices include: mean scaled score, scaled score standard deviation, mean score, and reliability range using KR20.

> Finding 24: The examination-level statistics indicate adequate performance for a licensure examination.

CONCLUSIONS

The steps taken by JCNDE to score the NBDHE appear to provide a fair and objective evaluation of candidate performance. The steps taken by JCNDE to evaluate examination performance also appear to be reasonable.

CHAPTER 7 | TEST SECURITY

STANDARDS

The following standards are most relevant to test security for licensure examinations, as referenced in the *Standards*.

> **Standard 6.6**
>
> Reasonable efforts should be made to ensure the integrity of test scores by eliminating opportunities for test takers to attain scores by fraudulent or deceptive means (p. 116).
>
> **Standard 6.7**
>
> Test users have the responsibility of protecting the security of test materials at all times (p. 117).

FINDINGS

Test Security – Examination Materials and Candidate Information

To ensure that the security of examination materials is maintained, JCNDE copyrights all examination items and materials to establish ownership and to restrict dissemination or unauthorized use (NBDHE Technical Report, 2020). In addition, JCNDE has developed policies and procedures for maintaining the custody of materials and conveying responsibility for examination security to examination developers, administrators, and users.

JCNDE screens all personnel who manage examination materials, including staff, vendors, and test constructor SMEs involved in examination development processes (NBDHE Technical Report, 2020). Staff are trained in procedures for handling secure materials and are required to comply with JCNDE policies regarding confidentiality and conflict of interest. In addition, test constructor SMEs involved in examination development processes must complete agreements regarding confidentiality, copyright assignment, and conflict of interest.

All computers used by JCNDE staff and by Pearson VUE for examination administration are protected with firewalls, login identifications, passwords, and other forms of security (NBDHE Technical Report, 2020). Access to electronic files is limited to authorized individuals. Access to facilities where NBDHE materials are stored is restricted, and electronic formats of examination materials are protected by firewalls, login identifications, passwords, and encryption.

> Finding 25: The security procedures practiced by JCNDE with regard to the maintenance of examination materials are consistent with professional guidelines and technical standards.

Test Security – Test Sites

JCNDE contracts with Pearson VUE for administration of the NBDHE, and Pearson VUE staff are trained in procedures for maintaining security of examination materials at test facilities (NBDHE Technical Report, 2020). In addition, JCNDE reviews Pearson VUE's operations to ensure compliance with security policy and procedures.

At test sites, candidates are required to provide current and valid government-issued identification to sit for the examination (NBDHE Candidate Guide, 2020). In addition, Pearson VUE staff uses biometric technology to capture each candidate's identity.

The 2020 NBDHE Candidate Guide lists items that candidates are prohibited from bringing into secure testing areas (NBDHE Candidate Guide, 2020). Prohibited items include, but are not limited to, outside books or reference materials, electronic devices, and accessories. In addition, the 2020 NBDHE Candidate Guide describes the examination rules of conduct and prohibited behaviors, including examination subversion or falsification of information.

During candidate check-in, Pearson VUE staff perform visual inspections to check for recording devices or other prohibited items. Pearson VUE staff may also use a wand to detect electronic devices.

All testing sessions for the NBDHE are monitored by staff at the test center. Proctors at Pearson VUE testing centers are trained to recognize potential test security breaches. In addition, testing sessions at Pearson VUE sites are video recorded.

> Finding 26: The security procedures practiced by JCNDE regarding test sites are consistent with professional guidelines and technical standards.

CONCLUSIONS

Given the findings, the test center security procedures at Pearson VUE appear to meet professional guidelines and technical standards.

CHAPTER 8 | COMPARISON OF THE NBDHE BLUEPRINT WITH THE CALIFORNIA DESCRIPTION OF PRACTICE OUTLINE

PARTICIPATION OF SUBJECT MATTER EXPERTS

OPES convened a two-day workshop on May 14–15, 2020 to evaluate the NBDHE test specifications resulting from the 2016 JCNDE OA and to compare them with the California registered dental hygienist description of practice based on the OPES 2019 California OA of the Registered Dental Hygienist Profession (California RDH OA, 2019).

OPES recruited seven SMEs to participate in the workshop. The SMEs represented the profession in terms of geographical location in California. Two of the SMEs had been licensed for 1–5 years, one had been licensed for 6–10 years, three had been licensed for 11–19 years, and one had been licensed for more than 20 years. All SMEs worked as dental hygienists in various settings.

WORKSHOP PROCESS

First, the SMEs completed OPES' security agreement, self-certification, secure area agreement, and personal data (demographic) forms. The OPES facilitator explained the importance of, and the guidelines for, security during and outside the workshop.

Next, the OPES facilitator gave a PowerPoint presentation about the purpose and importance of OA, validity, content validity, reliability, test administration standards, examination security, and the role of SMEs. The OPES facilitator also explained the purpose of the workshop.

The SMEs were instructed to evaluate and link each task and knowledge statement of the California description of practice to the disciplines and subdisciplines included on the NBDHE test specifications. The SMEs worked as a group to evaluate and link all of the task and knowledge statements of the California description of practice.

The main disciplines and subdisciplines of the NBDHE are provided in Table 1. Table 2 provides the content areas of the 2019 California description of practice.

TABLE 1 – COMPONENTS AND DISCIPLINES OF THE NBDHE BLUEPRINT

COMPONENT	WEIGHT
A. Discipline-Based Component	**57%**
1. Scientific Basis for Dental Hygiene Practice	17%
2. Provision of Clinical Dental Hygiene Services	33%
3. Community Health/Research Principles	7%
B. Case-Based Items	**43%**

TABLE 2 – CONTENT AREAS OF THE 2019 CALIFORNIA REGISTERED DENTAL HYGIENIST DESCRIPTION OF PRACTICE

Content Area	Content Area Description	Percent Weight
1. Treatment Preparation	This area assesses the candidate's knowledge of preparing the operatory and patient dental hygiene services.	5%
2. Dental Hygiene Treatment	This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.	40%
3. Patient Education	This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.	10%
4. Infection Control	This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.	15%
5. Documentation	This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental records.	5%
6. Laws, Regulations, and Ethics	This area assesses the candidate's knowledge of licensing requirements, professional conduct, patient confidentiality, use of telehealth methods and technology, and mandated reporting.	25%
Total		**100%**

FINDINGS

The SMEs compared the task and knowledge statements of the 2019 California description of practice outline and the NBDHE test specifications. The SMEs concluded that the NBDHE adequately assessed the knowledge required for entry-level dental hygiene practice in California in the following areas:

- Treatment preparation
- Dental hygiene treatment
- Patient education
- Infection control
- Documentation

The SMEs indicated that the NBDHE did not adequately assess the content area Laws, Regulations, and Ethics. However, this content is measured by the California-specific Registered Dental Hygienist Law and Ethics Examination.

Finding 27: The SMEs concluded that the content of the NBDHE adequately assesses the knowledge required for entry-level dental hygiene practice in California.

Finding 28: The SMEs concluded that the content of the NBDHE does not adequately assess the knowledge of laws and ethics required for practice in California. SMEs concluded that this content should continue to be measured using a California-specific law and ethics examination.

CONCLUSIONS

Given the findings, the content of the NBDHE sufficiently assesses the knowledge necessary for competent dental hygiene practice at the time of licensure in California.

CHAPTER 9 | CONCLUSIONS

COMPREHENSIVE REVIEW OF THE JCNDE NBDHE PROGRAM

OPES completed a comprehensive analysis and evaluation of the documents provided by JCNDE.

OPES finds that the procedures used to establish and support the validity and defensibility of the NBDHE (i.e., OA, examination development, passing scores and passing rates, test administration, examination scoring and performance, and test security procedures) meet professional guidelines and technical standards as outlined in the *Standards* and in California B&P Code § 139.

However, OPES finds that the service of board members and educators in examination development processes is not fully compliant with OPES 20-01, as mandated by B&P Code § 139. OPES recommends phasing out the service of board members and educators as SMEs.

Given the findings regarding the NBDHE, OPES supports the Dental Hygiene Board of California's continued use of the NBDHE for licensure in California as part of its licensure examination program.

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Dental Hygiene
Board of California

REVIEW OF THE CENTRAL REGIONAL DENTAL TESTING SERVICE (CRDTS) DENTAL HYGIENE EXAMINATION

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

DENTAL HYGIENE BOARD OF CALIFORNIA

REVIEW OF THE CENTRAL REGIONAL DENTAL TESTING SERVICE (CRDTS) DENTAL HYGIENE EXAMINATION

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

This report is mandated by California Business and Professions (B&P) Code § 139 and by DCA Licensure Examination Validation Policy OPES 18-02.

EXECUTIVE SUMMARY

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs used in the California licensure process comply with psychometric and legal standards. The Dental Hygiene Board of California (Board) requested that DCA's Office of Professional Examination Services (OPES) complete a comprehensive review of the Central Regional Dental Testing Services (CRDTS) patient-based Dental Hygiene Examination. The purpose of the OPES review was to evaluate the suitability of the patient-based CRDTS Dental Hygiene Examination for continued use in California licensure.

To become licensed as a registered dental hygienist in California, the Board requires candidates to have requisite education and experience and to pass three examinations:

1. The National Board Dental Hygiene Examination (NBDHE)
2. The Western Regional Examining Board (WREB) Dental Hygiene Examination or the CRDTS Dental Hygiene Examination
3. The California Registered Dental Hygienist Law and Ethics Examination

The CRDTS Dental Hygiene Examination is a patient-based clinical examination that measures skills in four areas:

1. Extra/intra Oral Assessment
2. Periodontal Probing
3. Scaling/Subgingival Calculus Removal
4. Supragingival Deposit Removal

In 2017, CRDTS collaborated with WREB to conduct an occupational analysis (OA) for the dental hygienist profession and to update the examination blueprint for the patient-based CRDTS Dental Hygiene Examination.

OPES, in collaboration with the Board and CRDTS, received and reviewed the results of the 2017 OA, as well as other documents provided by CRDTS. OPES performed a comprehensive evaluation of the documents to determine whether the following test program components met professional guidelines and technical standards: (a) OA, (b) examination development, (c) passing scores and passing rates, (d) test registration and administration, (e) examination scoring and performance, and (f) test security procedures. Follow-up emails were exchanged to clarify the procedures and practices used to validate and develop the patient-based CRDTS Dental Hygiene Examination.

OPES found that the procedures used to develop and administer the patient-based CRDTS Dental Hygiene Examination are *generally* consistent with professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* (2014) *(Standards)* and California Business and Professions (B&P) Code § 139. However, OPES made recommendations for CRDTS to consider, particularly regarding standardization, scoring, and documentation of the passing score process.

In addition to reviewing documents provided by CRDTS, OPES convened a workshop of licensed California registered dental hygienists to serve as subject matter experts (SMEs) to review the content of the patient-based CRDTS Dental Hygiene Examination. The SMEs were selected by the Board to represent the profession in terms of geographic location, experience, and specialty. The purpose of the review workshop was to compare the content of the patient-based CRDTS Dental Hygiene Examination with the California registered dental hygienist description of practice that resulted from the 2019 California Occupational Analysis of the Registered Dental Hygienist Profession (California RDH OA, 2019) performed by OPES. During this workshop, the SMEs compared the task and knowledge statements from the California description of practice to the examination content of the patient-based CRDTS Dental Hygiene Examination. A linkage study was performed to identify whether there were areas of California dental hygiene practice that are not measured by the CRDTS Dental Hygiene Examination.

The results of the linkage study indicated that skills associated with four of the six areas included in the California dental hygiene description of practice were adequately linked to the content of the patient-based CRDTS Dental Hygiene Examination. SMEs concluded that one of the content areas, Patient Education, was not adequately assessed by the CRDTS Dental Hygiene Examination. However, SMEs determined that this content area is assessed by other examinations. In addition, the SMEs indicated that the content area Laws, Regulations, and Ethics was not adequately assessed by the content of the patient-based CRDTS Dental Hygiene Examination and should continue to be measured by the California-specific law and ethics examination.

In its evaluation, OPES found that while the patient-based CRDTS Dental Hygiene Examination was *generally* consistent with technical standards regarding validity, there are standardization challenges associated with the use of live patients. OPES further found a consistently high passing rate on the patient-based CRDTS Dental Hygiene Examination. This may indicate that candidates receive sufficient training in their pre-licensure clinical examinations to prepare them for safe and effective dental hygiene practice. Given these findings, OPES recommends that the Board consider conducting an evaluation to determine whether a skills-based examination is necessary for assessing a candidate's competence for practice, or whether a knowledge-based examination may be sufficient to assess minimum competence for licensure.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1 | INTRODUCTION

PURPOSE OF THE COMPREHENSIVE REVIEW

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs used in the California licensure process comply with psychometric and legal standards. The public must be reasonably confident that an individual passing a licensure examination has the requisite knowledge and skills to competently and safely practice in the profession.

The Dental Hygiene Board of California (Board) requested that DCA's Office of Professional Examination Services (OPES) complete a comprehensive review of the Central Regional Dental Testing Service (CRDTS) patient-based Dental Hygiene Examination. The CRDTS Dental Hygiene Examination is a patient-based clinical examination that measures a candidate's competence in performing the skills required for dental hygiene practice in four areas:

1. Extra/intra Oral Assessment
2. Periodontal Probing
3. Scaling/Subgingival Calculus Removal
4. Supragingival Deposit Removal

Assessment also incorporates evaluation of a candidate's ability to prevent tissue trauma during prophylaxis procedures.

OPES' review of the patient-based CRDTS Dental Hygiene Examination had three purposes:

1. To evaluate the suitability of the patient-based CRDTS Dental Hygiene Examination for use in California.
2. To determine whether the patient-based CRDTS Dental Hygiene Examination meets the professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* (2014) (*Standards*)[1] and California Business and Professions (B&P) Code §139.
3. To identify any areas of California dental hygiene practice that the patient-based CRDTS Dental Hygiene Examination does not assess.

[1] See Chapter 10 for the complete reference to the *Standards.*

In relation to the *Standards*, evaluating the acceptability of an examination does not involve determining whether the examination satisfies each individual standard interpreted literally. The importance of each standard varies according to circumstances. Page 7 of the *Standards* states:

> Individual standards should not be considered in isolation. Therefore, evaluating acceptability depends on (a) professional judgment that is based on a knowledge of behavioral science, psychometrics, and the relevant standards in the professional field to which the test applies; (b) the degree to which the intent of the standard has been satisfied by the test developer and user; (c) the alternative measurement devices that are readily available; (d) research and experiential evidence regarding the feasibility of meeting the standard; and (e) applicable laws and regulations.

OPES, in collaboration with the Board, requested documentation from CRDTS to determine whether the following CRDTS Dental Hygiene Examination program components met professional guidelines and technical standards outlined in the *Standards* and B&P Code § 139: (a) occupational analysis (OA),[2] (b) examination development, (c) passing scores and passing rates,[3] (d) test registration and administration, (e) examination scoring and performance, and (f) test security procedures.

CALIFORNIA LAW AND POLICY

Section 139 (a) of the California B&P Code states:

> The Legislature finds and declares that occupational analyses and examination validation studies are fundamental components of licensure programs.

It further requires that DCA develop a policy to address the minimum requirements for psychometrically sound examination validation, examination development, and occupational analyses, including standards for the review of state and national examinations.

DCA Licensure Examination Validation Policy OPES 18-02 (OPES 18-02) specifies the *Standards* as the most relevant technical and professional standards to be followed to ensure that examinations used for licensure in California are psychometrically sound, job-related, and legally defensible.

FORMAT OF THE REPORT

The chapters of this report provide the relevant standards related to psychometric aspects of the patient-based CRDTS Dental Hygiene Examination and describe the findings and recommendations that OPES identified during its review.

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[2] An occupational analysis is also known as a job analysis, practice analysis, or task analysis.
[3] A passing score is also known as a pass point or cut score.

CHAPTER 2 | OCCUPATIONAL ANALYSIS

STANDARDS

The following standard is most relevant to conducting OAs for licensure examinations, as referenced in the *Standards.*

Standard 11.13

> 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 and evidence should be provided to support the claim that the knowledge or skills being assessed are required for credential-worthy performance in that occupation and are consistent with the purpose for which the credentialing program was instituted (pp. 181-182).

The comment following Standard 11.13 emphasizes its relevance:

> *Comment:* Typically, some form of job or practice analysis provides the primary basis for defining the content domain. If the same examination is used in the credentialing of people employed in a variety of settings and specialties, a number of different job settings may need to be analyzed. Although the job analysis techniques may be similar to those used in employment testing, the emphasis for credentialing is limited appropriately to knowledge and skills necessary for effective practice...
>
> In tests used for licensure, knowledge and skills that may be important to success but are not directly related to the purpose of licensure (e.g., protecting the public) should not be included (p. 182).

California B&P Code § 139 requires that each California licensing board, bureau, commission, and program report annually on the frequency of its OAs and the validation and development of its examinations. OPES 18-02 states:

> Generally, an occupational analysis and examination outline should be updated every five years to be considered current; however, many factors are taken into consideration when determining the need for a different interval. For instance, an occupational analysis and examination outline must be updated whenever there are significant changes in a profession's job tasks and/or demands, scope of practice, equipment, technology, required knowledge, skills and abilities, or laws and regulations governing the profession (p. 4).

FINDINGS

In 2017, CRDTS collaborated with the Western Regional Examining Board (WREB) to conduct an OA for the dental hygiene profession. This OA was conducted at the national level. Results of this OA were documented for a presentation at a CRDTS and WREB Joint Dental Hygiene Practice Analysis Meeting in 2018 (CRDTS and WREB Joint Meeting, 2018), and in the WREB 2017–18 Dental Hygiene Practice Analysis: Report of Findings Prepared for the CRDTS and WREB Joint Dental Hygiene Practice Analysis Committee (WREB Practice Analysis Report, 2020).

Occupational Analysis – Methodology and Time Frame

The purpose of the OA was to provide evidence to state licensing boards in support of decisions regarding candidate readiness for professional practice, to draw reliable inferences regarding minimal competence from candidate performance, and to determine the appropriate content to assess performance levels and set passing standards (CRDTS and WREB Joint Meeting, 2018). The methodology used to conduct the OA was an online survey that described the practices (job tasks) performed by dental hygienists.

The survey was developed by CRDTS and WREB and was designed to be comparable to surveys administered by both testing agencies in prior OAs. A Joint Dental Hygiene Practice Analysis Committee (Practice Analysis Committee) was also involved in the development process. The Practice Analysis Committee comprised six subject matter experts (SMEs), who were selected from WREB and CRDTS member states. All SMEs had a minimum of 20 years of experience in the dental hygiene profession and were experienced board examiners or dental hygiene educators (WREB Practice Analysis Report, 2020).

The online survey was then completed by dental hygienists who were members of the American Dental Hygienists' Association (ADHA).

> Finding 1: The most recent OA was completed in 2017. The OA was conducted within a time frame considered to be current and legally defensible.
>
> Finding 2: The previous OA conducted by CRDTS occurred in 2012. The interval between the previous OA and the start of the current one complies with DCA policy established under B&P Code § 139, which specifies that an OA should be conducted every 5 years.

Occupational Analysis – Development of Survey Instrument

In 2017, CRDTS and WREB collaboratively developed a survey to perform an OA of dental hygiene practice. The survey was developed by evaluating the major content domains and practices (tasks) listed on previous surveys administered by both organizations. Similar practice statements were combined, and additional restorative and anesthesia practices were added (WREB email communication, June 2020). Three WREB SMEs from the Practice Analysis Committee reviewed the practice (task) statements and the final survey. CRDTS SMEs on the Practice Analysis Committee also reviewed the statements and survey (WREB email communication, June 2020).

The final survey included three sections. The first section comprised eight demographic questions designed to gather information about the survey respondents and their practice setting. This section also included questions specifically for respondents who practiced in a clinical setting. The section asked them how frequently they performed adult prophylaxis procedures, non-surgical periodontal procedures, and periodontal maintenance procedures. The second section of the survey comprised 49 practices (tasks) that were distributed across three content areas related to dental hygiene practice. Respondents were asked to rate each practice (task) on two rating scales: importance to practice (very important, somewhat important, or less important) and frequency of performance of the task (routinely, occasionally, or rarely). The third section of the survey asked respondents to provide comments or suggestions (WREB Practice Analysis Report, 2020).

> Finding 3: The procedure used by CRDTS to develop the survey instrument generally complies with professional guidelines and technical standards.
>
> Finding 4: The development of the survey involved six SMEs, all of whom were licensed more than 20 years. To better represent the profession in terms of entry level practice, practice setting, and geographical location, more than six SMEs should be involved in the survey development process.

Occupational Analysis – Sampling Plan

The sampling plan for the study involved sending invitation emails to all of the 14,418 members of the ADHA in October 2017 (WREB Practice Analysis Report, 2020).

Of the 14,418 members, 27% of the respondents completed the survey with enough detail to provide valid data. Of the 3,901 usable respondents, 27% were from the western region of the United States, with 228 (5.8%) from California.

> Finding 5: The intent of the sampling plan and the overall response rate were acceptable. The number of survey respondents from California was sufficient to ensure representation of licensed California registered dental hygienists.

Occupational Analysis – Survey Results

After administering the survey, CRDTS and WREB collected the data and analyzed the survey results. Analyses included descriptive statistics calculated for each dental hygiene practice (task) included on the survey. Ratings on frequency and importance scales were combined using a multiplicative model that resulted in a potential range of 1 to 9. The frequency-importance product values were rank-ordered and presented to the Practice Analysis Committee for review.

Analyses also included correlation and linear regression to compare results for dental hygiene practices (tasks) with the results obtained on previous OA surveys. Overall, frequency-importance values for practices (tasks) included on the current OA had a correlation of .94 with those included on a previous OA conducted by CRDTS in 2012 (WREB Practice Analysis Report, 2020).

> Finding 6: The respondents comprised dental hygienists throughout the United States. Of the respondents, 48.4% had been practicing for 20 years or longer, 22.1% had been practicing for 10–20 years, 10% had been practicing for 5–10 years, and 18.6% had been practicing for less than 5 years. Approximately 51% of respondents were from CRDTS and WREB member states, while 49% were from other states.
>
> A majority of respondents indicated practicing in a private setting (75.6%), while 19.5% indicated that they worked in an educational setting. Fewer than 10% of respondents gave their practice setting as either a public health agency, corporate dental office, hospital/care facility, or the military.
>
> Four questions on the survey were directed toward dental hygienists who were actively practicing in a clinical setting. These questions pertained to the frequency of adult prophylaxis, non-surgical periodontal procedures, and periodontal maintenance procedures performed. All other practices (tasks) were rated by all survey respondents.

Occupational Analysis – Decision Rules and Final Examination Blueprint

The results of the survey were reviewed by the Practice Analysis Committee in April 2018. The Practice Analysis Committee SMEs discussed the results of the survey in conjunction with CRDTS' current examination blueprint. SMEs evaluated whether there were any prominent shifts in practice and whether any changes were required on the current CRDTS Dental Hygiene Examination (WREB Practice Analysis Report, 2020).

The Practice Analysis Committee SMEs indicated that there were no major shifts in the practices (tasks) performed by dental hygienists. The SMEs further determined that the practices (tasks) of intraoral examination, periodontal assessment, gingival recession assessment, and non-surgical periodontal treatments continue to be important and should remain the major components of the patient-based CRDTS Dental Hygiene Examination (WREB Practice Analysis Report, 2020).

Finding 7: The linkage between the practices (tasks) required for entry-level dental hygienists and the major content areas of the CRDTS Dental Hygiene Examination demonstrates a sufficient level of validity, thereby meeting professional guidelines and technical standards.

RECOMMENDATIONS

Recommendation 1: Results of OAs are used to develop licensure examinations that measure the competencies required for practice. To ensure that examination content accurately reflects these competencies, survey responses should be obtained from licensed dental hygienists who are currently practicing. With the exception of responses to four questions, it appears that ratings of practices on the OA survey included responses from licensees who may not have been actively providing clinical services. OPES recommends that future OAs exclude responses obtained from dental hygienists who are retired or otherwise not currently engaged in dental hygiene practice.

Recommendation 2: Licensure examinations should measure the competencies required at initial licensure, and not those gained over time. As such, examination content should be based on the results of an OA that includes a representative sample of entry-level practitioners. Entry-level is generally defined as a practitioner licensed 5 years or less. OPES recognizes the sampling limitations involved in conducting an OA of this scope and commends the efforts made by CRDTS and WREB to sample from this demographic. However, OPES recommends that future OAs attempt to increase the participation of practitioners licensed less than 5 years to ensure adequate representation of entry-level perspectives.

CONCLUSIONS

The OA conducted by CRDTS in conjunction with WREB appears to be reasonably consistent with professional guidelines and technical standards. Additionally, the examination blueprint for the patient-based CRDTS Dental Hygiene Examination appears to be based on the results of the OA, which is consistent with professional guidelines and technical standards.

CHAPTER 3 | EXAMINATION DEVELOPMENT

STANDARDS

Examination development includes many steps within an examination program, from the development of an examination outline to scoring and analyzing items after the administration of an examination. Several specific activities involved in the examination development process are evaluated in this section. The activities include development of examination content, linkage of examination content to the examination outline, and developing scoring criteria.

The following standards are most relevant to examination development for licensure examinations, as referenced in the *Standards.*

> **Standard 4.7**
>
> The procedures used to develop, review, and try out items and to select items from the item pool should be documented (p. 87).
>
> **Standard 4.12**
>
> Test developers should document the extent to which the content domain of a test represents the domain defined in the test specifications (p. 89).

The following regulations are relevant to the integrity of the examination development process:

> California B&P Code § 139 requires the Department of Consumer Affairs to develop a policy on examination validation which includes minimum requirements for psychometrically sound examination development.
>
> DCA Policy Participation in Examination Development Workshops OPES 20-01 (OPES 20-01), as mandated by B&P Code § 139, specifies that board members, committee members, and instructors should not serve as expert consultants in the licensure examination development process. This is due to potential conflict of interest, undue influence, and security considerations.

FINDINGS

Examination Development – Subject Matter Experts

In 1978, CRDTS adopted an examination model for the patient-based Dental Hygiene Examination. The examination model resulted from a large-scale national study that involved 22 field studies conducted by the ADHA, according to the CRDTS' National Dental Examination Report for the Year Ending 2017 (CRDTS Technical Report, 2017).

Following adoption of the 1978 model, CRDTS performed additional calibration and statistical analyses. In 2004, CRDTS worked in conjunction with the American Board of Dental Examiners

(ADEX) to develop a national dental hygiene clinical examination representative of all regional testing agencies. The results of this development project formed the basis of the CRDTS Dental Hygiene Examination.

In 2009, CRDTS discontinued its association with ADEX, but maintained the design and structure of the original patient-based CRDTS Dental Hygiene Examination (CRDTS Technical Report, 2017). Since 2009, CRDTS has maintained responsibility for refining the patient-based Dental Hygiene Examination based on the most current OA and statistical data.

The content of the patient-based CRDTS Dental Hygiene Examination undergoes periodic review and revision by the CRDTS Dental Hygiene Examination Review Committee (ERC), according to the CRDTS 2020 Dental Hygiene Candidate Manual (CRDTS Candidate Manual, 2020, p. 4). The ERC comprises representatives from CRDTS member states, dental hygiene educators, and special consultants. The ERC reviews the results of practice surveys, current curricula, and standards of competency to ensure that the content and protocol of the patient-based CRDTS Dental Hygiene Examination remains current and relevant to practice.

> Finding 8: The procedures used to develop and review the content of the patient-based CRDTS Dental Hygiene Examination appear relatively consistent with professional guidelines and technical standards. However, the use of board members and educators in the examination development process is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Examination Development – Linkage to Examination Blueprint

In 2018, the Practice Analysis Committee met to verify the linkage between the results of the OA and the content domains of the patient-based CRDTS Dental Hygiene Examination blueprint (examination specifications). The ERC also reviewed the results of the OA and confirmed that the content domains specified in the patient-based CRDTS Dental Hygiene Examination blueprint are accurate (CRDTS telephone communication, December 2020).

> Finding 9: The methods used to establish the linkage between examination content and the competencies necessary for practice appear consistent with professional guidelines and technical standards.

Examination Development – Item Field Testing

The patient-based CRDTS Dental Hygiene Examination is a clinical examination that measures a candidate's ability to competently perform in four main content domains of dental hygiene practice. The items included in the content domains are the product of years of field testing and refinement (CRDTS Technical Report, 2017). In addition, CRDTS performs ongoing reviews of item performance in frequent ERC meetings.

> Finding 10: The procedures used to develop, review, and field test items comprising the patient-based CRDTS Dental Hygiene Examination appear consistent with professional guidelines and technical standards.

Examination Development – Examination Forms

The content domains included in the patient-based CRDTS Dental Hygiene Examination remain consistent across examination administrations. Items included on the examination are differentially weighted according to subtest (content areas). The subtest Extra-intra Oral Assessment consists of 8 items (2 points each); Periodontal Probing consists of 12 items (1 point each); Scaling/subgingival Calculus Removal consists of 12 items (5 points each); and Supragingival Deposit Removal consists of 6 items (2 points each) (CRDTS Candidate Manual, 2020). The subtests (content areas) and assessed items are linked to the existing examination blueprint, which resulted from the 2017 OA.

The CRDTS Dental Hygiene Examination undergoes frequent review by the ERC (CRDTS telephone conversation, May 2020). The ERC reviews analyses of candidate performance and technical information about examiner agreement. Based on these analyses, ERC makes recommendations for adjustment or refinement to examination content, administration procedures, or scoring.

> Finding 11: The procedures used to develop and refine examination content included on the patient-based CRDTS Dental Hygiene Examination are generally consistent with professional guidelines and technical standards. However, the use of board members and educators is not compliant with OPES 20-01, as mandated by B&P Code § 139.

RECOMMENDATIONS

> Recommendation 3: OPES recognizes that CRDTS requires the participation of practitioners from member states to develop and administer examinations. In order to be fully compliant with OPES 20-01, OPES recommends phasing out or limiting the service of board members and educators during examination development processes.

CONCLUSIONS

Given the findings, the examination development activities conducted by CRDTS appear to be generally consistent with professional guidelines and technical standards with regard to development of examination content, to the linkage of examination content to the examination blueprint, and to the testing and review of examination performance. To reduce the potential for conflict of interest, OPES recommends phasing out the use of board members and educators as SMEs.

CHAPTER 4 | PASSING SCORES AND PASSING RATES

STANDARDS

The passing score of an examination is the score that represents the level of performance that divides those candidates for licensure who are minimally competent from those who are not competent.

The following standards are most relevant to passing scores, cut points, or cut scores for licensure examinations, as referenced in the *Standards.*

> **Standard 5.21**
>
> When proposed score interpretations involve one or more cut scores, the rationale and procedures used for establishing cut scores should be documented clearly (p. 107).
>
> **Standard 11.16**
>
> The level of performance required for passing a credentialing test should depend on the knowledge and skills necessary for credential-worthy performance in the occupation or profession and should not be adjusted to control the number or proportion of persons passing the test (p. 182).

The supporting commentary on passing or cut scores for Chapter 5 of the *Standards*, "Scores, Scales, Norms, Score Linking, and Cut Scores," states that the standard-setting process used should be clearly documented and defensible. The qualifications of the judges involved and the process of selecting them should be part of the documentation. A sufficiently large and representative group of judges should be involved, and care must be taken to ensure that judges understand the process and procedures they are to follow (p. 101).

In addition, the supporting commentary for Chapter 11 of the *Standards*, "Workplace Testing and Credentialing," states that the focus of tests used in credentialing is on "the standards of competence needed for effective performance (e.g., in licensure this refers to safe and effective performance in practice)" (p. 175). It further states, "Standards must be high enough to ensure that the public, employers, and government agencies are well served, but not so high as to be unreasonably limiting" (p. 176).

FINDINGS

Passing Scores – The CRDTS Dental Hygiene Examination: Process, Use of Subject Matter Experts, and Methodology

The passing score for the patient-based CRDTS Dental Hygiene Examination is set at 75 out of 100 possible points. CRDTS adopted this passing score to establish uniformity with states that have a passing score set in regulation and to align with the cut score used by the Joint Commission on National Dental Examinations (CRDTS Technical Report, 2017).

CRDTS is a testing agency, and the final decision regarding passing scores is up to the individual state licensing agency. California has adopted the CRDTS-recommended passing score of 75 for the patient-based CRDTS Dental Hygiene Examination.

> Finding 12: It is unclear whether the methods used to set the passing score for the patient-based CRDTS Dental Hygiene Examination meet professional guidelines and technical standards. The CRDTS Technical Report (2017) references a test development project (CORE) that was conducted in conjunction with the Northeast Regional Board in 1993. This project sought to establish a uniform cut score that would be "acceptable in any state" (CRDTS Technical Report, 2017, p. 25). As a result of this project, CRDTS reweighted its rating scale. Additionally, this report indicates that in the fall of 2003, CRDTS changed the passing score for the Dental Hygiene Examination from 70 to 75. However, no information was provided regarding the 1993 study, the processes used to establish the passing score, or how the passing score relates to current standards of minimum competence for safe practice.

Passing Rates

CRDTS tracks passing rates for individual educational programs within each state and provides annual reports to licensing agencies and each dental hygiene school (CRDTS Technical Report, 2017). These reports provide information regarding candidate mean scores and overall pass rates by educational institution, as well as candidate mean scores on each of the four major subtests (content areas) included on the patient-based CRDTS Dental Hygiene Examination. Data for educational institutions with fewer than four candidates are excluded from analyses.

OPES requested reports of pass rates for the past five years. However, the patient-based CRDTS Dental Hygiene Examination was discontinued in early 2020 due to the COVID-19 pandemic, and data were not provided for candidates who took the examination in 2020. Therefore, results analyzed for this report are based solely on data for the years 2015–2019.

> Finding 13: For the years 2015–2019, passing rates for California candidates across educational institutions were consistently high. The number of candidates who took the examination each year ranged from 191–226. The number of educational institutions included in the analyses ranged from 10–13. Overall pass rates for the majority of educational institutions tended to be above 90%, with many demonstrating a pass rate of 100%. In each of the years evaluated, there were two educational institutions with pass

rates below 90%. These institutions varied across years; however, data indicated that candidates at these institutions tended to incur penalties related to treatment selection and patient rejection, which likely had a significant impact on mean scores.

Statistics regarding candidate performance on individual sections of the examination indicated that California candidates tended to perform well on all subtests (content areas). In all of the years analyzed, candidate mean scores for the majority of educational institutions were typically within one point of the maximum possible points on the subtests (content areas) Extra/intra Oral Assessment, Periodontal Probing, and Supragingival Deposit Removal. The content area Scaling/Subgingival Calculus Removal produced the greatest variability in candidate mean scores; however, this variability may reflect treatment selection penalties and variance associated with case complexity.

CRDTS states that the high passing rates are to be expected given the high level of training candidates receive before taking the patient-based CRDTS Dental Hygiene Examination (CRDTS Technical Report, 2017).

Finding 14: Reports provided by CRDTS exclude data for educational institutions where fewer than four candidates took the examination. As a result, complete and accurate data for California candidates is not readily available. In addition, the data presented does not allow evaluation of the impact of penalties on candidate scores.

RECOMMENDATIONS

Recommendation 4: OPES recognizes that many CRDTS member states may legislate an absolute passing standard, which is commonly set at 75%. However, OPES has advised that California boards avoid using absolute passing scores for licensure examinations and instead use a criterion-referenced passing score methodology that reflects the competencies required for practice. Many regional or national examination programs use a scaled scoring process based on minimum competence to meet this requirement. It is possible that the methodology used by CRDTS to establish its passing score complies with professional standards and guidelines; however, it is unclear from the documentation provided.

Further, the documentation provided references projects and passing score changes that occurred in 1993 and 2003. OPES recommends that CRDTS clearly document the processes used to establish the passing score for the patient-based Dental Hygiene Examination and how the passing score relates to minimum competence standards. Further, this documentation should describe the role of SMEs in providing professional judgements and should specify ongoing steps taken to ensure that the passing score reflects *current* competency standards.

Recommendation 5: Reports provided by CRDTS allow its member states to evaluate candidate performance by educational institution. Data for educational institutions with fewer than four candidates is not reported. As a result, it is difficult to fully evaluate the performance of California candidates on the examination. OPES recommends that CRDTS provide information in reports regarding the performance of all California candidates. Further, reports do not provide information regarding the number of penalties assessed except for the penalties associated with treatment selection and tissue trauma. OPES recommends that CRDTS include this information in its reports to allow for a full assessment of how California candidates perform on the examination.

CONCLUSIONS

Given the findings, the process of establishing passing scores fails to demonstrate a robust methodology. It is unclear whether the methodologies used by CRDTS in setting the passing score for the patient-based CRDTS Dental Hygiene Examination demonstrate a sufficient degree of validity to meet professional guidelines and technical standards.

Given the findings, the passing rates for the CRDTS Dental Hygiene Examination indicate that California candidates perform exceptionally well. If the passing score appropriately reflects minimum competence, the high passing rates may indicate that California candidates are receiving adequate training in education programs to prepare them for demonstrating minimum competence for practice.

CHAPTER 5 | TEST REGISTRATION AND ADMINISTRATION

STANDARDS

The following standards are most relevant to standardizing the test administration process for licensing examinations, as referenced in the *Standards.*

Standard 3.4

Test takers should receive comparable treatment during the test administration and scoring process (p. 65).

Standard 4.15

The directions for test administration should be presented with sufficient clarity so that it is possible for others to replicate the administration conditions under which the data on reliability, validity, and (where appropriate) norms were obtained. Allowable variations in administration procedures should be clearly described. The process for reviewing requests for additional testing variations should also be documented (p. 90).

Standard 4.16

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 materials, practice or sample questions, criteria for scoring, and a representative item identified with each item format or major area in the test's classification or domain should be provided to the test takers prior to the administration of the test or should be included in the testing material as part of the standard administration instructions (p. 90).

Standard 6.1

Test administrators should follow carefully the standardized procedures for administration and scoring specified by the test developer and any instructions from the test user (p. 114).

Standard 6.2

When formal procedures have been established for requesting and receiving accommodations, test takers should be informed of these procedures in advance of testing (p. 115).

Standard 6.3

Changes or disruptions to standardized test administration procedures or scoring should be documented and reported to the test user (p. 115).

Standard 6.4

The testing environment should furnish reasonable comfort with minimal distractions to avoid construct-irrelevant variance (p. 116).

Standard 6.5

Test takers should be provided appropriate instructions, practice, and other support necessary to reduce construct-irrelevant variance (p. 116).

Standard 8.1

Information about test content and purposes that is available to any test taker prior to testing should be available to all test takers. Shared information should be available free of charge and in accessible formats (p. 133).

Standard 8.2

Test takers should be provided in advance with as much information about the test, the testing process, the intended test use, test scoring criteria, testing policy, availability of accommodations, and confidentiality protection as is consistent with obtaining valid responses and making appropriate interpretations of test scores (p. 134).

FINDINGS

The patient-based CRDTS Dental Hygiene Examination is administered throughout the calendar year at test sites located in CRDTS' member states. Due to the COVID-19 pandemic, administration of the patient-based CRDTS Dental Hygiene Examination was temporarily suspended at many testing locations in 2020. However, CRDTS continued offering the patient-based examination where facilities were available through 2020, and CRDTS intends to continue offering it in 2021.

CRDTS provides information about the patient-based CRDTS Dental Hygiene Examination to candidates and prospective candidates through its website at https://www.crdts.org.

Test Administration – Candidate Registration

Candidates register to take the patient-based CRDTS Dental Hygiene Examination by applying online and providing proof of qualification to sit for the examination (CRDTS Candidate Manual, 2020). Candidates must provide a U.S. government-issued social security number that becomes part of the candidate's record. Candidates are assigned a 10-digit number that becomes associated with all candidate forms and that can be used by candidates when accessing the CRDTS website (CRDTS Candidate Manual, 2020). Candidates are also required to submit a passport quality photo that becomes associated with their record.

The CRDTS website and the 2020 Candidate Manual provide detailed instructions and information regarding the application and registration process, including:

- Applying for the examination
- Uploading required documents
- Paying for an examination
- Monitoring candidate status

Finding 15: The CRDTS registration process appears straightforward. The information available to candidates is detailed and comprehensive. The candidate registration process appears to meet professional guidelines and technical standards.

Test Administration – Accommodation Requests

CRDTS complies with the Americans with Disabilities Act and provides reasonable accommodations to candidates with documented disabilities. Candidates with a disability are required to submit, along with their application, a written request for an auxiliary aid or modification (CRDTS Candidate Manual, 2020). In addition, candidates must provide documentation from a qualified health care provider, who must specify the portion of the exam for which the auxiliary aid or modification is needed. In determining whether to grant the use of auxiliary aids or modifications, CRDTS reserves the right to consider implications for examination security.

Finding 16: CRDTS' accommodation procedures appear consistent with professional guidelines and technical standards.

Test Administration – Test Centers and Test Sites

The patient-based CRDTS Dental Hygiene Examination is administered over several days at dental hygiene schools that serve as test sites. These test sites are located throughout California and other member states (CRDTS website). Testing dates are site-specific and arranged between CRDTS and the test site. Candidates are assigned to either a morning or afternoon testing session (CRDTS Candidate Manual, 2020).

Finding 17: Candidates have access to test sites in participating dental hygiene schools with trained examiners and controlled testing conditions.

Test Administration – Directions and Instructions to Candidates

The CRDTS website provides detailed information about the patient-based CRDTS Dental Hygiene Examination. In addition, the 2020 Candidate Manual provides detailed information to candidates about:

- Scope of the examination and examination procedures
- Examination materials and instruments
- Patient selection guidelines
- Reporting to the test center and test site
- Candidate orientation
- Test center and test site procedures

- Security procedures
- Standards of conduct
- Infection control requirements
- Examination scoring criteria
- Examination forms (to be completed before or during examination administration)

Finding 18: The directions and instructions provided to candidates appear straightforward. The information available to candidates is detailed and comprehensive.

Test Administration – Standardized Procedures and Testing Environment

All candidates are tested in the same type of environment, using the same equipment, under the same conditions (CRDTS Candidate Manual, 2020). All candidates are assessed on the same clinical skills, which are performed on a live patient in a clinic setting. All candidates are required to use the same specified set of instruments during the examination process. In addition, expendable dental hygiene materials are provided by test sites to all candidates. Candidates are required to provide protective eyewear for themselves and patients.

As part of the examination process, candidates are required to submit a live patient for acceptance and approval. Patients must meet specific criteria, including 6–10 teeth that have qualifying deposits of calculus (CRDTS Candidate Manual, 2020). While candidates incur point penalties for patient rejections, they are encouraged to submit an Alternate Submission with their initial selection. A maximum of four treatment submissions is allowed.

Finding 19: The procedures established for the test administration process and testing environment appear to be consistent with professional guidelines and technical standards.

Finding 20: The variability associated with use of live patients presents challenges to standardization. CRDTS has taken steps to increase standardization by defining criteria for minimum qualifying calculus; however, it is unclear how increased levels of complexity are accounted for with regard to minimum competence standards. While the level of complexity associated with calculus removal appears to vary based on patient presentation, scoring is dichotomous (points are assigned based on the presence or absence of remaining calculus).

CRDTS recognizes these challenges and actively monitors the reliability of the patient-based Dental Hygiene Examination. CRDTS has also begun offering an alternate examination that uses a typodont in place of a live patient, as referred to in The CRDTS Report, Winter 2018 (CRDTS Annual Report, 2018). The typodont is frequently used as a clinical training device to build skills before students are allowed to provide treatment on live patients or used as a remedial training device for building deficient skills. The typodont offers greater standardization in the testing process.

However, OPES does not endorse the use of this alternate examination in the absence of validity evidence that establishes the adequacy of the typodont as a measure of skills required for treating live patients in independent practice. OPES has agreed to evaluate any such evidence once provided by CRDTS.

RECOMMENDATIONS

Recommendation 6: OPES recognizes the standardization challenges associated with candidate submissions of live patients. However, standardization is an essential feature in administering examinations that are legally defensible, valid, and fair to candidates. OPES recommends that CRDTS continue to investigate new technologies and alternate means of assessing candidate skills as they relate to competence to practice as a dental hygienist.

CONCLUSIONS

Given the findings, the test administration protocols put in place by CRDTS appear consistent with professional guidelines and technical standards. However, OPES recommends options be considered to address standardization issues associated with the use of live patients.

CHAPTER 6 | EXAMINER TRAINING, SCORING, AND PERFORMANCE STANDARDS

STANDARDS

The following standards are most relevant to examiner training, test scoring, and performance for licensing examinations, as referenced in the *Standards.*

Standard 2.3

For each total score, subscore, or combination of scores that is to be interpreted, estimates of relevant indices of reliability/precision should be reported (p. 43).

Standard 4.10

When a test developer evaluates the psychometric properties of items, the model used for that purpose (e.g., classical test theory, item response theory, or another model) should be documented. The sample used for estimating item properties should be described and should be of adequate size and diversity for the procedure. The process by which items are screened and the data used for screening, such as item difficulty, item discrimination, or differential item functioning (DIF) for major examinee groups, should also be documented. When model-based methods (e.g., IRT) are used to estimate item parameters in test development, the item response model, estimation procedures, and evidence of model fit should be documented (pp. 88-89).

Standard 4.20

The process for selecting, training, qualifying, and monitoring scorers should be specified by the test developer. The training materials, such as the scoring rubrics and examples of test takers' responses that illustrate the levels on the rubric score scale, and the procedures for training scorers should result in a degree of accuracy and agreement among scorers that allows the scores to be interpreted as originally intended by the test developer. Specifications should also describe processes for assessing scorer consistency and potential drift over time in raters' scoring (p. 92).

Standard 4.21

When test users are responsible for scoring and scoring requires scorer judgment, the test user is responsible for providing adequate training and instruction to the scorers and for examining scorer agreement and accuracy. The test developer should document the expected level of scorer agreement and accuracy and should provide as much technical guidance as possible to aid test users in satisfying this standard (p. 92).

Standard 6.8

Those responsible for test scoring should establish scoring protocols. Test scoring that involves human judgment should include rubrics, procedures, and criteria for scoring. When scoring of complex responses is done by computer, the accuracy of the algorithm and processes should be documented (p. 118.)

The following regulations are relevant to the integrity of the use of examiners in scoring clinical examinations:

California B&P Code § 139 requires the Department of Consumer Affairs to develop a policy on examination validation which includes minimum requirements for psychometrically sound examination development.

OPES 20-01, as mandated by B&P Code § 139, specifies that board members, committee members, and instructors should not serve as expert consultants in the licensure examination development process. This is due to potential conflict of interest, undue influence, and security considerations.

FINDINGS

Examiner Selection and Training

The patient-based CRDTS Dental Hygiene Examination relies on the judgment of examiners to determine whether a candidate has demonstrated the skills required for competent dental hygiene practice. CRDTS has formed an Examiner Evaluation and Assignment Committee (EEAC) that maintains an examiner preparation program and sets the criteria for selecting examiners, coordinators, and team captains (CRDTS Technical Report, 2017).

Examiners are nominated by member state boards and must meet specific selection criteria. Among other requirements, an examiner must: (a) be an active dental hygiene practitioner in good standing with their state board, (b) have completed an educational program approved by the Commission on Dental Accreditation (CODA); (c) have passed a clinical examination with a patient-based component; (d) be willing to apply CRDTS-established examination standards and evaluation criteria; and (e) agree to commit to participating in a minimum of three examinations (CRDTS Technical Manual, 2017; CRDTS email communication, December 2020).

Examiners are provided with a copy of the Dental Hygiene Examiner's Manual, which provides specific scoring criteria and criteria for assessing penalties (CRDTS Technical Report, 2017). In addition, examiners undergo a calibration training process (CRDTS Technical Report, 2017). During this process, examiners engage in rating exercises designed to produce accurate and consistent ratings. In addition, all new examiners must observe examination administrations for one year before becoming an active examiner.

CRDTS maintains profiles for all examiners. After each administration, examiners are asked to evaluate fellow team members in terms of behavior, preparedness, adherence to protocols, and work ethic (Technical Report, 2017). These reports, along with the results of each examiner's rating accuracy and consistency, become part of a profile maintained for each examiner. Each year, the EEAC reviews examiner profiles for efficacy and revises roles if necessary. Examiners who do not provide accurate or consistent ratings may not be reappointed.

> Finding 21: The selection and training of examiners for the CRDTS Dental Hygiene Examination is generally consistent with professional guidelines and technical standards. However, the use of board members and educators as examiners is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Examination Scoring

The patient-based CRDTS Dental Hygiene Examination uses a compensatory scoring model to assess a candidate's performance across four clinical domains (CRDTS Technical Report, 2017). A criterion-based scoring system is used to differentiate between acceptable and unacceptable performance in each clinical domain (CRDTS Candidate Manual, 2020). Once a candidate has completed treatment procedures on a patient, three examiners independently evaluate the candidate's performance using established scoring criteria. Scores are assigned based on the median rating of the three examiners.

CRDTS indicates that it uses a criterion-based scoring system to score items performed in each content domain on the patient-based Dental Hygiene Examination (CRDTS Candidate Manual, 2020). The stated purpose is to differentiate "between acceptable and unacceptable performance" by applying established criteria for each procedure performed (CRDTS Candidate Manual, 2020, p. 12).

Points on the examination are deducted for treatment selection or performance errors that are confirmed by two of three examiners (CRDTS Candidate Manual, 2020; CRDTS Technical Report, 2017). These point deductions are as follows:

- Patient submission rejection – 7 points each (first two rejections only)
- Improper record keeping – 2 points
- Failure to properly complete anesthetic documentation – 2 points
- Unprofessional demeanor – 2 points
- Infection control / asepsis violations – 2 points
- Patient management / inadequate pain control – 5 points
- Tissue trauma – 5 points each (up to two)

CRDTS has also identified critical errors that result in automatic failure. These critical errors include damage to three or more areas of gingiva or other tissues, amputated papilla, exposure of the alveolar process, laceration or damage requiring suture or periodontal packing, unreported broken instrument tip in sulcus, or ultrasonic burn requiring follow-up treatment (CRDTS Candidate Manual, 2020).

In addition to being assessed point penalties for performance and critical errors, candidates are assessed a 10-point time penalty if they arrive 1–15 minutes late to the host test site (CRDTS Candidate Manual, 2020).

A final score is calculated by applying point deductions on each of the subtests (content areas) (CRDTS Technical Report, 2017). Candidates must receive a minimum score of 75 of 100 possible points to pass the examination.

> Finding 22: CRDTS indicates that it uses a criterion-based scoring system to differentiate between "acceptable and unacceptable" performance. However, no information was provided regarding how the scoring criteria were developed.
>
> Finding 23: The scoring criteria are applied equitably and are generally consistent with professional guidelines and technical standards.
>
> Finding 24: Scoring penalties predominantly reflect errors or deficiencies associated with performance. However, the late penalty appears to be unrelated to performance standards required for safe and effective practice.
>
> Finding 25: In the content area Scaling/Subgingival Calculus Removal, candidates are assigned 5 points per item (surface) if examiners confirm the absence of detectable calculus following treatment. Similarly, 2 points per item (surface) are assigned in the content area Supragingival Deposit Removal. Scoring is dichotomous, and it appears that point assignments are not related to the level of case complexity.

Examination Performance

CRDTS performs analyses of test functioning and examiner performance for each examination administration (CRDTS Technical Report, 2017).

After each administration, CRDTS calculates descriptive statistics regarding overall examination performance, as well as for subtests (content areas). These statistics include: low and high scores, mean scores, standard deviation, and skewness. CRDTS also analyzes classical test statistics for each item within each of the subtests (content areas). Each item is analyzed in terms of mean item difficulty and discrimination power. OPES did not receive these analyses; however, the 2017 CRDTS Technical Report included these data for the 2017 administration. These 2017 data suggested a high degree of consistency and stability among items included in each of the subtests. OPES reviewed other reports of mean scores and pass rates across administrations, which suggested that results for the most recent administrations are likely consistent with the data present in the 2017 CRDTS Technical Report.

CRDTS also estimates the reliability of test scores each administration using a stratified alpha (CRDTS Technical Report, 2017). OPES was not provided with these estimates; however, the 2017 CRDTS Technical Report presents the result of analyses conducted in 2017 for each subtest and for the overall examination. The reliability coefficient for the 2017 administration

was .75, which is sufficient for a performance examination with the number of items included in the patient-based CRDTS Dental Hygiene Examination.

In addition, CRDTS also performs analyses of examiner rating performance. These analyses include evaluation of examiner agreement, which is typically high for all subtests. For the years 2016–2019, the percentages of agreement for all three examiners across the different subtests, as well as the percentages of agreement to confirm scoring, were within generally accepted ranges. CRDTS also evaluates examiner harshness or leniency (CRDTS Technical Report, 2017). For the years 2016–2019, CRDTS reported that "outliers" occurred at an acceptably low percentage of ratings made. No information was provided about how outliers were calculated or what constituted acceptable levels of agreement. Overall, data provided for the 2016–2019 administrations of the patient-based CRDTS Dental Hygiene Examination (2019) indicated examination and examiner statistics within generally accepted ranges.

Finding 26: Documentation regarding examination performance was limited. However, the data provided suggest that examination-level statistics are likely adequate for performance examinations.

Finding 27: Documentation regarding examiner performance, particularly regarding "outliers," was limited. However, the information provided indicated examiner performance statistics are likely adequate for performance examinations.

RECOMMENDATIONS

Recommendation 7: OPES recognizes that CRDTS requires the participation of practitioners from member states to develop and administer examinations. In order to be fully compliant with OPES 20-01, OPES recommends phasing out the service of board members and educators as examiners in the administration of the patient-based CRDTS Dental Hygiene Examination.

Recommendation 8: CRDTS states that it uses a criterion-based scoring system to differentiate between acceptable and unacceptable performance. OPES recommends that CRDTS provide additional documentation regarding how these scoring criteria were developed and how they related to minimum competence standards for safe, entry-level practice. This documentation should include a description of the use of SME judgments in determining these criteria.

Recommendation 9: The content and scoring criteria for licensure examinations should clearly reflect the competencies necessary for practice. The scoring criteria used on the patient-based CRDTS Dental Hygiene Examination appear to generally reflect the competencies required for dental hygiene practice, with penalties for performance error or critical errors. However, the time penalty appears unrelated to competency for practice. OPES recommends reviewing scoring criteria to define how this penalty relates to the competencies required for practice or removing this penalty from the scoring process.

Recommendation 10: CRDTS has provided minimum qualifying calculus standards to satisfy patient treatment submission criteria. It appears that the higher the level of detectible calculus, the less likely candidates are to face penalties associated with patient treatment rejections. However, it is unclear whether there is a relationship between more challenging cases and successful treatment outcomes. Further, it is unclear whether more challenging cases reflect minimum competence for professional practice or are associated with higher levels of competence. OPES recommends that CRDTS clarify the relationship between case complexity and minimum competence standards.

Recommendation 11: OPES recommends that CRDTS provide additional documentation of analyses conducted on overall examination performance and examiner agreement. Documentation regarding examiner agreement should include information about rater agreement across test sites, as well as how instances of rater consistency or leniency are defined, evaluated, and managed. In addition, documentation should provide an explanation for reporting examiner agreement for the subtests Periodontal Probing and Supragingival Deposit Removal as a single proportion.

CONCLUSIONS

The steps taken by CRDTS to score the patient-based Dental Hygiene Examination generally appear to provide for a relatively fair and objective evaluation of candidate performance. However, OPES recommends that CRDTS review scoring criteria to establish a clear connection between the time penalty and competence for dental hygiene practice or that CRDTS consider revision of this penalty. OPES further recommends that CRDTS clarify the link between case complexity and minimum competence with regard to dichotomous scoring of calculus removal.

The steps taken by CRDTS to evaluate examination and examiner performance appear to be reasonable. However, OPES recommends that CRDTS provide additional information and documentation regarding examiner agreement and analyses pertaining to examiner harshness or leniency.

CHAPTER 7 | TEST SECURITY

STANDARDS

The following standards are most relevant to test security for licensure examinations, as referenced in the *Standards.*

Standard 6.6

Reasonable efforts should be made to ensure the integrity of test scores by eliminating opportunities for test takers to attain scores by fraudulent or deceptive means (p. 116).

Standard 6.7

Test users have the responsibility of protecting the security of test materials at all times (p. 117).

Standard 8.9

Test takers should be made aware that having someone else take the test for them, disclosing confidential test material, or engaging in any other form of cheating is unacceptable and that such behavior may result in sanctions (p. 136).

Standard 9.21

Test users have the responsibility to protect the security of tests, including that of previous editions (p. 147).

FINDINGS

Test Security – Examination Materials and Candidate Information

For the patient-based CRDTS Dental Hygiene Examination, the content, scoring criteria, and passing score are made public and are available in the 2020 CRDTS Candidate Manual.

All examination materials and equipment used to administer the examination are prepared by CRDTS staff for distribution to test sites before the date of administration (CRDTS email communication, December 2020). Materials and scoring equipment are individually numbered and securely sealed in containers for transport to test sites by a national shipping company (CRDTS Technical Report, 2017). At each test site, the containers are verified and stored in a locked room. Only CRDTS staff have access to and authority to unseal the containers. After test administration, CRDTS staff securely seal examination materials and equipment in the containers for return shipping.

During the registration process, candidates are required to submit a passport quality photograph (CRDTS Candidate Manual, 2020). This photograph becomes part of each candidate's Candidate Profile and is printed on a Candidate ID Badge. Candidates are required to provide a

valid form of identification upon check-in at examination sites and must wear their Candidate ID Badge throughout the examination. All examination materials are preprinted with each candidate's sequence number and individual ID number, and a candidate's materials are matched against their Candidate ID Badge for accuracy (CRDTS Technical Report, 2017). In addition, electronic equipment used at testing sites to score examinations is preloaded with each candidate's ID number and the ID numbers of all examiners assigned to test sites.

All examiners and candidates are required to sign non-disclosure agreements, certifying confidentiality compliance regarding examination-related materials (CRDTS email communication, December 2020). Candidate are permitted to bring the Candidate Manual and approved examination materials to test sites, but all other outside references or materials are prohibited. In addition, candidates are prohibited from bringing recording devices, cell phones, smartwatches, or other electronic devices into test sites (CRDTS Candidate Manual, 2020).

CRDTS provides backup electronic equipment at each test site. A dedicated wireless system is used to encrypt and securely upload examiner evaluations of candidate performance. The system is monitored by an IT proctor throughout the examination to ensure proper uploading of results. After administration, test files are downloaded to a flash drive and uploaded to CRDTS' secure scoring website to prepare for final scoring and release of results (CRDTS Technical Report, 2017).

> Finding 28: The security procedures practiced by CRDTS with regard to the maintenance of examination materials and candidate information are consistent with professional guidelines and technical standards.

Test Security – Test Sites

CRDTS maintains test site security policies and procedures. Only authorized CRDTS personnel, examiners, and candidates are allowed to access test facilities providing test administration. CRDTS personnel, examiners, and candidates are required to wear identification at all times during test administration.

> Finding 29*:* The security procedures practiced by CRDTS regarding test sites are consistent with professional guidelines and technical standards.

CONCLUSIONS

Given the findings, the test security policies, procedures, and protocols meet professional guidelines and technical standards.

CHAPTER 8 | COMPARISON OF THE CALIFORNIA REGISTERED DENTAL HYGIENIST EXAMINATION OUTLINE TO THE CRDTS DENTAL HYGIENE EXAMINATION CONTENTS

PARTICIPATION OF SUBJECT MATTER EXPERTS

OPES convened a 2-day workshop on May 14–15, 2020 to evaluate and compare the following items:

- The task and knowledge statements of the California description of practice resulting from the 2019 California Occupational Analysis of the Registered Dental Hygienist Profession (California RDH OA, 2019).
- The examination content of the patient-based CRDTS Dental Hygiene Examination.

OPES recruited seven registered dental hygienists to participate in the workshop as SMEs.

The SMEs represented the profession in terms of geographic location in California. Two of the SMEs had been licensed for 1–5 years, one had been licensed for 6–10 years, three had been licensed for 11–19 years, and one had been licensed for more than 20 years. All SMEs worked as dental hygienists in various settings.

WORKSHOP PROCESS

First, the SMEs completed OPES' security agreement, self-certification, secure area agreement, and personal data (demographic) forms. The OPES facilitator explained the importance of, and the guidelines for, security during and outside the workshop. The SMEs were then asked to introduce themselves.

Next, the OPES facilitator gave a PowerPoint presentation about the purpose and importance of occupational analysis, validity, content validity, reliability, test administration standards, examination security, and the role of SMEs. The OPES facilitator also explained the purpose of the workshop.

The SMEs were instructed to evaluate and link each task and knowledge statement of the California description of practice to the task statements of the patient-based CRDTS Dental Hygiene Examination blueprint. To ensure that each SME understood the linkage process, the OPES facilitator had the SMEs work as a group to evaluate and link all of the task and knowledge statements of the California description of practice.

The content domain of the patient-based CRDTS Dental Hygiene Examination is provided in Table 1. Table 2 provides the content areas of the 2019 California description of practice.

TABLE 1 – CRDTS NATIONAL DENTAL HYGIENE EXAMINATION BLUEPRINT CONTENT DOMAINS

Domain	Weight
1. Extra/intra Oral Assessment	16%
2. Periodontal Probing	12%
3. Scaling/Subgingival Calculus Removal	60%
4. Supragingival Deposit Removal	12%
Total	**100%**

TABLE 2 – CONTENT AREAS OF THE 2019 CALIFORNIA REGISTERED DENTAL HYGIENIST EXAMINATION OUTLINE

	Content Area	Content Area Description	Weight
1.	Treatment Preparation	This area assesses the candidate's knowledge of preparing the operatory and patient dental hygiene services.	5%
2.	Dental Hygiene Treatment	This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.	40%
3.	Patient Education	This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.	10%
4.	Infection Control	This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.	15%
5.	Documentation	This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental records.	5%
6.	Laws, Regulations, and Ethics	This area assesses the candidate's knowledge of licensing requirements, professional conduct, patient confidentiality, use of telehealth methods and technology, and mandated reporting.	25%
	Total		**100%**

FINDINGS

The SMEs compared the task and knowledge statements of the 2019 California description of practice outline and the CRDTS Dental Hygiene Examination blueprint. The SMEs concluded that the patient-based CRDTS Dental Hygiene Examination adequately assessed the skills required for entry-level dental hygiene practice in California in the following four areas:

- Treatment Preparation
- Dental Hygiene Treatment
- Infection Control
- Documentation

The SMEs indicated that the patient-based CRDTS Dental Hygiene Examination did not adequately assess the content area Patient Education, but this content area was determined to be adequately assessed by other assessment measures. In addition, SMEs indicated that the patient-based CRDTS Dental Hygiene Examination did not adequately assess the content area Laws, Regulations, and Ethics. However, this content is measured by the California-specific Registered Dental Hygienist Law and Ethics Examination.

Finding 30: The SMEs concluded that the content of the patient-based CRDTS Dental Hygiene Examination adequately assesses the general skills required for entry-level dental hygiene practice in California identified in the California RDH OA, 2019.

Finding 31: The SMEs concluded that the content of the patient-based CRDTS Dental Hygiene Examination does not adequately assess the laws and ethics required for practice in California. SMEs concluded that this content should continue to be measured using a California-specific law and ethics examination.

CONCLUSIONS

Overall, the SMEs concluded that the content of the patient-based CRDTS Dental Hygiene Examination sufficiently assesses the skills dental hygienists are expected to have mastered at the time of licensure.

CHAPTER 9 | CONCLUSIONS

COMPREHENSIVE REVIEW OF THE CRDTS DENTAL HYGIENIST EXAMINATION

OPES completed a comprehensive analysis and evaluation of the documents provided by CRDTS.

OPES finds that the procedures used to establish and support the validity and defensibility of the patient-based CRDTS Dental Hygiene Examination (i.e., OA, examination development, test registration and administration, examination scoring and performance, and test security) *generally* meet professional guidelines and technical standards outlined in the *Standards* and B&P Code § 139. However, to be fully compliant with OPES 20-01, OPES recommends phasing out the service of board members and educators in examination development processes. Further, the process of establishing passing scores fails to demonstrate a robust methodology.

In addition, OPES made several recommendations related to standardization, scoring, and documentation processes. These recommendations are as follows:

1) OPES recommends that CRDTS consider methods to improve standardization in relation to patient selection. The use of live patients in licensure examinations presents challenges to standardization; however, standardization is an essential feature of examinations that are legally defensible, valid, and fair. CRDTS regularly reviews the performance of the patient-based CRDTS Dental Hygiene Examination and takes steps to maximize standardization; however, it appears that there may be some variability with regard to patient presentation and case complexity. CRDTS has defined a minimum qualifying calculus standard associated with minimum competence, but it is unclear how higher levels of complexity are addressed. Scoring on calculus removal is dichotomous, regardless of case complexity. OPES recommends that CRDTS review the patient selection component of the examination and provide a clear connection between scoring criteria, case complexity, and minimum competence.

2) Scoring criteria should be directly related to the competencies required for practice and should not reflect undesirable behaviors that are not related to these professional competencies. Therefore, OPES recommends that CRDTS review the late penalty deduction. This penalty should be revised, or a connection should be established between this penalty and minimum competence.

3) OPES recommends that CRDTS take steps to increase documentation of processes used in the examination development process. Recommendations include providing clear descriptions of all procedures used to develop the examination, set the passing score, and establish scoring criteria. In addition, while CRDTS provides the Board with annual reports regarding the performance of California candidates by educational institution, it excludes candidates from educational institutions with fewer than four candidates. OPES recommends that reports be revised to include information for all

California candidates, or that additional reports be provided containing this information. Further, OPES recommends that CRDTS provide information regarding the number and type of all penalties assessed on California candidates so that an accurate evaluation of candidate performance can be made.

Based on the evaluations presented in this report, OPES finds that the content of the patient-based CRDTS Dental Hygiene Examination *generally* measures the skills related to California dental hygiene practice.

However, practical examinations typically face issues with one or more of the following: standardizing procedures and materials, inter-rater reliability, validating scoring criteria, and setting passing scores that reflect minimum competence. These issues are exacerbated by the addition of live patients. OPES recommends that the Board consider conducting an evaluation to determine whether a skills-based examination remains a necessary component of assessing a candidate's competence for practice. Given the level of training and clinical assessment that dental hygiene candidates receive in educational programs, requiring a knowledge-based examination may be sufficient to assess minimum competence for licensure.

CHAPTER 10 | REFERENCES

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DHBC
Dental Hygiene
Board of California

REVIEW OF THE WESTERN REGIONAL EXAMINING BOARD (WREB) DENTAL HYGIENE EXAMINATION

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

DENTAL HYGIENE BOARD OF CALIFORNIA

REVIEW OF THE WESTERN REGIONAL EXAMINING BOARD (WREB) DENTAL HYGIENE EXAMINATION

February 2021

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

This report is mandated by California Business and Professions (B&P) Code § 139 and by DCA Licensure Examination Validation Policy OPES 18-02.

EXECUTIVE SUMMARY

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs used in the California licensure process comply with psychometric and legal standards. The Dental Hygiene Board of California (Board) requested that DCA's Office of Professional Examination Services (OPES) complete a comprehensive review of the patient-based Western Regional Examining Board (WREB) Dental Hygiene Examination. The purpose of the OPES review was to evaluate the suitability of the patient-based WREB Dental Hygiene Examination for use in California licensure.

To become licensed as a registered dental hygienist in California, the Board requires candidates to have requisite education and experience and to pass three examinations:

1. The National Board Dental Hygiene Examination (NBDHE)
2. The Western Regional Examining Board (WREB) Dental Hygiene Examination or the Central Regional Dental Testing Service (CRDTS) Dental Hygiene Examination
3. The California Registered Dental Hygienist Law and Ethics Examination

The WREB Dental Hygiene Examination is a patient-based clinical examination that measures a candidate's skill in four areas:

1. Extraoral and Intraoral Examination
2. Periodontal Assessment
3. Calculus Removal
4. Tissue Management

Within these areas, candidates are specifically evaluated on their ability to adhere to patient selection criteria, and to perform:

- Extraoral and intraoral examination
- Periodontal pocket measurement and recording (12 surfaces)
- Gingival recession assessment and recording (3 qualifying surfaces)
- Classification of furcation involvement
- Classification of mobility
- Identification of type of radiographic bone loss
- Classification of severity of bone loss
- Classification of severity of periodontal disease
- Calculus detection and removal (12 qualifying surfaces)
- Tissue management

In 2017, WREB collaborated with CRDTS to conduct an occupational analysis (OA) for the dental hygienist profession and to update the examination blueprint for the patient-based WREB Dental Hygiene Examination.

OPES, in collaboration with the Board, received and reviewed the results of the 2017 OA, as well as other documents provided by WREB. OPES performed a comprehensive evaluation of the documents to determine whether the following test program components met professional guidelines and technical standards: (a) OA, (b) examination development, (c) passing scores and passing rates, (d) test registration and administration, (e) examination scoring and performance, and (f) test security procedures. Follow-up emails were exchanged to clarify the procedures and practices used to validate and develop the patient-based WREB Dental Hygiene Examination.

OPES found that the procedures used to develop and administer the patient-based WREB Dental Hygiene Examination are generally consistent with professional guidelines and technical standards outlined in the *Standards for Educational and Psychological Testing* (2014) *(Standards)* and California Business and Professions (B&P) Code § 139. However, OPES made recommendations for WREB to consider, particularly regarding standardization and scoring.

In addition to reviewing documents provided by WREB, OPES convened a workshop of licensed California registered dental hygienists to serve as subject matter experts (SMEs) to review the content of the patient-based WREB Dental Hygiene Examination. The SMEs were selected by the Board to represent the profession in terms of geographic location, experience, and specialty. The purpose of the review workshop was to compare the content of the patient-based WREB Dental Hygiene Examination with the California registered dental hygienist description of practice that resulted from the 2019 California Occupational Analysis of the Registered Dental Hygienist Profession (California RDH OA, 2019) performed by OPES. During this workshop, the SMEs compared the task and knowledge statements from the California description of practice to the examination content of the patient-based WREB Dental Hygiene Examination. A linkage study was performed to identify whether there were areas of California dental hygiene practice that are not measured by the patient-based WREB Dental Hygiene Examination.

The results of the linkage study indicated that skills associated with four of the six areas included in the California dental hygiene description of practice were adequately linked to the content of the patient-based WREB Dental Hygiene Examination. SMEs concluded that one of the content areas, Patient Education, was not adequately assessed by the patient-based WREB Dental Hygiene Examination. However, SMEs determined that this content area is assessed by other examinations. In addition, the SMEs indicated that the content area Laws, Regulations, and Ethics was not adequately assessed by the content of the patient-based WREB Dental Hygiene Examination and should continue to be measured by the California-specific law and ethics examination.

In its evaluation, OPES found that while the patient-based WREB Dental Hygiene Examination was *generally* consistent with technical standards regarding validity, there are standardization challenges associated with the use of live patients. OPES further found a consistently high passing rate on the patient-based WREB Dental Hygiene Examination. This may indicate that candidates receive sufficient training in their pre-licensure clinical examinations to prepare them for safe and effective dental hygiene practice. Given these findings, OPES recommends that the

Board consider conducting an evaluation to determine whether a skills-based examination is necessary for assessing a candidate's competence for practice, or whether a knowledge-based examination may be sufficient to assess minimum competence for licensure.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1 | INTRODUCTION

PURPOSE OF THE COMPREHENSIVE REVIEW

Licensing boards and bureaus within the California Department of Consumer Affairs (DCA) are required to ensure that examination programs used in the California licensure process comply with psychometric and legal standards. The public must be reasonably confident that an individual passing a licensure examination has the requisite knowledge and skills to competently and safely practice in the profession.

The Dental Hygiene Board of California (Board) requested that DCA's Office of Professional Examination Services (OPES) complete a comprehensive review of the patient-based Western Regional Examining Board (WREB) Dental Hygiene Examination. The WREB Dental Hygiene Examination is a patient-based clinical examination that measures a candidate's competence in performing skills associated with calculus removal and periodontal assessments. The examination comprises four content areas:

1. Extraoral and Intraoral Examination
2. Periodontal Assessment
3. Calculus Removal
4. Tissue Management

Within these areas, candidates are specifically evaluated on their ability to adhere to patient selection criteria, and to perform:

- Extraoral and intraoral examinations
- Periodontal pocket measurements and recording (12 surfaces)
- Gingival recession assessments and recording (3 qualifying surfaces)
- Classification of furcation involvement
- Classification of mobility
- Identification of type of radiographic bone loss
- Classification of severity of bone loss
- Classification of severity of periodontal disease
- Calculus detection and removal (12 qualifying surfaces)
- Tissue management

OPES' review of the patient-based WREB Dental Hygiene Examination had three purposes:

1. To evaluate the suitability of the patient-based WREB Dental Hygiene Examination for continued use in California.

2. To determine whether the patient-based WREB Dental Hygiene Examination meets the professional guidelines and technical standards outlined in the *Standards for*

Educational and Psychological Testing (2014) *(Standards)*[1] and California Business and Professions (B&P) Code § 139.

3. To identify any areas of California dental hygiene practice that the patient-based WREB Dental Hygiene Examination does not assess.

In relation to the *Standards*, evaluating the acceptability of an examination does not involve determining whether the examination satisfies each individual standard interpreted literally. The importance of each standard varies according to circumstances. Page 7 of the *Standards* states:

> Individual standards should not be considered in isolation. Therefore, evaluating acceptability depends on (a) professional judgment that is based on a knowledge of behavioral science, psychometrics, and the relevant standards in the professional field to which the test applies; (b) the degree to which the intent of the standard has been satisfied by the test developer and user; (c) the alternative measurement devices that are readily available; (d) research and experiential evidence regarding the feasibility of meeting the standard; and (e) applicable laws and regulations.

OPES, in collaboration with the Board, requested documentation from WREB to determine whether the following patient-based WREB Dental Hygiene Examination program components met professional guidelines and technical standards outlined in the *Standards* and B&P Code § 139: (a) occupational analysis (OA),[2] (b) examination development, (c) passing scores and passing rates,[3] (d) test registration and administration, (e) examination scoring and performance, and (f) test security procedures.

CALIFORNIA LAW AND POLICY

Section 139 (a) of the California B&P Code states:

> The Legislature finds and declares that occupational analyses and examination validation studies are fundamental components of licensure programs.

It further requires that DCA develop a policy to address the minimum requirements for psychometrically sound examination validation, examination development, and occupational analyses, including standards for the review of state and national examinations.

DCA Licensure Examination Validation Policy OPES 18-02 (OPES 18-02) specifies the *Standards* as the most relevant technical and professional standards to be followed to ensure that examinations used for licensure in California are psychometrically sound, job-related, and legally defensible.

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[1] See Chapter 10 for the complete reference to the *Standards.*
[2] An occupational analysis is also known as a job analysis, practice analysis, or task analysis.
[3] A passing score is also known as a pass point or cut score.

FORMAT OF THE REPORT

The chapters of this report provide the relevant standards related to psychometric aspects of the patient-based WREB Dental Hygiene Examination and describe the findings and recommendations that OPES identified during its review.

CHAPTER 2 | OCCUPATIONAL ANALYSIS

STANDARDS

The following standard is most relevant to conducting OAs for licensure examinations, as referenced in the *Standards.*

> **Standard 11.13**
>
> 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 and evidence should be provided to support the claim that the knowledge or skills being assessed are required for credential-worthy performance in that occupation and are consistent with the purpose for which the credentialing program was instituted (pp. 181-182).

The comment following Standard 11.13 emphasizes its relevance:

> *Comment:* Typically, some form of job or practice analysis provides the primary basis for defining the content domain. If the same examination is used in the credentialing of people employed in a variety of settings and specialties, a number of different job settings may need to be analyzed. Although the job analysis techniques may be similar to those used in employment testing, the emphasis for credentialing is limited appropriately to knowledge and skills necessary for effective practice . . .
>
> In tests used for licensure, knowledge and skills that may be important to success but are not directly related to the purpose of licensure (e.g., protecting the public) should not be included (p. 182).

California B&P Code § 139 requires that each California licensing board, bureau, commission, and program report annually on the frequency of its OAs and the validation and development of its examinations. OPES 18-02 states:

> Generally, an occupational analysis and examination outline should be updated every five years to be considered current; however, many factors are taken into consideration when determining the need for a different interval. For instance, an occupational analysis and examination outline must be updated whenever there are significant changes in a profession's job tasks and/or demands, scope of practice, equipment, technology, required knowledge, skills and abilities, or laws and regulations governing the profession (p. 4).

FINDINGS

In 2017, WREB collaborated with the Central Regional Dental Testing Service (CRDTS) to conduct an OA for the dental hygiene profession. This OA was conducted at the national level. Results of this OA were documented for a presentation at a CRDTS and WREB Joint Dental Hygiene Practice Analysis Meeting in 2018 (CRDTS and WREB Joint Meeting, 2018), and in the WREB 2017–18 Dental Hygiene Practice Analysis: Report of Findings Prepared for the CRDTS and WREB Joint Dental Hygiene Practice Analysis Committee (WREB Practice Analysis Report, 2020). Additional information regarding this study was obtained through other technical reports and documentation provided by WREB, from WREB's website, and through email communication with WREB representatives.

Occupational Analysis – Goals, Methodology and Time Frame

The purpose of the OA was to provide evidence to state licensing boards in support of decisions regarding candidate readiness for professional practice, to draw reliable inferences regarding minimal competence from candidate performance, and to determine the appropriate content to assess performance levels and set passing standards (CRDTS and WREB Joint Meeting, 2018). The methodology used to conduct the OA was an online survey that described the practices (job tasks) performed by dental hygienists.

The survey was developed by WREB and CRDTS and was designed to be comparable to surveys administered by both testing agencies in prior OAs. A Joint Dental Hygiene Practice Analysis Committee (Practice Analysis Committee) was also involved in the development process. The Practice Analysis Committee comprised six subject matter experts (SMEs), who were selected from WREB and CRDTS member states. All SMEs had a minimum of 20 years of experience in the dental hygiene profession and were experienced board examiners or dental hygiene educators (WREB Practice Analysis Report, 2020).

The online survey was then completed by dental hygienists who were members of the American Dental Hygienists' Association (ADHA).

> Finding 1: The most recent OA was completed in 2017. The OA was conducted within a time frame considered to be current and legally defensible.
>
> Finding 2: The previous OA conducted by WREB occurred in 2009. This interval exceeds the DCA policy established under B&P Code § 139, which specifies that an OA should be conducted every 5 years.

Occupational Analysis – Development of Survey Instrument

In 2017, WREB and CRDTS collaboratively developed a survey to perform an OA of dental hygiene practice. The survey was developed by evaluating the major content domains and practices (tasks) listed on previous surveys administered by both organizations. Similar practice statements were combined, and additional restorative and anesthesia practices were added (WREB email communication, June 2020). Three WREB SMEs from the Practice Analysis

Committee reviewed the practice (task) statements and the final survey. CRDTS SMEs on the Practice Analysis Committee also reviewed the statements and survey (WREB email communication, June 2020).

The final survey included three sections. The first section comprised eight demographic questions designed to gather information about the survey respondents and their practice setting. This section also included questions specifically for respondents who practiced in a clinical setting. The section asked them how frequently they performed adult prophylaxis procedures, non-surgical periodontal procedures, and periodontal maintenance procedures. The second section of the survey comprised 49 practices (tasks) that were distributed across three content areas related to dental hygiene practice. Respondents were asked to rate each practice (task) on two rating scales: importance to practice (very important, somewhat important, or less important) and frequency of performance of the task (routinely, occasionally, or rarely). The third section of the survey asked respondents to provide comments or suggestions (WREB Practice Analysis Report, 2020).

> Finding 3: The procedures used by WREB to develop the survey instrument generally comply with professional guidelines and technical standards.
>
> Finding 4: The development of the survey involved six SMEs, all of whom were licensed more than 20 years. To better represent the profession in terms of geographical location and level of experience, more than six SMEs should be involved in the survey development process.

Occupational Analysis – Sampling Plan

The sampling plan for the study consisted of sending invitation emails to all of the 14,418 members of the ADHA in October 2017 (WREB, Practice Analysis Report, 2020).

Of the 14,418 members, 27% of the respondents completed the survey with enough detail to provide valid data. Of the 3,901 usable respondents, 27% were from the western region of the United States, with 228 (5.8%) from California.

> Finding 5: The intent of the sampling plan and the overall response rate were acceptable. The number of survey respondents from California was sufficient to provide representation of licensed California registered dental hygienists.

Occupational Analysis – Survey Results

After administering the survey, WREB and CRDTS collected the data and analyzed the survey results. Analyses included descriptive statistics calculated for each dental hygiene practice (task) included on the survey. Ratings on frequency and importance scales were combined using a multiplicative model that resulted in a potential range of 1 to 9. The frequency-importance product values were rank-ordered and presented to the Practice Analysis Committee for review.

Analyses also included correlation and linear regression to compare results for dental hygiene practices (tasks) with the results obtained from previous OA surveys. Overall, frequency-importance values for practices (tasks) included on the current OA had a correlation of .98 with those included on a previous OA conducted by WREB in 2009 (WREB Practice Analysis Report, 2020).

> Finding 6: The respondents included dental hygienists throughout the United States. Of the respondents, 48.4% had been practicing for 20 years or longer, 22.1% had been practicing for 10–20 years, 10% had been practicing for 5–10 years, and 18.6% had been practicing for less than 5 years. Approximately 51% of respondents were from WREB and CRDTS member states, while 49% were from other states.
>
> A majority of respondents indicated practicing in a private setting (75.6%), while 19.5% indicated that they worked in an educational setting. Fewer than 10% of respondents gave their practice setting as either a public health agency, corporate dental office, hospital/care facility, or the military.
>
> Four questions on the survey were directed toward dental hygienists who were actively practicing in a clinical setting. These questions pertained to the frequency of adult prophylaxis, non-surgical periodontal procedures, and periodontal maintenance procedures performed. All other practices (tasks) were rated by all survey respondents.

Occupational Analysis – Decision Rules and Final Examination Blueprint

The results of the survey were reviewed by the Practice Analysis Committee in April 2018. The Practice Analysis Committee SMEs discussed the results of the survey in conjunction with WREB's current examination blueprint. SMEs evaluated whether there were any prominent shifts in practice and whether any changes were required on the current WREB Dental Hygiene Examination (WREB Practice Analysis Report, 2020).

The Practice Analysis Committee SMEs indicated that there were no major shifts in the practices (tasks) performed by dental hygienists. The SMEs further determined that the practices (tasks) of intraoral examination, periodontal assessment, gingival recession assessment, and non-surgical periodontal treatments continue to be important and should remain the major components of the patient-based WREB Dental Hygiene Examination (WREB Practice Analysis Report, 2020).

> Finding 7: The linkage between the practices (tasks) required for entry-level dental hygienists and the major content areas of the WREB Dental Hygiene Examination demonstrates a sufficient level of validity, thereby meeting professional guidelines and technical standards.

RECOMMENDATIONS

Recommendation 1: DCA policy established under B&P Code § 139 specifies that, generally, boards should perform an OA every 5 years. OPES recommends that WREB adopt this interval for conducting OAs.

Recommendation 2: Results of OAs are used to develop licensure examinations that measure the competencies required for practice. To ensure that examination content accurately reflects these competencies, survey responses should be obtained from licensed dental hygienists who are currently practicing. With the exception of responses to four questions, it appears that ratings of practices on the WREB OA survey included responses from licensees who may not have been actively providing clinical services. OPES recommends that future OAs exclude responses obtained from dental hygienists who are retired or otherwise not currently engaged in dental hygiene practice.

Recommendation 3: Licensure examinations should measure the competencies required at initial licensure, and not those gained over time. As such, examination content should be based on the results of an OA that includes a representative sample of entry-level practitioners. Entry-level is generally defined as a practitioner licensed 5 years or less. OPES recognizes the sampling limitations involved in conducting an OA of this scope, and commends the efforts made by WREB to sample from this demographic. However, OPES recommends that future OAs attempt to increase the participation of practitioners licensed less than 5 years to ensure adequate representation of entry-level perspectives.

CONCLUSIONS

The OA conducted by WREB appears to be reasonably consistent with professional guidelines and technical standards. Additionally, the examination blueprint for the patient-based WREB Dental Hygiene Examination appears to be based on the results of the OA, which is consistent with professional guidelines and technical standards.

CHAPTER 3 | EXAMINATION DEVELOPMENT

STANDARDS

Examination development includes many steps within an examination program, from the development of an examination outline to scoring and analyzing items after the administration of an examination. Several specific activities involved in the examination development process are evaluated in this section. The activities include development of examination content, linkage of examination content to the examination outline, and developing scoring criteria.

The following standards are most relevant to examination development for licensure examinations, as referenced in the *Standards.*

> **Standard 4.7**
>
> The procedures used to develop, review, and try out items and to select items from the item pool should be documented (p. 87).
>
> **Standard 4.12**
>
> Test developers should document the extent to which the content domain of a test represents the domain defined in the test specifications (p. 89).

The following regulations are relevant to the integrity of the examination development process:

> California B&P Code § 139 requires the Department of Consumer Affairs to develop a policy on examination validation which includes minimum requirements for psychometrically sound examination development.
>
> DCA Policy Participation in Examination Development Workshops OPES 20-01 (OPES 20-01), as mandated by B&P Code § 139, specifies that board members, committee members, and instructors should not serve as expert consultants in the licensure examination development process. This is due to potential conflict of interest, undue influence, and security considerations.

FINDINGS

Examination Development – Subject Matter Experts (SMEs)

In 1979, WREB began administration of the patient-based WREB Dental Hygiene Examination (WREB email communication, June 2020). The predominant content areas have remained relatively consistent: extraoral and intraoral examination, periodontal assessment, calculus detection, and calculus removal. However, elements within the examination have undergone revision, including the number of tooth surfaces evaluated, the type and extent of calculus accepted, and weighing and scoring. Revisions were made based on evidence regarding professional practice. Revisions included evaluation by SMEs, review of multi-year data analyses, and field testing where applicable (WREB email communication, June 2020).

At least once a year, the content of the WREB Dental Hygiene Examination undergoes review by the WREB Dental Hygiene Examination Review Board (ERB) and other examination-specific committees (WREB Practice Analysis Report, 2020). The ERB consists of representatives from WREB's member states, and includes dental hygienists, dental hygiene educators, and dentists who serve as SMEs. SMEs who serve on WREB committees also review the results of practice analysis surveys, current dental hygiene curricula, and standards of competency to assure that the content and protocol of the patient-based WREB Dental Hygiene Examination remain current and relevant to practice.

> Finding 8: The procedures used to develop and review the content of the patient-based WREB Dental Hygiene Examination appear relatively consistent with professional guidelines and technical standards. However, the use of educators in the development process is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Examination Development – Linkage to Examination Blueprint

In 2018, the Practice Analysis Committee met and verified the linkage between the results of the most current OA and the content domains of the patient-based WREB Dental Hygiene Examination blueprint (examination specifications). In addition, other WREB committees reviewed the results of the OA and confirmed the accuracy of the content domains specified in the patient-based WREB Dental Hygiene Examination blueprint (WREB Practice Analysis Report, 2020).

> Finding 9: The methods used to establish the linkage between examination content and the competencies necessary for practice are consistent with professional guidelines and technical standards.

Examination Development – Item Field Testing

The WREB Dental Hygiene Examination is a patient-based clinical examination that measures a candidate's ability to competently perform skills in four main areas of dental hygiene practice. According to the WREB 2019 Technical Report for Dental Hygiene Examinations (WREB Technical Report, 2020), the items included in the content domains of the WREB Dental Hygiene Examination are the product of years of field testing and refinement. In addition, WREB performs ongoing SME review of item performance in frequent committee meetings. WREB also performs statistical analyses to provide empirical evidence regarding the functioning of examination content (WREB Technical Report, 2020).

> Finding 10: The procedures used to develop, review, and field test items that comprise the patient-based WREB Dental Hygiene Examination are consistent with professional guidelines and technical standards.

Examination Development – Examination Forms

The content domains included in the patient-based WREB Dental Hygiene Examination remain consistent across examination administrations. Candidates are assessed on skills related to

calculus removal and periodontal assessments. The assessment is made on one qualifying quadrant of a patient's mouth, which must contain 12 surfaces of qualifying calculus (WREB Technical Report, 2020). The content area Extraoral and Intraoral Examination comprises two evaluation items (2 points total); Periodontal Assessment comprises four selected-response items (2 points each) and 15 periodontal probing and recession items (1 point each); and Calculus Removal and Tissue Management together comprise 12 items (6.25 points each), according to the WREB 2020 Dental Hygiene Examination Candidate Guide (WREB Candidate Guide, 2020).

WREB maintains a Dental Hygiene Committee that is responsible for development, review, and revision of the patient-based WREB Dental Hygiene Examination (WREB email communication, August 2020). The WREB Dental Hygiene Committee consists of six SMEs who are licensed dental hygienists and have served as a board member or a board designee from member states. At least one committee member is an educator from an accredited dental hygiene program. In addition, the committee is supported by two additional non-voting committee members and a professional psychometrician.

The Dental Hygiene Committee meets several times per year to evaluate psychometric data regarding the examination, review current dental hygiene practices and test specifications, and recommend exam development/revisions, when applicable (WREB email communication, August 2020). Any proposed changes to examination content are then reviewed and approved by a separate committee, the WREB Dental Hygiene Examination Review Board (HERB).

The HERB is an examination oversight body comprising representatives from each WREB member state, including the board chair and an educator-member (WREB email communication, August 2020). Additional (non-voting) members include the President of the WREB Board of Directors and two dental hygiene consultants in examination development and administration. The HERB meets annually to review the patient-based WREB Dental Hygiene Examination and approve any changes to examination content recommended by the Dental Hygiene Committee.

> Finding 11: The procedures used to develop and refine examination content included on the patient-based WREB Dental Hygiene Examination are generally consistent with professional guidelines and technical standards. However, the use of board members and educators is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

RECOMMENDATIONS

> Recommendation 4: OPES recognizes that WREB requires the participation of practitioners from member states to develop and administer examinations. In order to be fully compliant with OPES 20-01, OPES recommends phasing out or limiting the service of board members and educators during examination development processes.

CONCLUSIONS

Given the findings, the examination development activities conducted by WREB appear to be generally consistent with professional guidelines and technical standards with regard to development of examination content, to the linkage of examination content to the examination blueprint, and to the testing and review of examination performance. To reduce the potential for conflict of interest, OPES recommends phasing out the use of board members and educators as SMEs.

CHAPTER 4 | PASSING SCORES AND PASSING RATES

STANDARDS

The passing score of an examination is the score that represents the level of performance that divides those candidates for licensure who are minimally competent from those who are not competent.

The following standards are most relevant to passing scores, cut points, or cut scores for licensure examinations, as referenced in the *Standards.*

> **Standard 5.21**
>
> When proposed score interpretations involve one or more cut scores, the rationale and procedures used for establishing cut scores should be documented clearly (p. 107).
>
> **Standard 11.16**
>
> The level of performance required for passing a credentialing test should depend on the knowledge and skills necessary for credential-worthy performance in the occupation or profession and should not be adjusted to control the number or proportion of persons passing the test (p. 182).

The supporting commentary on passing or cut scores for Chapter 5 of the *Standards*, "Scores, Scales, Norms, Score Linking, and Cut Scores," states that the standard-setting process used should be clearly documented and defensible. The qualifications of the judges involved and the process of selecting them should be part of the documentation. A sufficiently large and representative group of judges should be involved, and care must be taken to ensure that judges understand the process and procedures they are to follow (p. 101).

In addition, the supporting commentary for Chapter 11 of the *Standards*, "Workplace Testing and Credentialing," states that the focus of tests used in credentialing is on "the standards of competence needed for effective performance (e.g., in licensure this refers to safe and effective performance in practice)" (p. 175). It further states, "Standards must be high enough to ensure that the public, employers, and government agencies are well served, but not so high as to be unreasonably limiting" (p. 176).

FINDINGS

Passing Scores – The Patient-Based WREB Dental Hygiene Examination: Process, Use of Subject Matter Experts, and Methodology

The passing score for the patient-based WREB Dental Hygiene Examination is set at 75 out of 100 possible points. OPES has advised that California boards avoid using absolute passing scores for licensure examinations and instead use a criterion-referenced passing score methodology that reflects the competencies required for practice. WREB recognizes the arbitrary nature of absolute passing scores in licensure examinations; however, some of WREB's member states have passing scores set in statute. Therefore, WREB has scaled the passing score of the patient-based WREB Dental Hygiene Examination using a criterion-based scoring system (WREB Technical Report, 2020).

To link the passing score to performance criteria, the Dental Hygiene Committee developed minimum competence performance definitions for each area of the examination, as well as definitions of performance above and below this level (WREB Technical Report, 2020). The Dental Hygiene Committee then determined a critical scoring criterion and assigned points based on minimum competence standards for each item on the examination.

> Finding 12: The use of a criterion-referenced passing standard to set the recommended passing score appears to be generally consistent with professional guidelines and technical standards.

Passing Rates

WREB tracks passing rates for individual states and provides annual reports that demonstrate how California candidates perform on examinations relative to all other candidates. This data is provided for first-time test takers, repeat test takers, and overall performance.

> Finding 13: For the years 2015–2020, passing rates for all California candidates consistently ranged from 90 to 93% (approximately). Passing rates for first time test takers consistently ranged from 90 to 94% (approximately). In the WREB Overview of Recent Results for Graduates of California Dental Hygiene Programs, 2020 (WREB Overview of Recent Results, 2020), WREB states that the high passing rates are to be expected "given candidates have been approved by their educational institution as ready to challenge a criterion-referenced clinical examination of minimum competence" (WREB Overview of Recent Results, 2020, p. 3). (Note: The patient-based WREB Dental Hygiene Examination was discontinued in early 2020 due to the COVID-19 pandemic. Therefore, 2020 results were based on only 212 candidates. However, the results for these candidates were consistent with those of prior years.)
>
> WREB has found that the likelihood of success decreases with the number of examination attempts. However, passing rates for all California candidates across attempts at the end of each of the examination seasons for the five years reviewed ranged from 99.2% to 99.8%.

Finding 14: WREB made an adjustment to scoring criteria in 2018 that resulted in a slight increase in the candidate passing rate. This adjustment is described further in Chapter 6. OPES supports this change in scoring criteria, which reduced sources of construct-irrelevant variance associated with radiographs and patient selection.

CONCLUSIONS

Given the findings, the passing score methodologies used by WREB to set the passing score for the patient-based WREB Dental Hygiene Examination demonstrate a sufficient degree of validity, thereby meeting professional guidelines and technical standards.

The passing rates for the patient-based WREB Dental Hygiene Examination indicate that California candidates perform exceptionally well. OPES concurs with WREB's assessment that the high passing rates may indicate that California candidates are receiving adequate training in education programs to prepare them for demonstrating minimum competence for practice.

CHAPTER 5 | TEST REGISTRATION AND ADMINISTRATION

STANDARDS

The following standards are most relevant to standardizing the test administration process for licensing examinations, as referenced in the *Standards.*

Standard 3.4

Test takers should receive comparable treatment during the test administration and scoring process (p. 65).

Standard 4.15

The directions for test administration should be presented with sufficient clarity so that it is possible for others to replicate the administration conditions under which the data on reliability, validity, and (where appropriate) norms were obtained. Allowable variations in administration procedures should be clearly described. The process for reviewing requests for additional testing variations should also be documented (p. 90).

Standard 4.16

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 materials, practice or sample questions, criteria for scoring, and a representative item identified with each item format or major area in the test's classification or domain should be provided to the test takers prior to the administration of the test or should be included in the testing material as part of the standard administration instructions (p. 90).

Standard 6.1

Test administrators should follow carefully the standardized procedures for administration and scoring specified by the test developer and any instructions from the test user (p. 114).

Standard 6.2

When formal procedures have been established for requesting and receiving accommodations, test takers should be informed of these procedures in advance of testing (p. 115).

Standard 6.3

Changes or disruptions to standardized test administration procedures or scoring should be documented and reported to the test user (p. 115).

Standard 6.4

The testing environment should furnish reasonable comfort with minimal distractions to avoid construct-irrelevant variance (p. 116).

Standard 6.5

Test takers should be provided appropriate instructions, practice, and other support necessary to reduce construct-irrelevant variance (p. 116).

Standard 8.1

Information about test content and purposes that is available to any test taker prior to testing should be available to all test takers. Shared information should be available free of charge and in accessible formats (p. 133).

Standard 8.2

Test takers should be provided in advance with as much information about the test, the testing process, the intended test use, test scoring criteria, testing policy, availability of accommodations, and confidentiality protection as is consistent with obtaining valid responses and making appropriate interpretations of test scores (p. 134).

FINDINGS

The WREB Dental Hygiene Examination is administered throughout the calendar year at test sites located in WREB's member states. Due to the COVID-19 pandemic, WREB temporarily suspended administration of the patient-based examination in 2020. However, WREB subsequently resumed testing on a limited basis through the end of 2020 and has indicated an intent to resume full administration in 2021.

WREB provides information about the patient-based WREB Dental Hygiene Examination to candidates and prospective candidates through its website at https://www.wreb.org.

Test Administration – Candidate Registration

Candidates register to take the WREB Dental Hygiene Examination by submitting an application and creating an online candidate profile. Candidates are required to submit a name that matches personal identification that must be provided the day of the examination. In addition, candidates are required to submit a photograph that will be used for their Candidate ID Badge, which must be worn the day of the examination.

The WREB website and 2020 WREB Candidate Guide provide detailed instructions and information regarding the application and registration process, including:

- Creating a Candidate Profile
- Scheduling requests
- Providing poof of qualification
- Paying for an examination
- Monitoring candidate status

Finding 15: WREB's registration process appears straightforward. The information available to candidates is detailed and comprehensive. The candidate registration process appears to meet professional guidelines and technical standards.

Test Administration – Accommodation Requests

WREB complies with the Americans with Disabilities Act and provides reasonable accommodations to candidates with documented disabilities. Candidates with a disability are required to submit a Special Accommodations Request Form 45 days prior to the examination, along with documentation from a health care professional attesting to the need for accommodation (WREB Candidate Guide, 2020). WREB attempts to make reasonable accommodations provided they do not interfere with the skills the examination is intended to measure or provide an unfair advantage (WREB Technical Report, 2020).

Finding 16: WREB's accommodation procedures appear consistent with professional guidelines and technical standards.

Test Administration – Test Centers and Test Sites

The WREB Dental Hygiene Examination is administered over several days at dental hygiene schools that serve as test sites. These test sites are located throughout California and other member states (WREB website). Testing dates are site-specific and arranged between WREB and the test site. Candidates are assigned to either a morning or afternoon testing session (WREB Candidate Guide, 2020).

Finding 17: Candidates have access to participating dental hygiene schools with trained examiners and controlled testing conditions.

Test Administration – Directions and Instructions to Candidates

The WREB website provides detailed information about the patient-based WREB Dental Hygiene Examination. In addition, the 2020 WREB Candidate Guide provides detailed information to candidates regarding:

- Scope of the examination and examination procedures
- Examination materials and instruments
- Patient selection guidelines
- Reporting to the test center and test site
- Candidate orientation
- Test center and test site procedures
- Security procedures
- Standards of conduct
- Infection control requirements
- Examination scoring criteria
- Examination forms (completed before, or during, examination administration)

Candidates are also provided with an onsite question and answer session and tour of the clinic before the start of the exam. During this time, candidates are provided with instructions regarding clinic layout, emergency protocols, infection control policies, proper disposal of biohazardous materials, sterilization procedures, and operation of equipment (WREB Candidate Guide, 2020).

> Finding 18: The directions and instructions provided to candidates appear straightforward. The information available to candidates is detailed and comprehensive.

Test Administration – Standardized Procedures and Testing Environment

Candidates are tested in similar operatories at test sites, using the same equipment, under the same conditions (WREB Candidate Guide, 2020). All candidates are assessed on the same clinical skills, which are performed on a live patient in a clinical setting. All candidates are required to use the same specified set of instruments during the examination process. In addition, expendable dental hygiene materials are provided by test sites to all candidates. Candidates are required to provide protective eyewear for themselves and patients.

As part of the examination process, candidates are required to submit live patients for acceptance and approval. Patients must meet specific criteria, including one quadrant with 12 surfaces of minimum qualifying subgingival calculus (WREB Candidate Guide, 2020). While candidates incur point penalties for patient rejections, they may make up to three submissions for acceptance.

> Finding 19: The procedures established for the test administration process and testing environment appear to be consistent with professional guidelines and technical standards.

Finding 20: The variability associated with the use of live patients presents challenges to standardization. WREB is aware of these challenges and has taken steps to address the issue. WREB evaluated candidate performance between 2013 and 2017 and found that candidates who submitted patients that required "more challenging treatment" were less likely to incur penalties for patient rejection. However, these candidates were less likely to be successful on the treatment portion of the examination. In 2018, WREB revised the patient selection process, allowing candidates to submit up to four additional teeth in addition to a quadrant, without necessarily having to treat all submitted teeth. The modifications made in 2018 also included changes in the definitions of qualifying calculus to "improve clarity and better reflect the treatment needs of the wider patient population" (WREB Overview of Recent Results, 2020, p. 2).

While the revisions made in 2018 resulted in an increase in passing rates, it is unclear to what extent standardization was improved. WREB has defined criteria for minimum qualifying calculus; however, it is unclear how increased levels of complexity are accounted for with regard to minimum competence standards. While the level of complexity associated with calculus removal appears to vary significantly when using live patients, scoring is dichotomous (points are assigned based on the presence or absence of remaining calculus).

WREB has been researching the viability of alternatives to patient-based assessments, including a typodont simulation using custom-designed materials. However, WREB has found that a typodont simulation would not be a sufficiently valid and defensible alternative. WREB has indicated it will continue exploring the simulation alternatives as more realistic simulations can be demonstrated.

RECOMMENDATIONS

Recommendation 5: OPES recognizes the standardization challenges associated with candidate submissions of live patients. However, standardization is an essential feature in administering examinations that are legally defensible, valid, and fair to candidates. OPES recommends that WREB continue to investigate new technologies and alternate means of assessing candidate skills as they relate to competence to practice as a dental hygienist.

CONCLUSIONS

Given the findings, the test administration protocols put in place by WREB appear consistent with professional guidelines and technical standards. However, OPES recommends options be considered to address standardization issues associated with the use of live patients.

CHAPTER 6 | EXAMINER TRAINING, SCORING, AND PERFORMANCE STANDARDS

STANDARDS

The following standards are most relevant to examiner training, test scoring, and performance for licensing examinations, as referenced in the *Standards.*

Standard 2.3

For each total score, subscore, or combination of scores that is to be interpreted, estimates of relevant indices of reliability/precision should be reported (p. 43).

Standard 4.10

When a test developer evaluates the psychometric properties of items, the model used for that purpose (e.g., classical test theory, item response theory, or another model) should be documented. The sample used for estimating item properties should be described and should be of adequate size and diversity for the procedure. The process by which items are screened and the data used for screening, such as item difficulty, item discrimination, or differential item functioning (DIF) for major examinee groups, should also be documented. When model-based methods (e.g., IRT) are used to estimate item parameters in test development, the item response model, estimation procedures, and evidence of model fit should be documented (pp. 88-89).

Standard 4.20

The process for selecting, training, qualifying, and monitoring scorers should be specified by the test developer. The training materials, such as the scoring rubrics and examples of test takers' responses that illustrate the levels on the rubric score scale, and the procedures for training scorers should result in a degree of accuracy and agreement among scorers that allows the scores to be interpreted as originally intended by the test developer. Specifications should also describe processes for assessing scorer consistency and potential drift over time in raters' scoring (p. 92).

Standard 4.21

When test users are responsible for scoring and scoring requires scorer judgment, the test user is responsible for providing adequate training and instruction to the scorers and for examining scorer agreement and accuracy. The test developer should document the expected level of scorer agreement and accuracy and should provide as much technical guidance as possible to aid test users in satisfying this standard (p. 92).

Standard 6.8

Those responsible for test scoring should establish scoring protocols. Test scoring that involves human judgment should include rubrics, procedures, and criteria for scoring. When scoring of complex responses is done by computer, the accuracy of the algorithm and processes should be documented (p. 118).

OPES 20-01, as mandated by B&P Code § 139, specifies that board members, committee members, and instructors should not serve as expert consultants in the licensure examination development process. This is due to potential conflict of interest, undue influence, and security considerations.

FINDINGS

Examiner Selection and Training

The patient-based WREB Dental Hygiene Examination relies on the judgment of examiners in determining whether a candidate has demonstrated the skills required for competent dental hygiene practice. The Dental Hygiene Committee sets the criteria for selecting examiners (WREB Technical Report, 2020). Examiners are predominantly members or designees of licensing boards that comprise WREB's member states. Approximately 25% of examiners are educators. All examiners are required to be actively licensed and in good standing and have no license restrictions. They must submit proof of license renewal each year (WREB Technical Report, 2020).

All examiners are required to complete a series of tutorials and self-assessments in preparation for scoring examinations (WREB Technical Report, 2020). Examiners review WREB secure online training materials and then attend orientation and calibration sessions. During these sessions, examiners practice applying scoring criteria using examples of clinical performance. The judgments provided by examiners during these sessions are compared with scores provided by members of examination committees using the performance criteria. Calibration exercises are continued until examiners reach an acceptable level of agreement.

The Dental Hygiene Committee also monitors examiner performance during examinations (WREB Technical Report, 2020). Examiners who demonstrate low percentages of agreement, high percentages of harshness or lenience, or erratic grading patterns receive remedial training and are monitored for proper application of grading criteria definitions. Continued lack of agreement may result in dismissal from the examination pool (WREB Technical Report, 2020).

WREB maintains a statistical profile of examiners, which is used as the basis for assigning examiners to test sites (WREB Technical Report, 2020). Site assignments are made to provide stability in grading across examiners and examination administrations. To minimize conflicts of interest, educators are not allowed to serve as examiners at the school test site where they teach (WREB Technical Report, 2020). WREB requires that member states be involved in examination development and administration, and examiners from member states are prioritized in making examiner assignments at test sites.

Finding 21: The selection and training of examiners for the patient-based WREB Dental Hygiene Examination is generally consistent with professional guidelines and technical standards. However, the use of board members and educators as examiners is not fully compliant with OPES 20-01, as mandated by B&P Code § 139.

Examination Scoring

The patient-based WREB Dental Hygiene Examination uses a criterion-based scoring system (WREB Technical Report, 2020). Once a candidate has completed treatment procedures on a patient, three examiners independently evaluate the candidate's performance using established scoring criteria. Scores are assigned based on the median rating of the three examiners.

Points on the examination are deducted for patient selections that do not meet required criteria and for performance errors that are confirmed by two of three examiners (WREB Technical Report, 2020). Point deductions for rejection and performance errors are assigned as follows:

- Patient treatment submission rejection – 4 points each (up to three rejections).
- Extraoral and intraoral examination – 2 points (partial credit of one point may be given).
- Probing and recession error – 1 point each (up to 12 out of 15 possible points).
- Remaining calculus – 6.25 points each.
- Tissue trauma – 6.50 points each (WREB Candidate Guide, 2020).

In addition to point penalties for performance errors, candidates are assessed a 4-point or 3-minute clinical treatment time deduction for each minute a patient is late for check-in procedures, and a 1-point deduction for each minute the patient is late for check-out procedures (WREB Candidate Guide, 2020).

A final score is calculated by applying point deductions from a total of 100 possible points (WREB Technical Report, 2020). Candidates must receive a minimum score of 75 of 100 possible points to pass the examination.

Finding 22: The scoring criteria are applied equitably and are generally consistent with professional guidelines and technical standards.

Finding 23: Scoring penalties predominantly reflect errors or deficiencies associated with performance. However, the late penalty appears to be unrelated to performance standards required for safe and effective practice.

Finding 24: A scoring penalty of 6.25 points is assigned for the presence of detectable calculus. This scoring is dichotomous and appears to be assigned irrespective of the level of case complexity.

Examination Performance

WREB performs analyses of test functioning and rater performance for each examination administration (WREB Technical Report, 2020). Classical test theory statistics are used to evaluate rating scale proportions and descriptive statistics of rated examination components. The many-faceted Rasch model is also used to evaluate performance characteristics associated with candidate ability, task difficulty, and scoring (WREB Technical Report, 2020).

Following each examination administration, WREB performs several analyses to evaluate examiner rating performance. These analyses include evaluation of both examiner agreement and examiner harshness or leniency (WREB Technical Report, 2020). To evaluate rater agreement, WREB conducts comparison analyses between ratings assigned by one examiner and the mean of the ratings provided by the other two examiners for each examination component (WREB Technical Report, 2020). Ratings that deviate from the mean by one point represent an insufficient level of agreement. WREB examiners are expected to be within one point of the mean in at least 80% of assigned ratings (WREB Technical Report, 2020).

Infit and outfit mean-square fit statistics (many-faceted Rasch model) are analyzed to identify examiner ratings that indicate either harsh or lenient extremes. Examiners with ratings at extremes of either range may be referred for additional training (WREB Technical Report, 2020). Additional analyses of examiner teams at each test site are conducted using the Rasch model to ensure comparability of ratings across examination sites and sessions (WREB Technical Report, 2020).

Data provided for the most recent complete administration of the patient-based WREB Dental Hygiene Examination (2019) indicated examination and examiner statistics within generally accepted ranges.

> Finding 25: The examination-level statistics and examiner performance statistics indicate adequate performance for licensure examinations.

RECOMMENDATIONS

> Recommendation 6: OPES recognizes that WREB requires the participation of practitioners from member states to develop and administer examinations. In order to be fully compliant with OPES 20-01, OPES recommends phasing out the service of board members and educators as examiners in the administration of the patient-based WREB Dental Hygiene Examination.
>
> Recommendation 7: The content and scoring criteria for licensure examinations should clearly reflect the competencies necessary for practice. The scoring criteria used on the patient-based WREB Dental Hygiene Examination generally reflect the competencies required for dental hygiene practice, with penalties for performance error or critical deficiencies. However, the time penalty appears unrelated to competency for practice. OPES recommends reviewing scoring criteria to define how this penalty relates to the competencies required for practice or removing this penalty from the scoring process.

Recommendation 8: In 2018, WREB modified patient submission criteria. As WREB noted, candidates who selected more challenging cases were less likely to face patient rejection but were more likely to be unsuccessful on treatment portions of the examination (WREB Overview of Recent Results, 2020). It is unclear whether more challenging cases reflect minimum competence for professional practice or are associated with higher levels of competence. OPES recommends that WREB clarify the relationship between case complexity and minimum competence standards.

CONCLUSIONS

The steps taken by WREB to score the patient-based WREB Dental Hygiene Examination generally appear to provide for a fair and objective evaluation of candidate performance. However, OPES recommends that WREB review scoring criteria to establish a clear connection between the time penalty and competence for dental hygiene practice or that WREB consider revision of this penalty. OPES further recommends that WREB clarify the link between case complexity and minimum competence with regard to dichotomous scoring of calculus removal.

The steps taken by WREB to evaluate examination and examiner performance appear to be reasonable.

CHAPTER 7 | TEST SECURITY

STANDARDS

The following standards are most relevant to test security for licensure examinations, as referenced in the *Standards.*

Standard 6.6

Reasonable efforts should be made to ensure the integrity of test scores by eliminating opportunities for test takers to attain scores by fraudulent or deceptive means (p. 116).

Standard 6.7

Test users have the responsibility of protecting the security of test materials at all times (p. 117).

Standard 8.9

Test takers should be made aware that having someone else take the test for them, disclosing confidential test material, or engaging in any other form of cheating is unacceptable and that such behavior may result in sanctions (p. 136).

Standard 9.21

Test users have the responsibility to protect the security of tests, including that of previous editions (p. 147).

FINDINGS

Test Security – Examination Materials and Candidate Information

For the patient-based WREB Dental Hygiene Examination, the content, scoring criteria, and passing score are made public and are available in the 2020 WREB Candidate Guide.

All examination materials and equipment used to administer the examination are prepared by WREB staff for distribution to test sites before the date of administration (WREB email communication, November 2020). Materials and scoring equipment are individually numbered and securely sealed in containers for transport to test sites. Each container is assigned a unique identifier and securely shipped to a test site using a national shipping company. At each test site, the containers are verified and stored in a locked room. Only WREB staff have access to and authority to unseal the containers. Once the containers are opened, WREB staff use point keyed locks throughout examination processes. Following test administration, WREB staff securely seal examination materials and equipment in the containers for return shipping.

During the registration process, candidates are required to submit a passport quality photograph (WREB email communication, November 2020). This photograph becomes part of the

Candidate Profile and is printed on the Candidate ID Badge. This badge must be presented by a candidate at the examination site, along with another valid form of identification, before the candidate will be admitted. All examination materials are numbered with each candidate's unique Candidate ID Number. Candidates are required to wear the Candidate ID Badge throughout the examination, and each candidate's materials are matched against each Candidate ID Badge for accuracy. Candidates must return their ID Badge and examination materials at the completion of the exam.

All examiners and candidates are required to sign non-disclosure agreements, certifying confidentiality compliance regarding examination-related materials (WREB Technical Report, 2020). Candidate are permitted to bring the 2020 WREB Candidate Guide to test sites, but all other outside references or materials are prohibited. In addition, candidates are prohibited from bringing recording devices, cell phones, smartwatches, or other electronic devices into test sites. Candidate clothing and eyeglasses are inspected on the day of the examination for prohibited items (WREB Technical Report, 2020).

At test sites, WREB uses dedicated equipment and a secure electronic scoring system (ESS) to maintain the security of candidate information and examination data (WREB email communication, November 2020). The ESS requires a uniquely encrypted key for access, and it is used to transmit scoring data from examiner electronic devices to an onsite server via a secure local network. The network can only be accessed by WREB staff. Each day, designated WREB staff synch information used during examination administration from the WREB office, and synch data back at the end of the day.

The WREB server is equipped with backup capability. In addition, WREB staff use an external USB hard drive to prevent catastrophic ESS data loss.

> Finding 26: The security procedures practiced by WREB with regard to the maintenance of examination materials and candidate information are consistent with professional guidelines and technical standards.

Test Security – Test Sites

WREB maintains test site security policies and procedures. Only authorized WREB personnel, examiners, and candidates are allowed to access test facilities providing test administration. WREB personnel, examiners, and candidates are required to wear identification at all times during test administration.

Finding 27: The security procedures practiced by WREB regarding test sites are consistent with professional guidelines and technical standards.

CONCLUSIONS

Given the findings, the test security policies, procedures, and protocols meet professional guidelines and technical standards.

CHAPTER 8 | COMPARISON OF THE CALIFORNIA REGISTERED DENTAL HYGIENIST DESCRIPTION OF PRACTICE TO THE PATIENT-BASED WREB DENTAL HYGIENE EXAMINATION BLUEPRINT

PARTICIPATION OF SUBJECT MATTER EXPERTS

OPES convened a 2-day workshop on May 14–15, 2020 to evaluate and compare the following items:

- The task and knowledge statements of the California description of practice resulting from the 2019 California Occupational Analysis of the Registered Dental Hygienist Profession (California RDH OA, 2019).
- The examination content of the patient-based WREB Dental Hygiene Examination.

OPES recruited seven registered dental hygienists to participate in the workshop as SMEs.

The SMEs represented the profession in both northern and southern California. Two of the SMEs had been licensed for 1–5 years, one had been licensed for 6–10 years, three had been licensed for 11–19 years, and one had been licensed for more than 20 years. All SMEs worked as dental hygienists in various settings.

WORKSHOP PROCESS

First, the SMEs completed OPES' security agreement, self-certification, secure area agreement, and personal data (demographic) forms. The OPES facilitator explained the importance of, and the guidelines for, security during and outside the workshop. The SMEs were then asked to introduce themselves.

Next, the OPES facilitator gave a PowerPoint presentation about the purpose and importance of occupational analysis, validity, content validity, reliability, test administration standards, examination security, and the role of SMEs. The OPES facilitator also explained the purpose of the workshop.

The SMEs were instructed to evaluate and link each task and knowledge statement of the California description of practice to the task statements of the patient-based WREB Dental Hygiene Examination blueprint. The SMEs worked as a group to evaluate and link all of the task and knowledge statements of the California description of practice.

The content domain of the patient-based WREB Dental Hygiene Examination is provided in Table 1. Table 2 provides the content areas of the 2019 California RDH description of practice.

TABLE 1 – PATIENT-BASED WREB DENTAL HYGIENE EXAMINATION BLUEPRINT DOMAIN SECTIONS

Domain Section	Weight
1. Extraoral and Intraoral Examination 2. Periodontal Assessment	25%
3. Calculus Removal 4. Tissue Management	75%
Total	**100%**

TABLE 2 – CONTENT AREAS OF THE 2019 CALIFORNIA REGISTERED DENTAL HYGIENIST DESCRIPTION OF PRACTICE

Content Area	Content Area Description	Weight
1. Treatment Preparation	This area assesses the candidate's knowledge of preparing the operatory and patient dental hygiene services.	5%
2. Dental Hygiene Treatment	This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.	40%
3. Patient Education	This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.	10%
4. Infection Control	This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.	15%
5. Documentation	This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental records.	5%
6. Laws, Regulations, and Ethics	This area assesses the candidate's knowledge of licensing requirements, professional conduct, patient confidentiality, use of telehealth methods and technology, and mandated reporting.	25%
Total		**100%**

FINDINGS

The SMEs compared the task and knowledge statements of the 2019 California RDH description of practice outline and the patient-based WREB Dental Hygiene Examination blueprint. The SMEs concluded that the patient-based WREB Dental Hygiene Examination adequately assessed the skills required for entry-level dental hygiene practice in California in the following four areas:

- Treatment Preparation
- Dental Hygiene Treatment
- Infection Control
- Documentation

The SMEs indicated that the patient-based WREB Dental Hygiene Examination did not adequately assess the content area Patient Education, but this content was determined to be adequately assessed by other assessment measures. In addition, SMEs indicated that the patient-based WREB Dental Hygiene Examination did not adequately assess the content area Laws, Regulations, and Ethics. However, this content is measured by the California-specific Registered Dental Hygienist Law and Ethics Examination.

> Finding 28: The SMEs concluded that the content of the patient-based WREB Dental Hygiene Examination adequately assesses the general skills required for entry-level dental hygiene practice in California identified in the California RDH OA, 2019.
>
> Finding 29: The SMEs concluded that the content of the patient-based WREB Dental Hygiene Examination does not adequately assess the laws and ethics required for practice in California. SMEs concluded that this content should continue to be measured using a California-specific law and ethics examination.

CONCLUSIONS

Overall, the SMEs concluded that the content of the patient-based WREB Dental Hygiene Examination sufficiently assesses the skills dental hygienists are expected to have mastered at the time of licensure.

CHAPTER 9 | CONCLUSIONS

COMPREHENSIVE REVIEW OF THE PATIENT-BASED WREB DENTAL HYGIENE EXAMINATION

OPES completed a comprehensive analysis and evaluation of the documents provided by WREB.

OPES finds that the procedures used to establish and support the validity and defensibility of the patient-based WREB Dental Hygiene Examination (i.e., OA, examination development, passing scores and passing rates, test registration and administration, examination scoring and performance, and test security) *generally* meet professional guidelines and technical standards outlined in the *Standards* and B&P Code § 139. However, to be fully compliant with OPES 20-01, OPES recommends phasing out the service of board members and educators in examination development processes.

In addition, OPES made recommendations related to standardization and scoring processes. These recommendations are as follows:

1) OPES recommends that WREB consider methods to improve standardization in relation to patient selection. The use of live patients in licensure examinations presents challenges to standardization; however, standardization is an essential feature of examinations that are legally defensible, valid, and fair. WREB regularly reviews the performance of the WREB Dental Hygiene Examination and takes steps to maximize standardization; however, it appears that there may be some variability with regard to patient presentation and case complexity. WREB has defined a minimum qualifying calculus standard associated with minimum competence, but it is unclear how higher levels of complexity are addressed. Scoring on calculus removal is dichotomous, regardless of case complexity. OPES recommends that WREB review the patient selection component of the examination and provide a clear connection between scoring criteria, case complexity, and minimum competence.

2) OPES recommends that WREB review the scoring deductions associated with late arrival penalties. Scoring criteria should be directly related to the competencies required for practice and should not reflect undesirable behaviors that are not related to professional competencies. Therefore, OPES recommends that WREB review the late penalty deduction. This penalty should be revised, or a connection should be established between this penalty and minimum competence.

   OPES notes that WREB regularly evaluates the contribution of these penalties to overall passing rates. WREB has indicated that these penalties rarely result in a candidate failing the examination; however, both patient rejections and late penalties remain a significant contributor to point deductions. They also may create unnecessary stress for candidates.

Based on the evaluations presented in this report, OPES finds that the content of the patient-based WREB Dental Hygiene Examination *generally* measures the skills related to California dental hygiene practice.

However, practical examinations typically face issues with one or more of the following: standardizing procedures and materials, inter-rater reliability, validating scoring criteria, and setting passing scores that reflect minimum competence. These issues are exacerbated by the addition of live patients. OPES recommends that the Board consider conducting an evaluation to determine whether a skills-based examination remains a necessary component of assessing a candidate's competence for practice. Given the level of training and clinical assessment that dental hygiene candidates receive in educational programs, requiring a knowledge-based examination may be sufficient to assess minimum competence for licensure.

CHAPTER 10 | REFERENCES

American Educational Research Association, American Psychological Association, National Council on Measurement in Education, and Joint Committee on Standards for Educational and Psychological Testing. (2014). *Standards for educational and psychological testing*.

California Business and Professions (B&P) Code § 139. State of California.

California Code of Regulations (CCR) Title 16 § 2021.3. State of California.

Department of Consumer Affairs (DCA). Policy OPES 20-01 *Participation in examination development workshops*. State of California.

Department of Consumer Affairs (DCA). Policy OPES 18-02 *Licensure examination validation*. State of California.

Office of Professional Examination Services (OPES). (2019). *Occupational analysis of the registered dental hygienist profession.* State of California. Department of Consumer Affairs.

Western Regional Examining Board (WREB). (2020). *2017–18 dental hygiene practice analysis: Report of findings prepared for the CRDTS and WREB Joint Dental Hygiene Practice Analysis Committee.*

Western Regional Examining Board (WREB). (2020). *WREB 2020 dental hygiene examination candidate guide.*

Western Regional Examining Board (WREB). (2020). *Overview of recent results for graduates of California dental hygiene programs.*

Western Regional Examining Board (WREB). (2020). *WREB 2019 dental hygiene examinations technical report.*

STATE OF CALIFORNIA
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MEMORANDUM

DATE	October 8, 2022
TO	Dental Hygiene Board of California
FROM	Anthony Lum Executive Officer
SUBJECT	**FULL 6: Discussion and Possible Action on the Recommendations of the Alternative Pathway to Licensure Taskforce**

BACKGROUND

At the March 20, 2021, Board meeting, the Board voted to reconstitute the Alternative Pathways to Licensure (APL) Taskforce that had previously been assembled years before to research optional pathways to dental hygiene licensure than the patient-based clinical examination. The APL Taskforce researched and discussed the issue thoroughly, as it's a very complex task to create alternative options to replace the clinical examination with respect to the law. They met on the following days to discuss alternative options and ideas to bring forth recommendations to the Licensing and Examination Committee:

Thursday, May 20, 2021

Friday, June 4, 2021

Friday, July 2, 2021

Thursday, March 10, 2022

Thursday, July 14, 2022

Thursday, September 22, 2022

After multiple discussions and vetting several options, the taskforce prepared a recommendation for the Full Board's consideration.

RECOMMENDATION

Staff requests the full Board to consider, discuss, and approve the APL Taskforce's recommendations and request the Legislature to consider amendments to Statute (Business and Professions Code section 1917(a)).

Requested Sunset Amendments to the Business and Professions Code

Section 1917

The dental hygiene board shall grant initial licensure as a registered dental hygienist (RDH) to a person who satisfies all of the following requirements:

~~(a) Completion of an educational program for registered dental hygienists, approved by the dental hygiene board, accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution.~~

~~(b) Within the preceding three years, satisfactory completion of the dental hygiene examination given by the Western Regional Examining Board or any other clinical or dental hygiene examination approved by the dental hygiene board.~~

(a) Completion of either of the following:

(1) Satisfactory completion of a California educational program for RDHs, approved by the dental hygiene board, accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution. If an applicant fails to apply for licensure within three years of completion of a dental hygiene board-approved California educational program for RDHs, the applicant shall be required to satisfactorily complete a dental hygiene licensure examination approved by the dental hygiene board; or

(2) Satisfactory completion of a non-California educational program for RDHs, accredited by the Commission on Dental Accreditation, recognized by the dental hygiene board, and conducted by a degree-granting, postsecondary institution within the United States or Canada, and within three years of the application date satisfactory completion of a dental hygiene licensure examination approved by the dental hygiene board.

~~(c)~~(b) Satisfactory completion of the National Board Dental Hygiene Examination.

~~(d)~~(c) Satisfactory completion of the examination in California law and ethics as prescribed by the dental hygiene board.

~~(e)~~(d) Submission of a completed application form and all fees required by the dental hygiene board.

~~(f)~~(e) Satisfactory completion of dental hygiene board-approved instruction in gingival soft-tissue curettage, nitrous oxide-oxygen analgesia, and local anesthesia.

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MEMORANDUM

DATE	October 8, 2022
TO	Dental Hygiene Board of California
FROM	Adina A. Pineschi-Petty DDS Education, Legislative, and Regulatory Specialist
SUBJECT	**FULL 7: Discussion and Possible Action to Amend Title 16, Section 1119 (formerly 1115), Retired Licensure.**

BACKGROUND

At the March 19, 2022 Full Board WebEx Teleconference, the Board was advised that during DCA's review of proposed California Code of Regulations (CCR), Title 16, Division 11, section 1115 (section 1115) regarding Retired Licensure, DCA suggested edits to the forms to prevent duplication and provide consistency among forms utilized by the Board.

The Board considered and approved the proposed edits to the forms for section 1115 and directed staff to take all steps necessary to complete the rulemaking process, including authorizing the Executive Officer to make any non-substantive changes to the proposed regulation, and adopting the proposed regulation as described in the modified text notice for section 1115.

During the review by the Office of Administrative Law (OAL), OAL:

1) rejected the changes made to the forms [DHBC RLC-01 (New 11/2020) and DHBC RLC-02 (New 10/2020)] as "non-substantive" and recommended reversion to the modified version forms previously adopted by the Board at its January 22, 2022 meeting; and
2) recommended changing the numbering of the regulation from section 1115 to 16 CCR section 1119 (section 1119) to align towards the end of the licensing section as retirement occurs towards the end of a career, as well as to allow for other possible regulations that may apply prior to "retirement."

STAFF RECOMMENDATION:

Staff recommends the Board consider and approve the modified text and forms to the prior version approved at the January 22, 2022 meeting, directing staff to take all steps necessary to complete the rulemaking process, including authorizing the Executive Officer to make any non-substantive changes to the proposed regulation, and adopt the proposed regulation at section 1119.

PROPOSED MOTION LANGUAGE

Approve the proposed modified text and forms to the prior version approved at the January 22, 2022 for section 1119, directing staff to take all steps necessary to complete the rulemaking process, including authorizing the Executive Officer to make any non-substantive changes to the proposed regulation, and adopt the proposed regulation as described in the modified text notice for section 1119.

Pros: If the Board approves the modified forms for section 1119, the proposal will move forward in the regulatory process.

Cons: If the modified forms are not approved for section 1119, the proposal will not move forward in the regulatory process. Given the timeline from when this package was originally noticed, any further work on this topic would start a completely new package.

Documents Included for Reference for Section 1119:

1. Modified Text, as noticed for comment January 28 – February 14, 2022.
2. Associated forms (DHBC RLC-01 (New 11/2020) and DHBC RLC-02 (New 10/2020)), as noticed for comment January 28 – February 14, 2022.

TITLE 16. DENTAL HYGIENE BOARD OF CALIFORNIA - DEPARTMENT OF CONSUMER AFFAIRS ADOPTED LANGUAGE

ORDER OF ADOPTION

Legend:	
Underlined	Indicates added regulatory language.

Adopt Section 1119 of Title 16 of the California Code of Regulations (CCR) to read as follows:

Article 4. Licensing

[NOTE: The text of Section 1117 is not being changed. Section 1117 is displayed to place it in Title 16, Division 11, Article 4.]

§1117. Reporting Dental Relationships Between Registered Dental Hygienists in Alternative Practice and Licensed Dentists

[No change to text.]

Note: Authority cited: Sections 1905 and 1906, Business and Professions Code. Reference: Section 1930, Business and Professions Code.

§1119. Retired Licensure.

(a) A retired license shall be issued to a registered dental hygienist (RDH), registered dental hygienist in alternative practice (RDHAP), or registered dental hygienist in extended functions (RDHEF) if the licensee meets the following requirements:

(1) Holds an active license or an inactive license that was not placed on inactive status as a result of revocation or suspension;

(2) Submits to the Board a completed "Application for a Retired RDH, RDHAP, or RDHEF License" DHBC RLC-01 (New 11/20), hereby incorporated by reference; and

(3) Submits an $80 fee to the Board.

(b) Once the Board has issued a retired license, the holder of a retired license shall:

(1) Be exempt from continuing education requirements;

(2) Be exempt from renewal of the retired license; and

(3) Utilize his or her professional title only with the unabbreviated word "retired" preceding or after the professional designation.

(c) The holder of a retired license shall not engage in any activity for which an active RDH, RDHAP, or RDHEF license is required.

(d) The Board shall not be prevented from investigating violations or taking action against a retired license for violations of laws governing the practice of dental hygiene.

(e) To restore a license to active status, the holder of a retired license shall comply with the following requirements:

(1) Submit a completed "Application for Reactivation of a Retired RDH, RDHAP, or RDHEF License" DHBC RLC-02 (New 10/20), hereby incorporated by reference;

(2) Payment of a $160 fee as required by the Board;

(3) Submit proof of completion of current continuing education requirements pursuant to 16 CCR sections 1016 and 1017; and

(4) Comply with fingerprint submission requirements pursuant to 16 CCR section 1132.

(f) The holder of a retired license shall be allowed to provide to the public, without supervision, dental hygiene educational services, oral health training programs, oral health screenings, and application of fluoride varnish free of charge in any oral health public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity, at a sponsored event by a sponsoring entity. The retired licensee shall refer any screened individuals with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan. For purposes of this section, the following shall apply:

(1) "Sponsored event" shall be defined as in paragraph (4) of subdivision (b) of Section 1626.6 of the Code.

(2) "Sponsoring entity" shall be defined as in paragraph (6) of subdivision (b) of Section 1626.6 of the Code.

Note: Authority cited: Sections 464, 1905, 1906 and 1944, Business and Professions Code. Reference: Sections 464, 1906 and 1944, Business and Professions Code.

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Application for a Retired RDH, RDHAP, or RDHEF License

Business & Professions Code (BPC) sections 464, 1905, and 1906, and California Code of Regulations (CCR) Title 16, Division 11 section 1119.

Non-Refundable Application Fee: $80
(Must accompany application)

Please type or print legibly.

DHBC USE ONLY
Receipt _____ RC _____
Date Filed _____ $ _____
Approved _____ Denied _____
RDH/RDHAP/RDHEF# _____

License Number ☐ RDH ☐ RDHAP ☐ RDHEF	Date	Is your current license available? ☐ Yes** ☐No If yes, attach documentation to application.
Last Name	First Name	Middle Name
Address of Record*		
City	State	Zip Code
Home Phone Number	Mobile Phone Number	
Email Address		

*The address you enter on this application is public information and will be available on the Internet pursuant to BPC section 1902.2(b). If you do not want your home address to be made public, you may instead provide a post office box or your business address.

IMPORTANT – PLEASE READ CAREFULLY

- ****Enclose your current license issued by the Board, if available, with this application.**
- A holder of a retired license may not engage in any activity for which an active license issued by the DHBC is required.
- In order to be eligible for a retired license, you must hold an active or inactive license issued by the Board as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions that was not placed on inactive status as a result of revocation or suspension.
- If your license is expired, you must clear all outstanding requirements and renew the license before your application for a retired license will be processed. Expired licenses that cannot be renewed will not be processed.

- The holder of a retired license is not required to renew that license.
- The holder of a retired license is exempt from continuing education requirements.
- The holder of a retired license shall be permitted to use his or her professional title only with the unabbreviated word "retired" preceding or after the professional designation.
- Changing to a retired status does not prevent the DHBC from investigating potential violations or taking action against your license for confirmed violations of laws governing the practice of dental hygiene.

I have read and understand the information provided on this application, and I meet the requirements for a retired license. I certify that if I have not enclosed my current license, the license is lost. I hereby request that my license be placed in retired status. I certify under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

Signature: _____ Date: _____

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by the Dental Hygiene Board of California, 2005 Evergreen Street, Suite 1350, Sacramento, CA 95815, Executive Officer, 916-263-1978, in accordance with Business & Professions Code, section 1900 et seq. The information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Each individual has the right to review his or her own personal information maintained by the agency as set forth in the Information Practices Act unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may, under limited circumstances, be made public.

DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1350 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhbc.ca.gov

Application for Reactivation of a Retired RDH, RDHAP, or RDHEF License

Business & Professions Code (BPC) sections 464, 1905, and 1906, and California Code of Regulations (CCR) Title 16, Division 11 sections 1016, 1017, and 1119.

Non-Refundable Application Fee: $160
(Must accompany application)

DHBC USE ONLY
Receipt _____ RC _____
Date Filed _____ $ _____
Approved _____ Denied _____
RDH/RDHAP/RDHEF# _____

Please type or print legibly.

Date	License Number ☐ RDH ☐ RDHAP ☐ RDHEF	Date License was Retired
Last Name	First Name	Middle Name
Address of Record*		
City	State	Zip Code
Home Phone Number	Mobile Phone Number	
Email Address		

*The address you enter on this application is public information and will be available on the Internet pursuant to BPC section 1902.2(b). If you do not want your home address to be made public, you may instead provide a post office box or your business address.

IMPORTANT – PLEASE READ CAREFULLY

You may not practice dental hygiene, dental hygiene in alternative practice, or dental hygiene in extended functions until the Dental Hygiene Board of California (Board) approves your request to restore your retired license to active status.

1. In order to reactivate a retired license, you must complete the same number of continuing education units that are required to renew an active license and submit the certificates of completion to the Board. Please refer to 16 CCR sections 1016 and 1017 for continuing education requirements.

2. 16 CCR section 1132 requires licensees to furnish a full set of electronic fingerprints for the purpose of conducting a criminal history record check and criminal offender record information search. The Board shall not restore a retired license to active status until the licensee has complied with this requirement, if applicable.

3. Enclose your original retired license.

4. Please certify the following:

(a) Since retirement of DHBC licensure, I have not been convicted of, or under investigation for, any violation of the law in this or any other state, the United States, or other country.

Note: You do not need to disclose traffic infractions with penalties under $1,000 unless the infraction involved alcohol, dangerous drugs, or controlled substances.

☐ Yes ☐ No (if no, please explain on an attached sheet).

(b) Since retirement of DHBC licensure, I have not been subject to discipline against any other healthcare license I hold.

☐ Yes ☐ No (if no, please explain on an attached sheet.

I have read and understand the information provided on this application, and hereby request that my retired license be restored to active status. I certify under penalty of perjury, under the laws of the State of California, that the foregoing is true and correct.

Signature: Date:

INFORMATION COLLECTION AND ACCESS

The information requested herein is mandatory and is maintained by the Dental Hygiene Board of California, 2005 Evergreen Street, Suite 1350, Sacramento, CA 95815, Executive Officer, 916-263-1978, in accordance with Business & Professions Code, section 1900 et seq. The information requested will be used to determine eligibility. Failure to provide all or any part of the requested information will result in the rejection of the application as incomplete. Each individual has the right to review his or her own personal information maintained by the agency as set forth in the Information Practices Act unless the records are exempt from disclosure. Applicants are advised that the names(s) and address(es) submitted may, under limited circumstances, be made public.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DENTAL HYGIENE BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1350 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhbc.ca.gov

MEMORANDUM

DATE	October 8, 2022
TO	Dental Hygiene Board of California
FROM	Anthony Lum Executive Officer
SUBJECT	**FULL 8: Discussion and Possible Action on Draft 2022/23 Sunset Review Report**

BACKGROUND

Sunset Review is the process where the Legislature has an opportunity to review a board program to determine whether to continue it or not. Board programs must complete this process every 4-5 years as a method to inform the Legislature how the program is doing, update on prior issues and their progress, whether there are any new issues for the program to address and is an opportunity for the Board to request additional resources for Board's needs, if necessary.

For each Sunset Review, staff assemble a very complex and detailed draft report containing information from the past four years addressing questions from the Legislature for the Board to consider and make revisions, if needed. This meeting is the first opportunity for the Board to review the draft report and make any recommended edits or changes to be brought back at a subsequent Board meeting for approval prior to submission to the Legislature. The due date this year for the report to be submitted to the Legislature is January 1, 2023.

RECOMMENDATION

Staff recommends for the Board to review the draft 2022/23 Sunset Review report in its entirety and provide recommendation and guidance for any edits or revisions to the report to be returned at the next meeting with revisions for approval.

DENTAL HYGIENE BOARD OF CALIFORNIA
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of September 24, 2022

Section 1 – Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.[1] Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

In 2002, the Joint Legislative Sunset Review Committee (JLSRC) agreed that "dental hygienists had reached the point where their responsibilities warranted a regulatory body, separate from Dental Board of California (DBC)." The Dental Hygiene Committee of California (DHCC) was created in fiscal year (FY) 2009/10 as result of the passage of Senate Bill (SB) 853 (Ch. 31, Statutes of 2008) in 2008.

In 2018, SB 1482 (Ch. 858, Statutes of 2018) provided the authority for the DHCC to change to the Dental Hygiene Board of California (DHBC = Board). This change was substantial for several reasons. First, the name change legitimized the Board as an independent, autonomous government body and not a subdivision of another entity. Second, the replacement of "committee" with "board" emphasized that the Board is not affiliated or under the purview of the DBC. Although the committee was never under the purview of the DBC since its inception, it was perceived to be under the DBC as many dental hygiene licensing entities across the nation are structured this way. The Board continues to be the only self-regulating dental hygiene oversight government agency with the mission of consumer protection in the United States.

The Board has the authority regarding all aspects of the licensing, enforcement, and investigation authority regarding dental hygienists, and the approval of all dental hygiene educational programs (DHEP) in California that provide the formal education to become a licensed dental hygienist. According to the Business and Professions Code (BPC), Section 1900, the purpose of the Board is "to permit the full utilization of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions in order to meet the dental care needs of all of the state's citizens."

The Board is responsible for overseeing three categories of dental hygienists: registered dental hygienist (RDH), registered dental hygienist in alternative practice (RDHAP), and registered dental hygienist in extended functions (RDHEF). As a self-regulating agency, the Board develops and administers written licensing law and ethics examinations, conducts occupational analyses of the various professional categories, evaluates, and approves educational programs and courses, pursues legislation, promulgates regulations, and has licensing and enforcement responsibilities of the profession. The Board also participates in outreach and support of the dental and dental hygiene community with the goal of ensuring the highest quality of oral healthcare for all Californians. The Board regulates the dental hygiene profession by the guidance of its statutes contained in the

[1] The term "board" in this document refers to a board, bureau, commission, committee, council, department, division, program, or agency, as applicable. Please change the term "board" throughout this document to appropriately refer to the entity being reviewed.

Business and Professions Code (BPC) §§ 1900 – 1967.4 and California Code of Regulations (CCR) sections 1100 – 1144 and several sections in DBC regulations pertaining to dental hygienists in the Dental Practice Act. The Board has the authority to use these regulations until the Board promulgates their own regulations pursuant to CCR section 1906(d). (cf., Section 12, Attachment B)

1. Describe the make-up and functions of each of the board's committees (cf., Section 12, Attachment B).

   The make-up of the Board consists of nine members (four dental hygienists, four public members, and one practicing general or public health dentist) - seven appointed by the Governor; one public member appointed by the Assembly Speaker of the House; and one public member appointed by the Senate Rules Committee. This is a change as prior to 2019, all Board members were appointed by the Governor. The function of the Board is to discuss, deliberate, address, hear public comment, and act upon any programmatic, legislative, regulatory, or other issue or policy that may affect the professional population, interested stakeholders, and the consumers of California.

   The make-up of each Board committee consists of three to four members as appointed by the Board President to review, discuss, deliberate, hear public comment, and vote on any issue(s) that pertain to the specific committee's jurisdiction and bring forth recommendation(s) to the full Board to discuss and take possible action.

   a) Education Committee –

   The purpose of the Education Committee is to oversee the dental hygiene educational programs and make recommendation to the Board on policy matters related to curriculum, faculty, administration, and approval. The oversight includes enforcing dental hygiene program standards to increase consistency, safety, and quality. May also determine recommendations to the Board of possible enforcement action against a DHEP for non-compliance of the law and Commission on Dental Accreditation (CODA) Standards and may aid in the development of informational brochures and other publications; and could participate in planning of outreach events for consumers, applicants, and licensees.

   b) Enforcement Committee –

   The purpose of the Enforcement Committee is to advise the Board on policy matters that relate to protecting the health and safety of consumers through the enforcement of laws and regulations governing the practice of dental hygiene. This includes maintenance of disciplinary guidelines, Uniform Standards, and other recommendations on the enforcement of the Board's statutes and regulations.

   c) Legislative and Regulatory Committee –

   The purpose of the Legislative and Regulatory Committee is to advocate for statutes, promulgate regulations, and adopt policies and procedures that strengthen and support the Board's mandates, mission, and vision. The Committee reviews and tracks legislation and makes recommendations to the Board for possible action. It also creates regulations that govern the profession which affects licensees and enhances consumer protection.

   d) Licensing and Examination Committee –

   The purpose of the Licensing and Examination Committee is to advise the Board on policy matters relating to the examining and licensing of individuals who want to practice dental hygiene in

California. This committee maintains licensing standards, qualifications, and the Law and Ethics examination(s) to protect consumers while allowing reasonable access to the profession.

Table 1a shows the attendance record for the board members over the past four years. It includes both current and past members who were recently replaced to show their attendance records.

Table 1a. Attendance	CURRENT BOARD MEMBER		
Denise Davis, Secretary, Public Member			
Date Appointed: 10/13/2020	Reappointed: TBD	Term ends: 01/01/2024	
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	No
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	CURRENT BOARD MEMBER		
Carmen Dones, President, RDH Educator Member			
Date Appointed: 11/21/2020	Reappointed: TBD	Term ends: 01/01/2024	
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	CURRENT BOARD MEMBER		
Susan Good, Public Member			
Date Appointed: 04/05/2013	Reappointed: 01/17/2014; 4/1/2018, Term ends: 1/1/2022 (currently in grace year)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	Yes
Full Committee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	Yes
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Enforcement Subcommittee	04/12/2019	Sacramento, CA	Yes
Licensing & Examination Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes

Full Board Meeting	08/06/2019	Teleconference	Yes
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	08/29/2020	Teleconference	Yes
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	**CURRENT BOARD MEMBER**		
Sonia "Pat" Hansen, RDH Member			
Date Appointed: 07/08/2022	Reappointed: TBD	Term ends: 01/01/2026	
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
NOTE: This Board member was appointed in July 2022 and did not participate in any meetings prior to the end of the 2021/22 fiscal year.			

Table 1a. Attendance	**CURRENT BOARD MEMBER**		
Joyce Noel Kelsch, Vice President, RDHAP Member			
Date Appointed: 8/23/2012	Reappointed: 1/16/2016; 12/24/2020, Term ends: 01/01/2024		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	8/08/2018	Teleconference	Yes
Full Committee	11/16/2018	Fresno, CA	Yes
Legislative & Regulatory Subcommittee	11/16/2018	Fresno, CA	Yes
Licensing & Examination Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	Yes
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Enforcement Subcommittee	04/12/2019	Sacramento, CA	Yes
Legislative & Regulatory Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	No
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Legislative & Regulatory Subcommittee	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	08/29/2020	Teleconference	Yes
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	Yes

Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	No

Table 1a. Attendance	**CURRENT BOARD MEMBER**		
Sherman King, Public Member			
Date Appointed: 05/25/2022	Reappointed: TBD	Term ends: 01/01/2026	
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
NOTE: This Board member was appointed in May 2022 but did not participate in any meetings prior to the end of the 2021/22 fiscal year.			

Table 1a. Attendance	**CURRENT BOARD MEMBER**		
Timothy Martinez, DMD, Dentist Member			
Date Appointed: 8/23/2012	Reappointed: 1/17/2014; 4/17/2018, Term ends: 01/01/2022 (currently in grace year)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	Yes
Full Committee	11/16/2018	Fresno, CA	Yes
Enforcement Subcommittee	11/16/2018	Fresno, CA	Yes
Legislative & Regulatory Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	Yes
Full Board Meeting	04/12/2019	Sacramento, CA	No
Enforcement Subcommittee	04/12/2019	Sacramento, CA	No
Licensing & Examination Subcommittee	04/12/2019	Sacramento, CA	No
Full Board Meeting	04/13/2019	Sacramento, CA	No
Full Board Meeting	08/06/2019	Teleconference	Yes
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Licensing & Examination Subcommittee	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	08/29/2020	Teleconference	Yes
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	No
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	CURRENT BOARD MEMBER		
Nicolette Moultrie, RDH Member			
Date Appointed: 4/5/2012	Reappointed: 1/17/2014; 4/1/2018, Term ends: 01/01/2022 (currently in grace year)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	No
Full Committee	11/16/2018	Fresno, CA	Yes
Education Subcommittee	11/16//2018	Fresno, CA	Yes
Licensing & Examination Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	No
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Education Subcommittee	04/12/2019	Sacramento, CA	Yes
Licensing & Examination Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	Yes
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Education Subcommittee	11/22/2019	Glendale, CA	Yes
Licensing & Examination Subcommittee	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	08/29/2020	Teleconference	Yes
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	No
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	CURRENT BOARD MEMBER		
Erin Yee, Public Member			
Date Appointed: 1/4/2021	Reappointed: TBD Term ends: 01/01/2024		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Board Meeting	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	PREVIOUS BOARD MEMBER		
Dr. Michelle Hurlbutt, Past RDH Educator Member			
Date Appointed: 10/21/2009	Reappointed: 08/23/2012; 01/06/2016 Term Ended: 11/20/2021		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	Yes
Full Committee	11/16/2018	Fresno, CA	Yes
Education Subcommittee	11/16/2018	Fresno, CA	Yes
Enforcement Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	Yes
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Enforcement Subcommittee	04/12/2019	Sacramento, CA	Yes
Legislative & Regulatory Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	Yes
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Legislative & Regulatory Subcommittee	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	08/29/2020	Teleconference	Yes

Table 1a. Attendance	PREVIOUS BOARD MEMBER		
Sandra Klein, Past Public Member			
Date Appointed: 10/25/2015	Term Ended: 01/01/2020 (did not seek reappointment)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	Yes
Full Committee	11/16/2018	Fresno, CA	No
Legislative & Regulatory Subcommittee	11/16/2018	Fresno, CA	No
Licensing & Examination Subcommittee	11/16/2018	Fresno, CA	No
Full Committee Meeting	11/17/2018	Fresno, CA	No
Full Board Meeting	01/19/2019	Teleconference	Yes
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Enforcement Subcommittee	04/12/2019	Sacramento, CA	Yes
Licensing & Examination Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	No
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Licensing & Examination Subcommittee	11/22/2019	Glendale, CA	Yes

Table 1a. Attendance	PREVIOUS BOARD MEMBER		
Edcelyn Pujol, Past Public Member			
Date Appointed: 01/25/2016	Term Ended: 01/01/2020 (did not seek reappointment)		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	Yes
Full Committee	11/16/2018	Fresno, CA	Yes
Education Subcommittee	11/16/2018	Fresno, CA	Yes
Enforcement Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	No
Full Board Meeting	04/122019	Sacramento, CA	Yes
Education Subcommittee	04/12/2019	Sacramento, CA	Yes
Licensing & Examination Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	No
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Education Subcommittee	11/22/2019	Glendale, CA	Yes
Licensing & Examination Subcommittee	11/22/2019	Glendale, CA	Yes

Table 1a. Attendance	PREVIOUS BOARD MEMBER		
Garry Shay, Past Public Member			
Date Appointed: 4/5/2013	Reappointed: 1/17/2014; 4/1/2018 Term Ended: 5/20/2022		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	No
Full Committee	11/16/2028	Fresno, CA	Yes
Enforcement Subcommittee	11/16/2018	Fresno, CA	Yes
Legislative & Regulatory Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	No
Full Board Meeting	01/19/2019	Teleconference	No
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Education Subcommittee	04/12/2019	Sacramento, CA	Yes
Legislative & Regulatory Subcommittee	04/12/2019	Sacramento, CA	Yes
Full Board Meeting	04/13/2109	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	No
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Education Subcommittee	11/22/2019	Glendale, CA	Yes
Legislative & Regulatory Subcommittee	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Member	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	No

Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1a. Attendance	**PREVIOUS BOARD MEMBER**		
Evangeline Ward, Past RDH Member			
Date Appointed: 2/12/2012	Reappointed: 1/17/2014; 4/1/2018 Term Ended: 5/10/2022		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	08/08/2018	Teleconference	No
Full Committee	11/16/2018	Fresno, CA	Yes
Education Subcommittee	11/16/2018	Fresno, CA	Yes
Licensing & Examination Subcommittee	11/16/2018	Fresno, CA	Yes
Full Committee Meeting	11/17/2018	Fresno, CA	Yes
Full Board Meeting	01/19/2019	Teleconference	Yes
Full Board Meeting	04/12/2019	Sacramento, CA	Yes
Education Subcommittee	04/12/2019	Sacramento, CA	Yes
Legislative & Regulatory Subcommittee	04/122019	Sacramento, CA	Yes
Full Board Meeting	04/13/2019	Sacramento, CA	Yes
Full Board Meeting	08/06/2019	Teleconference	Yes
Full Board Meeting	11/22/2019	Glendale, CA	Yes
Education Subcommittee	11/22/2019	Glendale, CA	Yes
Legislative & Regulatory Subcommittee	11/22/2019	Glendale, CA	Yes
Full Board Meeting	05/29/2020	Teleconference	Yes
Full Board Meeting	11/21/2020	Teleconference	Yes
Full Board Meeting	03/06/2021	Teleconference	Yes
Full Board Meeting	03/20/2021	Teleconference	Yes
Full Board Meeting	07/17/2021	Teleconference	Yes
Full Board Meeting	11/20/2021	Teleconference	Yes
Full Board Meeting	01/22/2022	Teleconference	Yes
Full Board Meeting	03/19/2022	Teleconference	Yes

Table 1b. Board/Committee Member Roster					
Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)
Denise Davis	10/13/2020	TBD	1/1/2024	Senate Rules Committee	Public
Carmen Dones, RDH Educator	11/21/2020	TBD	1/1/2024	Governor	Professional
Susan Good	4/5/2013	01/17/2014; 4/1/2018	December 31, 2021	Governor	Public

			(In grace year)		
Sonia Pat Hansen, RDH	7/8/2022	TBD	1/1/2026	Governor	Professional
Joyce Noel Kelsch, RDHAP	8/23/2012	1/16/2016; 12/24/2020	1/1/2024	Governor	Professional
Sherman King	5/25/2022	TBD	1/1/2026	Governor	Public
Timothy Martinez, DMD	8/23/2012	1/17/2014; 4/17/2018	December 31, 2021 (In grace year)	Governor	Professional
Nicolette Moultrie, RDH	4/5/2012	1/17/2014; 4/1/2018	December 31, 2021 (In grace year)	Governor	Professional
Erin Yee	1/4/2021	TBD	1/1/2025	Assembly Speaker	Public

2. In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

   In the past four years, the Board has been privileged to have dedicated and engaged members (both currently and in the past) that participate in the Board's meetings and activities. Whenever there has been a scheduled meeting, the number of members participating has either met or exceeded the minimum number (e.g., five members required to establish a quorum) required to vote and act upon an issue presented at a meeting. The Board has only had three meetings cancelled in the past four years not due to a lack of quorum, but potential COVID-19 issues. The cancelled meetings were April 17-18, 2020, October 21, 2021, and April 23, 2022. The cancellation of these meetings was for different reasons. The April 17-18, 2020, meeting was scheduled during the initial outbreak of the COVID-19 pandemic and restrictions were in place prohibiting mass gatherings at the time. The October 21, 2021, meeting was cancelled because the issue was resolved and no longer in need of a meeting for action. The April 23, 2022, teleconference meeting was cancelled because one of the meeting location's access hours (public library) was not available to the public during the meeting unbeknownst to the Board member as it was a different location with limited hours due to continued COVID-19 issues. As such, the meeting was cancelled. For both cancelled meetings, it delayed the Board from conducting its business, but the issues were addressed at subsequent meetings.

3. Describe any major changes to the board since the last Sunset Review, including, but not limited to:

   - **Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)**

     The Board underwent several changes since the last Sunset Review. In 2018 after its last Sunset Review, the then Dental Hygiene Committee of California received approval from the Legislature to change its official name to the Dental Hygiene Board of California affirming that the committee was functioning as an independent government agency within the Department of Consumer Affairs. In December 2020, the Board moved its office location from a second-floor office to the first floor of the same building affording the Board additional space for future anticipated program growth. The new space is 1.5 times larger than the prior office space. Also in 2018, the Board hired an Assistant Executive Officer to help with the programmatic daily

oversight of board functions and staff. This allowed the Executive Officer time to address his specific responsibilities and functions to address board business. The Board also extended the length of its strategic plan, as the prior expiration date was 2021, but there were a couple of important outstanding items to address, so the Board voted to extend it to 2023.

- **All legislation sponsored by the board and affecting the board since the last sunset review.**

  The Board sponsored or participated in the following legislation since its last Sunset Review Report was submitted in December 2017:

  Senate Bill (SB) 1482, Hill (Chapter 858, Statutes of 2018)

  DENTAL HYGIENISTS.

  - Removed the Dental Hygiene Committee from the jurisdiction of the Dental Board of California and continued the Dental Hygiene Committee of California by creating the Dental Hygiene Board of California within the Department of Consumer Affairs. The bill changed the manner of appointment of the hygiene board by requiring one public member to be appointed by the Senate Committee on Rules and one public member to be appointed by the Speaker of the Assembly rather than the Governor. The bill would extend the repeal date of the hygiene board and related appointment provisions to January 1, 2023.
  - Requires an out-of-state applicant or a specified licensee to instead furnish a hardcopy of fingerprint cards if electronic fingerprint images are not available or shared in the applicant's or licensee's state of residence.
  - Requires the dental hygiene board to conduct random audits of licensees to ensure compliance with the continuing education requirements.
  - Removed the California state clinical examination requirement and instead requires satisfactory completion of the dental hygiene examination given by the Western Regional Examining Board or any other clinical or dental hygiene examination approved by the dental hygiene board.
  - Requires the dental hygiene board to renew approval of educational programs for dental hygienists that certify to the hygiene board that the program continues to meet the requirements prescribed by the hygiene board, would authorize the hygiene board to conduct periodic surveys, evaluations, and site visits to educational programs, and would authorize the dental hygiene board to place a noncompliant educational program on probation, issue a citation and fine, or have its approval withdrawn.
  - Deleted the limit of $2100 for conducting site evaluations and instead specified that the fee to conduct a site visit to educational programs for dental hygienists shall not exceed the actual costs incurred by the dental hygiene board.
  - Limited the fee for a retired license to half of the current license renewal fee.
  - Incorporated additional changes to Section 101 and Section 1680 of the Business and Professions Code.

  This legislation, SB 1482, authored by Senator Hill was signed by Governor Brown and became effective September 27, 2018.

SB 786

Senate Committee on Business, Professions and Economic Development (Chapter 456, Statutes of 2019)

HEALING ARTS.

Existing law, the Dental Practice Act, provides for the licensure and regulation of dental hygienists by the Dental Hygiene Board of California within the Department of Consumer Affairs, and specifies that, for purposes of the dental hygiene provisions, "hygiene board" means the Dental Hygiene Board of California. This legislation replaced all references to "hygiene board" with "dental hygiene board."

This legislation, SB 786, authored by the Senate Committee on Business, Professions and Economic Development was signed by Governor Newsom and became effective September 9, 2019.

SB 1474

Senate Committee on Business, Professions and Economic Development (Chapter 312, Statutes of 2018)

BUSINESS AND PROFESSIONS

- Requires a registered dental hygienist to have completed the appropriate education and training required to perform a procedure or provide a service within the scope of their practice under the appropriate level of supervision.
- Requires a person to have satisfactorily completed a specified examination within the preceding three years as a condition of licensure as a registered dental hygienist.
- Specifies that the equivalent of a bachelor's degree is recognized as a minimum of 120 semester credit hours or 180 quarter credit hours in postsecondary education.

This legislation, SB 1474, authored by the Senate Committee on Business, Professions and Economic Development was signed by Governor Newsom and became effective September 29, 2019.

SB 534

Jones (Chapter 491, Statutes of 2021)

DENTAL HYGIENISTS.

- Requires a special teaching permit to remain valid for 4 years and would thereafter prohibit the board from renewing it. Requires an applicant for a special teaching permit to comply with the fingerprint submission requirements and requires an applicant, if teaching during clinical practice sessions, to furnish satisfactory evidence of having successfully completed a course in periodontal soft-tissue curettage, local anesthesia, and nitrous oxide-oxygen analgesia approved by the Board.
- Requires an applicant for licensure who has not taken a clinical examination before the board to additionally submit satisfactory evidence of having successfully completed a course or education and training in local anesthesia, nitrous oxide-oxygen analgesia, and periodontal soft-tissue curettage approved by the Board.
- Requires a new educational program for registered dental hygienists in alternative practice (RDHAP), or registered dental hygienists in extended functions to submit a feasibility study demonstrating a need for a new educational program and to apply for approval from the

Board before seeking approval for initial accreditation from the Commission on Dental Accreditation or an equivalent body, as determined by the Board.

- Makes it unprofessional conduct for a licensee to knowingly make a statement or sign a certificate or other document that falsely represents the existence or nonexistence of a fact directly or indirectly related to the practice of dental hygiene.
- Requires training for a disciplined licensee, if assigned, to be in a remedial education course approved by the Board.
- Authorizes an RDHAP to operate a mobile dental hygiene clinic (MDHC) in specified settings, if the RDHAP practice registers MDHC with the Board. The bill removed the requirement that a MDHC be provided by the property and casualty insurer as a temporary substitute site because the registered place of practice has been rendered and remains unusable due to loss or calamity.
- Authorizes the Board to conduct announced and unannounced reviews and inspections of a MDHC, as specified.
- Makes it unprofessional conduct for an RDHAP to operate a MDHC in a manner that does not comply with these provisions.
- Authorizes the Board to issue citations that contain fines and orders of abatement to an RDHAP for a violation of these provisions and related provisions, as specified.
- Imposes registration requirements on the physical facilities of the RDHAP.
- Requires an RDHAP who utilizes portable equipment to practice dental hygiene to register the physical facility where the portable equipment is maintained with the executive officer of the Board.
- Authorizes the Board to conduct announced and unannounced reviews and inspections of the physical facilities and equipment of an RDHAP practice, as specified.
- Makes it unprofessional conduct for an RDHAP to maintain a physical facility or equipment in a manner that does not comply with provisions regarding registration, maintenance, and inspections.
- Authorizes the Board to issue citations that contain fines and orders of abatement to a RDHAP for a violation of provisions regarding registration, maintenance, and inspections as well as related provisions, as specified.

LEGISLATION AFFECTING THE BOARD SINCE LAST SUNSET REVIEW:

Additionally, several bills affected Board operations and dental hygiene scope of practice since its last Sunset Review Report was submitted in December 2017. These include:

Assembly Bill (AB) 1277

Daly (Chapter 413, Statutes of 2017) (Urgency Legislation)

DENTISTRY: DENTAL BOARD OF CALIFORNIA: REGULATIONS.

Required the Dental Board of California (DBC) to amend regulation on the minimum standards for infection control to require water or other methods use for irrigation to be sterile or contain recognized disinfecting or antibacterial properties when performing dental procedures that expose dental pulp. Additionally, required the DBC to adopt emergency regulations and

prepare an emergency rulemaking for the OAL to meet the December 31, 2018, deadline for the final regulations.

This legislation, AB 1277, authored by Assembly Member Daly was signed by Governor Brown and became effective October 2, 2017.

AB 2138

Chiu (Chapter 995, Statutes of 2018)

LICENSING BOARDS: DENIAL OF APPLICATION: REVOCATION OR SUSPENSION OF LICENSURE: CRIMINAL CONVICTION.

- Authorizes a board to, among other things, deny, revoke, or suspend a license on the grounds that the applicant or licensee has been subject to formal discipline, as specified, or convicted of a crime only if the applicant or licensee has been convicted of a crime within the preceding 7 years from the date of application that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, regardless of whether the applicant was incarcerated for that crime, or if the applicant has been convicted of a crime that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made and for which the applicant is presently incarcerated or for which the applicant was released from incarceration within the preceding 7 years, except as specified.
- Prohibits a board from denying a person a license based on the conviction of a crime, or on the basis of acts underlying a conviction, as defined, for a crime, if the conviction has been dismissed or expunged, if the person has provided evidence of rehabilitation, if the person has been granted clemency or a pardon, or if an arrest resulted in a disposition other than a conviction.
- Requires the board to develop criteria for determining whether a crime is substantially related to the qualifications, functions, or duties of the business or profession.
- Requires the board to consider whether a person has made a showing of rehabilitation if certain conditions are met.
- Requires the board to follow certain procedures when requesting or acting on an applicant's or licensee's criminal history information.
- Requires the board to annually submit a report to the Legislature and post the report on its Internet Web site containing specified deidentified information regarding actions taken by a board based on an applicant or licensee's criminal history information.
- Prohibits the board from denying a license based solely on an applicant's failure to disclose a fact that would not have been cause for denial of the license had the fact been disclosed.
- Required the board to revise and recast to eliminate some of the more specific provisions regarding various actions in relation to denying or granting an applicant a license after a hearing.

This legislation, AB 2138, authored by Assembly Member Chiu was signed by Governor Brown and became effective September 30, 2018.

AB 496

Low (Chapter 351, Statutes of 2019)

BUSINESS AND PROFESSIONS.

Provides that the appointing authority has the power to remove a board member from office for specified reasons, including incompetence. Defines “licensee” to mean any person authorized by a license, certificate, registration, or other means to engage in a business or profession regulated or referred to, as specified, and would provide that any reference to licentiate be deemed to refer to licensee. Made other conforming and non-substantive changes, including replacing gendered terms with nongendered terms, updating cross-references, and deleting obsolete provisions.

This legislation, AB 496, authored by Assembly Member Low was signed by Governor Newsom and became effective September 27, 2019.

SB 653

Chang (Chapter 130, Statutes of 2020)

DENTAL HYGIENISTS: REGISTERED DENTAL HYGIENIST IN ALTERNATIVE PRACTICE: SCOPE OF PRACTICE.

Authorizes a registered dental hygienist to provide, without supervision, fluoride varnish to a patient and provide dental hygiene preventive services and oral screenings at specified sponsored events and nonprofit organizations. Additionally, authorizes an RDHAP to practice in specified clinics or in a professional corporation without being an employee of that clinic or professional corporation and to perform specified functions and duties of a registered dental hygienist in dental offices or both dental and medical settings, as specified.

This legislation, SB 653, authored by Senator Chang was signed by Governor Newsom and became effective September 24, 2020.

AB 2113

Low (Chapter 186, Statutes of 2020)

REFUGEES, ASYLEES, AND SPECIAL IMMIGRANT VISA HOLDERS: PROFESSIONAL LICENSING: INITIAL LICENSURE PROCESS.

Requires a board within the Department of Consumer Affairs to expedite, and authorize it to assist, the initial licensure process for an applicant who supplies satisfactory evidence to the board that they are a refugee, have been granted asylum, or have a special immigrant visa, as specified. Additionally, authorizes the board to adopt regulations necessary to administer these provisions.

This legislation, AB 2113, authored by Assembly Member Low was signed by Governor Newsom and became effective September 27, 2020.

AB 107

Salas (Chapter 693, Statutes of 2021)

LICENSURE: VETERANS AND MILITARY SPOUSES.

Expanded the requirement to issue temporary licenses to practice a profession or vocation to include licenses issued by any board within the department, except as provided.

- Requires an applicant for a temporary license to provide to the Board documentation that the applicant has passed a California law and ethics examination if otherwise required by the board for the profession or vocation for which the applicant seeks licensure.

- Requires a board to issue a temporary license within 30 days of receiving the required documentation if the results of a criminal background check do not show grounds for denial and would require a board to request the Department of Justice to conduct the criminal background check and to furnish the criminal background information in accordance with specified requirements.
- Requires, if necessary to implement the bill's provisions, a board to submit to the department for approval draft regulations necessary to administer these provisions.
- Exempts from these provisions a board that has a process in place by which an out-of-state licensed applicant in good standing who is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States is able to receive expedited, temporary authorization to practice while meeting state-specific requirements for a period of at least one year or is able to receive an expedited license by endorsement with no additional requirements superseding those for a temporary license, as described above.

This legislation, AB 107, authored by Assembly Member Salas was signed by Governor Newsom and became effective October 28, 2021.

- **All regulation changes approved by the board since the last sunset review. Include the status of each regulatory change approved by the board.**

The following regulatory packages were approved by the Board, have gone through the rulemaking process, approved by the Office of Administrative Law, filed with the Secretary of State, and have become effective since its last Sunset Review Report was submitted in December 2017:

- **Substantial Relationship and Rehabilitation Criteria - Sections 1135, 1136, and 1137 of Title 16 of the California Code of Regulations (CCR):**

Effective July 1, 2020, Assembly Bill (AB) 2138 (Chapter 995, Statutes of 2018) required boards within the Department of Consumer Affairs (DCA) to amend their existing regulations governing substantial relationship and rehabilitation criteria. Business and Professions Code (BPC) section 481 required the Board to develop criteria, when considering the denial, suspension, or revocation of a license, to determine whether a crime is substantially related to the qualifications, functions, or duties of the dental hygiene profession. In addition, BPC section 493 required the Board to determine whether a crime is substantially related to the qualifications, functions, or duties of the profession it regulates by employing specific criteria, including the nature and gravity of the offense, the number of years elapsed since the date of the offense, and the nature and duties of the profession. Similarly, BPC section 482 required the Board to develop criteria to evaluate the rehabilitation of a person when considering the denial, suspension, or revocation of a license.

16 CCR section 1135 established the criteria for determining when a crime is substantially related to the qualifications, functions, and duties of a licensee. 16 CCR sections 1136 and 1137 established the criteria for determining rehabilitation of an applicant or licensee when considering the denial, suspension, revocation, or reinstatement of a license on the basis of a criminal conviction.

Submitted to Secretary of State: February 5, 2021. Effective Date: February 5, 2021.

- **Registered Dental Hygienist Course in Periodontal Soft Tissue Curettage, Local Anesthesia, and Nitrous Oxide-Oxygen Analgesia (SLN) - Section 1107 of Title 16 of the CCR.**

The Board was apprised by stakeholders that the previous regulatory language regarding a Registered Dental Hygienist (RDH) course of instruction in Local Anesthesia, Nitrous Oxide-Oxygen Analgesia and Periodontal Soft Tissue Curettage (SLN) lacks clarity and no longer aligns with current educational and professional language. The Board addressed these problems with this proposed rulemaking.

The Board amended 16 CCR section 1107 to: (1) clarify the types of injections required by the Board for education for local anesthesia for the RDH; (2) update the regulation to be consistent with current educational terminology; (3) clarify the period of time for the beginning and end of administration of nitrous oxide-oxygen analgesia required for RDH clinical instruction; (4) incorporate updated forms for approval of educational courses and required biennial report; (5) replace the term “pre-clinical” with “preclinical” for consistency within the regulation; (6) update titles and revision dates on forms incorporated by reference (SLN-01 (9-2019), SLN-02 (10-2019), and SLN-03 (9-2019)); and (7) replace the term “Committee” with “Board” as the Board is now the Dental Hygiene Board of California as a result of Senate Bill 1482 (Hill, Chapter 858, Statutes of 2018).

Submitted to Secretary of State: April 20, 2021. Effective Date: July 1, 2021.

- **Approval of New RDH Educational Programs and Continuation of Approval for Approved RDH Educational Programs - Section 1104 of Title 16 of the CCR.**

This proposal amended regulatory language by updating references to the Board and the relevant standards governing RDH educational programs’ submission of Self Study Reports to the Board. The Board addressed these and other issues with this rulemaking package.

The Board amended 16 CCR section 1104 to: (1) reference Commission on Dental Accreditation (CODA) standards by reference to their title and location instead of the date on which they were last revised, and (2) replace the term “Committee” with “Board” as the Board is now the Dental Hygiene Board of California as a result of Senate Bill 1482 (Hill, Chapter 858, Statutes of 2018).

Submitted to Secretary of State: August 18, 2021. Effective Date: October 1, 2021.

- **Approval of Curriculum Requirements for Radiographic Decision-Making and Interim Therapeutic Restoration Courses for the Registered Dental Hygienist, Registered Dental Hygienist in Alternative Practice (RDHAP), and Registered Dental Hygienist in Extended Functions (RDHEF) - Section 1109 of Title 16 of the CCR.**

On September 27, 2014, Governor Edmund G. Brown Jr. signed AB 1174 (Bocanegra, Chapter 662, Statutes of 2014), which authorized additional duties for registered dental hygienists and RDHAPs and required the Board to adopt regulations to establish requirements for courses of instruction in Radiographic Decision Making (RDM) and Interim Therapeutic Restoration (ITR) for registered dental hygienists and RDHAPs.

Among other things, AB 1174 enacted section 1910.5, which became operative on January 1, 2018. BPC section 1910.5 requires the Board to establish by regulation requirements for courses of instruction in RDM and ITR for registered dental hygienists and RDHAPs using the competency-based training protocols established by the Health Workforce Pilot Project No. 172 through the Office of Statewide Health Planning and Development. Pursuant to BPC

section 1921, a RDHEF may perform any of the duties or functions authorized to be performed by a registered dental hygienist.

16 CCR section 1109 addressed the lack of a means for providers to apply for course approval in courses in RDM or ITR. 16 CCR section 1109 established the regulatory requirements that an educational provider must meet for the Board to issue an approval and renewal of approval for an RDM or ITR course. By apprising educational providers of the regulatory requirements to apply for RDM or ITR course approval, the Board is ensuring that educational providers have the necessary information regarding the conditions for approval and for continuation of approval of a course in RDM or ITR. BPC section 1905 authorizes the Board to evaluate all RDH educational programs that apply for approval and grant or deny approval of those applications. Accordingly, this proposal established requirements for courses offered to each category of RDH.

Submitted to Secretary of State: September 27, 2021. Effective Date: January 1, 2022.

- **Definitions - Section 1103 of Title 16 of the CCR.**

Stakeholders apprised the Board that the current regulatory language definitions regarding RDH educational programs do not adequately define areas of instruction. The Board proposed to address these and other issues with this proposed rulemaking.

Amendments to 16 CCR section 1103 (1) defined areas of instruction within RDH educational programs, and (2) replaced the term “Committee” with “Board” as the Board is now the Dental Hygiene Board of California as a result of Senate Bill 1482 (Hill, Chapter 858, Statutes of 2018).

Submitted to Secretary of State: November 1, 2021. Effective Date: January 1, 2022.

- **Requirements for RDH Educational Programs - Section 1105 of Title 16 of the CCR.**

BPC section 1941 requires an RDH educational program to continuously maintain a high-quality standard of instruction and, where appropriate, meet the minimum standards set by the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the Board. Existing law sets forth the criteria for the Board’s approval of RDH educational programs. Section 1105 prescribes the requirements for RDH educational program by which to secure and maintain approval by the Board.

The Board amended 16 CCR section 1105 to: (1) clarify the prerequisite course requirements for admission to an RDH educational program; (2) update the regulation to be consistent with current educational terminology; (3) clarify the requirements for supervising dentists within RDH educational programs; (4) allow approved, alternative coursework for prerequisite biomedical science during a declared state of emergency; (5) add clarifying explanations referenced within the regulation (6) renumber amendments for clarity; and (7) replace the term “Committee” with “Board” as the Board is now the Dental Hygiene Board of California as a result of Senate Bill (SB) 1482 (Hill, Chapter 858, Statutes of 2018).

Submitted to Secretary of State: January 25, 2022. Effective Date: April 1, 2022.

- **Reporting Dental Relationships Between Registered Dental Hygienists in Alternative Practice and Licensed Dentists - Section 1118 of Title 16 of the CCR.**

Senate Bill (SB) 653 (Chapter 130, Statutes of 2020) created BPC section 1926.01 which permits an RDHAP to perform the duties authorized pursuant to BPC section 1909, subdivisions (a) (performance of STC) and (b) (administration of LA) with documented consultation with a collaborating dentist in specific settings.

16 CCR section 1118 made BPC section 1926.01 specific by defining provisions by which RDHAPs may perform STC and administer LA in the defined settings of BPC section 1926.01(a), as well as for inclusion of the safety provisions of 1926.01(b). 16 CCR section 1118 provides requirements for RDHAPs to perform STC and administer LA in specific settings. These include: (1) documenting consultations with California licensed dentists to authorize the use of STC or LA for each patient to be treated by the RDHAP in STC or LA; (2) requiring the physical presence on the premises of one additional individual trained in basic life support and qualified to administer cardiopulmonary resuscitation during an emergency when STC or LA administration will take place; and (3) requiring access to portable oxygen administration equipment to assist with administration of basic life support.

Submitted to Secretary of State: February 10, 2022. Effective Date: April 1, 2022.

- **Required Curriculum - Section 1105.2 of Title 16 of the CCR.**

Existing law sets forth the criteria for the Board's approval, and continuation of approval, for RDH educational programs. Section 1105.2 prescribes the required curriculum that an RDH educational program shall meet for approval, and continuation of approval, by the Board.

Amendments to 16 CCR section 1105.2 included: (1) updating the regulation to be consistent with current educational terminology; (2) provided a process by which the Board will review out-of-state education in soft tissue curettage, local anesthesia, and nitrous oxide-oxygen analgesia (SLN) to ensure applicants educated out-of-state meet the educational requirements of 16 CCR 1107; (3) provided a process by which an out-of-state applicant for licensure may seek certification from the Board that they have met SLN requirements; (4) adopted provisions governing radiation safety and radiography techniques instruction; and (5) replaced the term "Committee" with "Board" as the Board is now the Dental Hygiene Board of California as a result of Senate Bill 1482 (Hill, Chapter 858, Statutes of 2018).

Submitted to Secretary of State: March 30, 2022. Effective Date: July 1, 2022.

- **Reporting Dental Relationships Between Registered Dental Hygienists in Alternative Practice and Licensed Dentists - Section 1117 of Title 16 of the CCR.**

BPC section 1930 requires an RDHAP to provide documentation to the Board of an existing relationship with at least one dentist for referral, consultation, and emergency services. The Board proposes to make BPC section 1930 specific by defining reporting requirements for RDHAPs to inform the Board of an existing relationship with at least one dentist for referral, consultation, and emergency services.

Amendments to 16 CCR section 1117 provided requirements for RDHAPs to report a relationship to the Board to include: (1) providing documentation Board of a relationship with at least one licensed dentist located in California for referral, consultation, and emergency services; (2) providing the documentation to the Board of a current relationship with at least one licensed dentist for referral, consultation, and emergency services at every biennial license renewal; (3) requiring the RDHAP to report any termination of the existing dentist relationship to the Board within 30 calendar days of the termination and provide documentation to the Board with at least one licensed dentist with whom a new relationship has been established for referral, consultation, and emergency services; (4) requiring, at all times during the relationship between the RDHAP and the dentist, the dentist's license must be current, active, and not under discipline prohibiting practice by the Dental Board of California (DBC); and (5) requiring if an RDHAP learns that the dentist with whom they have an existing relationship is being placed under discipline prohibiting practice by the DBC, the RDHAP shall terminate the existing dental relationship and notify the Board within 30 calendar days of the termination, and

provide documentation to the Board of a new relationship with at least one licensed dentist being established for referral, consultation, and emergency services.

Submitted to Secretary of State: April 1, 2022. Effective Date: July 1, 2022.

- **Unprofessional Conduct - Section 1138.1 of Title 16 of the CCR.**

BPC section 1950.5 sets forth a non-exclusive list of acts constituting unprofessional conduct by licensees. Currently, there is no regulation including additional conduct the Board considers to be unprofessional conduct.

Amended 16 CCR section 1138.1 added the following categories of unprofessional conduct: (1) failure to provide requested documentation to the Board; (2) failure to cooperate with Board investigations; and (3) failure to report convictions and disciplinary actions against the licensee.

Submitted to Secretary of State: May 16, 2022. Effective Date: July 1, 2022.

NON-SUBSTANTIVE REGULATIONS APPROVED BY THE BOARD AND CURRENTLY IN EFFECT:

- **DENTAL HYGIENE BOARD REFERENCE: Title 16, California Code of Regulations (CCR), Division 11 Title and Sections 1100, 1101, 1104.2, 1105.1, 1105.3, 1105.4, 1106, 1108, 1122, 1124, 1126, 1127, 1131, 1138, 1139, 1142, 1143 SECTION 100. CHANGE WITHOUT REGULATORY EFFECT**

Effective January 1, 2019, SB 1482 (Hill, Chapter 858, Statutes of 2018) changed the Dental Hygiene Committee of California (DHCC) to the Dental Hygiene Board of California (DHBC, Board). As a result of this statutory change from a “Committee,” to a “Board,” regulatory amendments were needed for Division 11 and sections 1100, 1101, 1104.2, 1105.1, 1105.3, 1105.4, 1106, 1108, 1122, 1124, 1126, 1127, 1131, 1138, 1139, 1142, 1143 of Division 11 to update the reference to the Board from “Committee” to “Dental Hygiene Board.”

Additionally, in section 1100(s), the word “planing” was misspelled as “planning.” Therefore, a regulatory amendment was needed to correct the spelling error.

Effective Date: May 10, 2022.

- **1104.1 PROCESS FOR APPROVAL OF A NEW RDH EDUCATIONAL PROGRAM SECTION 100. CHANGE WITHOUT REGULATORY EFFECT**

First, effective January 1, 2019, SB1482 (Hill, Chapter 858, Statutes of 2018) changed the Dental Hygiene Committee of California (DHCC) to the Dental Hygiene Board of California (DHBC, Board). As a result of this statutory change from a “Committee,” to a “Board,” regulatory amendments were needed to section 1104.1 to update the language in the regulation and form incorporated by reference, EDP-I-01 (Rev 12/15), from “Committee” to “Dental Hygiene Board.”

Second, effective January 1, 2022, SB 534 amended BPC section 1941 to require a proposed new educational program for registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions (collectively referred to as RDHs) to apply for approval from the board before seeking approval for initial accreditation from the Commission on Dental Accreditation or an equivalent body, as determined by the Board. As a result of this statutory change, amendments were needed to

update the reference to BPC section 1941 in the form incorporated by reference, EDP-I-01 (Rev 12/15).

Third, grammatical amendments were needed to clarify language and references in the form incorporated by reference, EDP-I-01 (Rev 12/15).

Effective Date: June 6, 2022.

REGULATIONS PACKAGES APPROVED BY THE BOARD AND IN THE REGULATORY PROCESS

The following regulatory packages were approved by the Board and the rulemaking documents are pending the regulatory review process:

- **Retired Status - Section 1119 of Title 16 of the CCR.**

The Board received inquiries regarding options for RDHs who wish to retire from practice. Currently, RDHs may only allow their licenses to lapse (become delinquent, expire, or cancel), or be placed in an inactive status, which requires payment of a fee. AB 2859 (Low, Chapter 473, Statutes of 2016) enacted BPC section 464, which authorized the Board to establish by regulation, a retired category of licensure for its licensees who are not actively engaged in the practice of their profession. The Board addressed these problems with this proposed rulemaking.

Proposed 16 CCR section 1119 will: (1) implement minimum eligibility requirements for obtaining and maintaining a retired license, including ineligibility criteria if the license is currently expired, suspended, revoked, or otherwise punitively restricted; (2) establish exemptions from continuing education and renewal requirements for the holder of a retired license; (3) prohibit a retired licensee from engaging in activity requiring a license; (4) provide that the Board is not prevented from investigating or taking actions against a retired license; and (5) establish criteria for the restoration of a retired license to active status. It will also adopt application forms for applying for inactive status and reactivating a retired license.

- **Reviews, Site Visits, Citation and Fine, and Probationary Status for Dental Hygiene Educational Programs - Section 1104.3 of Title 16 of the CCR.**

SB 1482 (Hill, Chapter 858, Statutes of 2018) (SB 1482) added BPC section 1941.5. BPC section 1941.5 provides express statutory authority for the Board to conduct periodic surveys, evaluations, and announced and unannounced site visits to existing and new DHEPs. Additionally, BPC section 1941.5 authorizes the Board to place an existing or new DHEP on probation with terms, issue a citation and fine, or withdraw approval of a DHEP if a DHEP does not comply with DHEP requirements and the Commission on Dental Accreditation of the American Dental Association (CODA) standards.

Proposed 16 CCR section 1104.3 will: (1) establish requirements for DHEPs to provide the Board access to program records to establish compliance with Board educational program requirements; (2) establish requirements for the Board to issue citations and fines to DHEPs if the Board determines a DHEP is in violation of any law, regulation, or standard applicable to a DHEP; and (3) establish requirements for the Board to place a DHEP on probation due to violation of any law, regulation, or standard applicable to a DHEP if the Board determines the violation, after review of evidence presented to the Board, warrants a probationary status.

- **Process for Approval of New RDH, RDHAP, and RDHEF Educational Programs - Section 1104.1 of Title 16 of the CCR.**

BPC section 1941 sets forth the criteria for the Board's process of approval of new RDH educational programs. Section 1104.1 provides the requirements and application for approval of a new RDH educational program.

The Board proposes to amend section 1104.1 to: (1) require new RDHAP and Registered Dental Hygienist in Extended Functions (RDHEF) educational programs to submit a feasibility study to the Board as a part of the application process; (2) reference Commission on Dental Accreditation (CODA) standards by reference to their title and location instead of the date on which they were last revised; and (3) update the form incorporated by reference, EDP-I-01 Rev 12/15, to make it consistent with regulatory language.

- **Mobile Dental Hygiene Clinics; Issuance of Approval - Section 1116 of Title 16 of the CCR.**

SB 534 (Jones, Chapter 491, Statutes of 2021) amended statutory requirements of BPC sections 1926.1 and 1926.2. The Board currently regulates 661 RDHAPs and has received multiple requests from RDHAPs to promulgate regulations which would allow RDHAPs to establish a Mobile Dental Hygiene Clinic (MDHC) to serve their patients who do not currently have access to, or the physical ability to access, traditional dental hygiene care.

To address the lack of a regulatory framework to govern and ensure consistency within the statutory requirements of BPC sections 1926.3 and 1926.4 established by SB 534, the Board is proposing to add new regulatory section 1116.5 under Title 16 of the CCR to establish requirements for MDHC operation.

- **Registered Dental Hygienist in Alternative Practice, Physical Facility Registration - Section 1116.5 of Title 16 of the CCR.**

SB 534 (Jones, Chapter 491, Statutes of 2021) amended statutory requirements of BPC sections 1926.3 and 1926.4. The Board currently regulates 661 RDHAPs and many have physical facilities serving their patients directly or where their portable equipment is maintained.

To address the lack of a regulatory framework to govern and ensure consistency within the statutory requirements of BPC sections 1926.3 and 1926.4 established by SB 534, the Board is proposing to add new regulatory section 1116.5 under Title 16 of the CCR to establish requirements for physical facility registration and operation.

- **Temporary Licensure (Military Spouses or Partners) - Section 1114 of Title 16 of the CCR.**

AB 107 (Salas, Chapter 693, Statutes of 2021) enacted BPC section 115.6 which requires the Board, on and after January 1, 2023, and after appropriate investigation, to issue temporary licenses to military spouse applicants if the applicant meets specified requirements. Applicants must provide evidence satisfactory to the Board the applicant is married to, or in a domestic partnership or other legal union with, an active-duty member of the United States (U.S.) Armed Forces who is assigned to a duty station in this state under official active-duty military orders.

To address the lack of a regulatory framework to issue a temporary license established by AB 107, the Board is proposing to add new regulatory section 1114 under Title 16 of the CCR to establish requirements for temporary licensure.

4. Describe any major studies conducted by the board (cf. Section 12, Attachment C).

   The Board completed an occupational analysis (OA) of the dental hygiene profession in 2019 with the assistance of the Department of Consumer Affairs' Office of Professional Examination Services (OPES). The results and final copy of the OA for RDH and RDHAP license categories is located in the Attachment section of this Sunset Review Report.

5. List the status of all national associations to which the board belongs.
   - Does the board's membership include voting privileges?
   - List committees, workshops, working groups, task forces, etc., on which the board participates.
   - How many meetings did board representative(s) attend? When and where?
   - If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

   Currently, the Board is a member state for the Central Regional Dental Testing Services (CRDTS), Inc. which provides regional clinical examination testing for dental hygiene licensee applicants. The Board is afforded voting privileges in being a member-state of CRDTS. A new board member or members have not been selected to replace the prior members who were a part of the CRDTS member-state but will be selected when the Board has the opportunity to discuss the issue. The Board does not belong to any national, regional, or local associations.

   The Board requires licensee candidates to pass the dental hygiene national examination to be eligible for licensure. The National Dental Hygiene Board Exam (NDHBE) fulfills the written examination requirement needed for a dental hygiene student to successfully complete an accredited dental hygiene program. Proof of graduation from a dental hygiene program that has been accredited by CODA and approved by the Board in California is required for licensure.

   The Joint Commission on National Dental Examinations (JCNDE) is the agency responsible for the development and administration of the NDHBE. The 15-member commission includes representatives from dental and dental hygiene schools, dental practices, state dental examining boards, dentists, dental hygienists, dental students, and the public. A standing committee of the JCNDE includes dental hygienists who serve as consultants regarding the NDHBE examination.

Section 2 – Performance Measures and Customer Satisfaction Surveys

6. Provide each quarterly and annual performance measure report for the board as published on the DCA website.

   Please see Section 13 – Attachments for the Board's quarterly and annual performance measure reports over the past three years for this Sunset Review Report.

7. Provide results for each question in the board's customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

   The Board's last contract for a customer service satisfaction survey expired years ago unbeknownst to the Board, as the link to the SurveyMonkey survey continued to be attached to all staff's email signature lines assuming the link was still operational. The Board is currently working with the Department of Consumer Affairs' (DCA) Office of Information Services (OIS) to implement a new satisfaction survey for outside Board contacts and the public to complete for feedback on the service the Board is providing. The new survey should be implemented soon so the Board can

begin to accumulate data for the next Sunset Review. The Board does operate a general phone line and email inbox where licensees and stakeholders including the public may comment and provide information directly to the Board to address their issues or contact staff. Overall, the comments received reflect a positive customer service experience and quick response to issues brought to the Board's attention.

Section 3 – Fiscal and Staff

Fiscal Issues

8. Is the board's fund continuously appropriated? If yes, please cite the statute outlining this continuous appropriation.

   No, the Board's fund is not continuously appropriated and is reviewed, amended, and approved on an annual basis by the Legislature and the Governor.

9. Describe the board's current reserve level, spending, and if a statutory reserve level exists.

   In review of the Board's latest Fund Condition, the Board has a current reserve of approximately $1.8 million which if no additional revenue is received, would last the Board about seven months. The Board spends about $175,000 per month but will increase once every current position vacancy is filled. Board staff work extensively to monitor all Board expenses and the fund reserve resulted from expenditure efficiencies where they were thoroughly vetted and justified prior to approval. Pursuant to Business and Professions Code section 128.5, subsection (a), the Board can maintain up to a maximum of 24 months reserve in its fund; however, its historical ongoing fund reserve is much lower than this.

10. Describe if/when a deficit is projected to occur and if/when a fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

    The Board recently increased its License Renewal Fees for Registered Dental Hygienists which is the primary fees that will maintain the fund for an extended period before another fee increase is required when future fund insolvency is anticipated. The latest fee increases were effective as of July 1, 2022, and projected to sustain the Board for at least five to six years depending upon the number of unexpected expenditures that arise during this time period. The last License Renewal Fee increases were approved by the Board in 2014 and sustained the Board for over eight years before additional revenue was needed to address the increasing cost of doing business. The 2014 fee increases maintained the fund's solvency an additional three years (eight total years) than what was originally projected when assessing the need for fee increases at that time.

Table 2. Fund Condition						
(Dollars in Thousands)	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23*	FY 2023/24*
Beginning Balance	$2,348	$2,572	$2,237	$1,939	$1,552	$1,822
Revenues and Transfers	-	-	-	-	-	-
Total Revenue	$ 1,873	$1,856	$1,887	$1,867	$3,276	$3,281
Budget Authority	$2,075	$2,369	$2,354	$2,511	$2,799	$2,799
Expenditures	$1,625	$2,127	$2,131	$2,151	$3,006	$3,090
Loans to General Fund	-	-	-	-	-	-
Accrued Interest, Loans to General Fund	-	-	-	-	-	-
Loans Repaid From General Fund	-	-	-	-	-	-
Fund Balance	$2,596	$2,301	$1,993	$ 1,655	$1,822	$2,013
Months in Reserve	14.5	12.6	10.0	6.2	7.1	7.6
						*Projected

11. Describe the history of general fund loans. When were the loans made? When have payments been made to the board? Has interest been paid? What is the remaining balance?

    The Board's small fund and balance was never requested to provide a general fund loan to assist other agencies or the State's General Fund, so there is no history of any general fund loans or return payments.

12. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

Table 3. Expenditures by Program Component								(list dollars in thousands)
	FY 2018/19		FY 2019/20		FY 2020/21		FY 2021/22	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	$202	$109	$272	$344	$282	$313	$322	$245
Examination	-	-	-	-	-	-	-	-
Licensing	$189	$48	$255	$63	$424	$110	$403	$83
Administration *	$350	$65	$439	$89	$306	$62	$434	$71
DCA Pro Rata	-	$535	-	$532	-	$516	-	$539
Diversion (if applicable)	-	-	-	-	-	-	-	-
TOTALS	$ 741	$757	$966	$ 1,028	$1,012	$1,001	$1,159	$938
*Administration includes costs for executive staff, board, administrative support, and fiscal services.								

13. Describe the amount the board has contributed to the BreEZe program. What are the anticipated BreEZe costs the board has received from DCA?

    To date, the Board has contributed about $1,084,778 over the last eight (8) fiscal years to the BreEZe program through FY 2020/21, as the final cost for FY 2021/22 hasn't been released as of this writing. The anticipated BreEZe costs the Board has received from DCA is incorporated into the contributed amount in this section.

14. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

The Board is a special fund agency that generates its revenue from its fees charged to its applicants and licensees through the collection of examination, licensing, and license renewal fees. These fees support the licensing, examination, enforcement, and administration programs, which includes processing and issuing licenses, maintaining Board records, the dental hygiene law and ethics examinations, mediating consumer complaints, investigation costs, enforcing statutes, disciplinary actions, personnel expenditures, administrative costs, and general operating expenses. The fees also pay for the oversight of the Board approved dental hygiene educational programs in California. The license renewal cycle is a biennial process where the license expires every two years on the last day of a licensee's birth month of an odd or even year depending upon when they were born. Here's an example: if a licensee is born in July of an even year and they renewed the license at the end of July 2020, their license would need to be renewed prior to July 31, 2022 (two years later) for them to continue possess a valid and current license. If it is a licensee's first renewal after license issuance, the duration they have an active license is normally less than 24 months by law and, once renewed, the license will be placed on a biennial renewal cycle to expire every 24 months. The Board's authority to charge the fees in its schedule is provided in BPC § 1944.

The Board has raised its fees as a last resort when it was evident that the fund was projected to be insolvent. The Board raised the following fees in the past five years:

1) Biennial License Renewal Fee for RDH and RDHEF – This fee was increased on July 1, 2022, from $160 to $300.

2) License Renewal Delinquency Fee for RDH and RDHEF – This fee was increased concurrently with the Biennial License Renewal Fee. It increased from $80 to $150.

3) Certification of Licensure Fee – This fee was increased from $25 to $50 to send information to other states and jurisdictions of a licensee's licensure status.

4) Special Permit Fee – This fee was increased from $150 to $300 for out-of-state teachers to come to California to temporarily teach in dental hygiene programs until they obtain a CA dental hygiene license.

Table 4. Fee Schedule and Revenue (list revenue dollars)

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)

Fee	Current Fee Amount	Statutory Limit	FY 2018/19 Revenue	FY 2019/20 Revenue	FY 2020/21 Revenue	FY 2021/22 Revenue	% of Total Revenue
RDH Delinquent License Renewal Fee	$80	½ Current License Renewal Fee	$24,240	$31,120	$44,160	$41,255	1.88%
RDHAP Delinquent License Renewal Fee	$80	½ Current License Renewal Fee	$960	$1,200	$1,120	$720	0.05%

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)							
Fee	Current Fee Amount	Statutory Limit	FY 2018/19 Revenue	FY 2019/20 Revenue	FY 2020/21 Revenue	FY 2021/22 Revenue	% of Total Revenue
RDHEF Delinquent License Renewal Fee	$80	½ Current License Renewal Fee	$160	$80	$0	$80	0.00%
RDHAP Delinquent FNP Renewal Fee	$80	½ Current License Renewal Fee	$0	$400	$400	$240	0.01%
Certification of Licensure Fee	$25	½ Current License Renewal Fee	$0	$0	$0	$0	0.00%
Curriculum Review & Site Evaluation Fee	$2,100	$2,100	$0	$0	$0	$0	0.00%
Duplicate License Fee	$25	$25	$12,550	$11,250	$14,450	$14,825	0.71%
Citation and Fines	Variable	Variable	$0	$1,200	$8,432	$87,555	1.30%
RDHAP Initial License Fee	$250	$250	$10,500	$5,250	$21,500	$19,060	0.75%
RDHAP Initial FNP Permit Fee	$160	$500	$1,440	$1,280	$1,840	$1,945	0.09%
RDHAP Initial ½ FNP Permit Fee	$80	$500	$240	$80	$160	$400	0.01%
RDH Application Fee – RDH Clinical Exam	N/A	N/A	$250	$0	$0	$0	0.00%
RDH Licensure By Credential (LBC) Application Fee	$250	$250	$0	$0	$0	$0	0.00%
RDHAP Application Fee	$100	$250	$5,520	$2,180	$8,600	$7,700	0.32%
RDH Application	$100	$250	$80,100	$46,000	$87,940	$74,400	3.86%

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)							
Fee	Current Fee Amount	Statutory Limit	FY 2018/19 Revenue	FY 2019/20 Revenue	FY 2020/21 Revenue	FY 2021/22 Revenue	% of Total Revenue
Fee							
RDH Original License Fee	$100	$250	$78,800	$46,000	$88,100	$74,400	3.84%
DHBC Suspended Revenue	Variable	Variable	$9,301	$8,765	$10,862	$12,327	0.55%
DHBC Prior Year Adjustment	Variable	Variable	($720)	($660)	($1,385)	($735)	-0.05%
Extramural Dental Facility Fee for Schools	$200	$250	$0	$0	$0	$0	0.00%
Mobile Dental Hygiene Unit Permit Fee	$100	$150	$0	$0	$0	$0	0.00%
Additional Office Permit Fee (for RDHAP)	$100	$250	$200	$0	$0	$0	0.00%
Special Permit Fee (teaching)	$160	$500	$0	$0	$0	$0	0.00%
DHBC Document Sales	Variable	Variable	$1,340	$595	$30	$0	0.03%
DHBC Sales of Documents	Variable	Variable	$0	$15	$0	$0	0.00%
DHBC Misc. Services to the Public General	Variable	Variable	$15	$13	$0	$0	0.00%
DHBC Misc. Services to the Public Trans	Variable	Variable	$0	$923	$0	$200	0.02%
DHBC investment Income – Surplus Money Investment	Variable	Variable	$55,673	$41,190	$10,455	$4,073	1.49%
DHBC Escheat Unclaimed	Variable	Variable	$0	$80	$0	$0	0.00%

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)							
Fee	Current Fee Amount	Statutory Limit	FY 2018/19 Revenue	FY 2019/20 Revenue	FY 2020/21 Revenue	FY 2021/22 Revenue	% of Total Revenue
Checks, Warrants, Bonds, and Coupons							
DHBC Cancelled Warrants Revenue	Variable	Variable	$100	$262	$605	$716	0.02%
DHBC Miscellaneous Revenue	Variable	Variable	$11,862	$15,980	$800	$700	0.39%
DHBC Dishonored Check Fee	$25	$25	$50	$75	$75	$25	0.00%
DHBC Settlements and Judgements – Other	Variable	Variable	$0	$0	$190	$0	0.00%
Renewal Fee	$300	$500	$0	$0	$0	$0	0.00%
RDHAP FNP Renewal Fee	$160	$500	$7,520	$10,567	$8,640	$9,127	0.48%
RDH License Renewal Fee	$160	$500	$1,525,645	$1,508,425	$1,522,800	$1,525,740	81.39%
RDHAP License Renewal Fee	$160	$500	$45,760	$53,200	$46,880	$57,600	2.72%
RDHAP ½ FNP Renewal Fee	$80	½ Current License Renewal Fee	$0	$0	$0	$0	0.00%
RDHEF License Renewal Fee	$160	$500	$1,280	$2,720	$960	$2,560	0.10%
CE Provider Annual Renewal Fee	$250	$500	$0	$0	$0	$0	0.00%
Mobile Dental Hygiene Unit Renewal Fee	$100	$500	$0	$0	$0	$0	0.00%
Additional Office Permit Renewal Fee	$100	$500	$0	$0	$0	$0	0.00%
Special	$300	$500	$0	$0	$0	$0	0.00%

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)							
Fee	Current Fee Amount	Statutory Limit	FY 2018/19 Revenue	FY 2019/20 Revenue	FY 2020/21 Revenue	FY 2021/22 Revenue	% of Total Revenue
Permit Renewal Fee (teaching)							
Over/Short Fees Renewals	Variable	Variable	$6	$11	$0	$0	0.00%
Refunds	Variable	Variable	$160	$25	$0	$0	0.00%
TOTAL	**-**	**-**	**$1,872,952**	**$1,788,226**	**$1,877,605**	**$1,934,913**	**100%**

15. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Table 5. Budget Change Proposals (BCPs)								
BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
1111-042-BCP-2017-GB	2017/18	Implement Ch. 410, Statutes of 2016 (AB 2105)	1.0 Associate Governmental Program Analyst (AGPA)	1.0 AGPA	$98,000 ongoing	$98,000 ongoing	$16,000 one-time; $8,000 ongoing	$16,000 one-time; $8,000 ongoing
1111-002-BCP-2019-GB	2019/20	Enforcement and Licensing Staff Augmentation	1.8 Staff Services Analyst (SSA)	1.8 SSA*	$84,000 ongoing *	$84,000 ongoing *	$15,000 one-time; $7,000 ongoing *	$15,000 one-time; $7,000 ongoing *
1111-013-BCP-2019-GB	2019/20	Implement Ch. 858, Statutes of 2018 (SB 1482)	1.0 Staff Services Analyst (SSA)	1.0 SSA	$84,000 ongoing	$84,000 ongoing	$15,000 one-time; $7,000 ongoing	$15,000 one-time; $7,000 ongoing

NOTE: *For BCP 1111-002-BCP-2019-GB, the Board requested 1.8 positions to combine with a 0.2 existing position to create 2.0 positions. The Board also absorbed the cost of the 0.8 position within its existing appropriation.

Staffing Issues

16. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

In the last four years since the prior Sunset Review, the Board has experienced minimal issues in using the budget change proposal process to obtain additional positions. The Board works closely with the DCA Office of Human Resources for any personnel issues such as the reclassification of positions and the recruitment of staff. The Board has experienced moderate turnover just as any program does and most of the staff that has left moved on for promotional opportunities. Although the Board has had many staff leave due to promotions, recruitment has been robust and only slowed due to the recovery time after the pandemic. There are signs that recruitment will be increasing, as the Board currently has several vacancies to fill; however, with many potential candidates electing for a hybrid or full telework schedule, it may increase the difficulty in finding appropriate candidates to fill positions.

In the interest of creating an appropriate and efficient board management structure for the future and for succession planning, the Board submitted an Exempt Position Request (EPR) to California Department of Human Resources (CalHR) at the end of 2021 to modestly elevate the executive officer's position to a higher exempt level equivalent to a manager 3 and commensurate of the position's responsibilities. By doing so, it would allow subordinate management staff to be hired and provide management structural space to eventually obtain program managers for rank-and-file oversight as the Board's programs grow. Currently, the executive officer's (EO) exempt level is equivalent to a manager 2 and the assistant executive officer's (AEO) level is equivalent to a manager 1. With existing staff already at the manager 1 (specialist) level and special investigator being similarly equivalent, the AEO can't supervise these positions, or any future program manager 1 positions obtained due to the human resources laws in effect where similar personnel levels can't supervise each other pursuant to the DCA Office of Human Resources. This means that the AEO can't supervise the manager specialist, special investigator, or any future program managers the Board plans to hire to appropriately oversee staff in their respective programs. This is the primary reason the modest EPR request was submitted to elevate the EO to the equivalent of a manager 3 level, and subsequently, hire a manager 2 level staff person for proper oversight of the remaining manager 1 level subordinate staff. Since the AEO can't supervise the manger 1 level staff, the EO must take the time oversee these staff which is not normally a part of the EO functions for the Board.

Unfortunately, the Board's EPR was denied and was informed that the decision makers at CalHR determined the EO's exempt level was appropriate for the Board's current size and responsibilities. The Board disagrees with the decision because other similarly sized DCA board programs do not have the additional responsibility of their professional educational program's oversight and approval which consists of nearly 30 schools. In addition, in normal board functions and structure, the EO is responsible for but does not oversee the daily office operations and staff which are functions delegated to the AEO and other subordinate managerial staff. This is so that the EO can direct most of his/her attention to addressing Board issues with policy making, board members, the department, the Legislature, executive level meetings, other state agencies, associations, school administrators, and many other interested stakeholders and functions. The Board plans to continue its efforts to submit EPR requests until it fulfills its goal to modestly elevate the executive officer position so that subsequent management staff can be obtained to adequately oversee program functions as the Board grows. This will also assist with staff retention and succession planning issues in the future. The Board is a specially funded agency, can afford the approval of the modest increase to the EO's exempt level and absorb its salary structure within its existing budget, and would have no fiscal impact to the state's General Fund. This

elevated step is not only important to maintain long-term management-level staff, but to maintain the institutional memory of the Board. The Board requests the Legislature to assist the Board with approval of this request. By approving this request, it would create an appropriate internal management structure, maintain institutional memory, and afford viable succession planning efforts to efficiently operate the Board's programs now and into the future for consumer protection.

17. Describe the board's staff development efforts and total spent annually on staff development (cf., Section 12, Attachment D).

The Board is fortunate to be a part of the Department of Consumer Affairs (DCA), who provide a plethora of educational and training course options for all staff to participate at minimal to no cost to the programs. The DCA training program is called SOLID Training Solutions and are funded through the departmental costs. They provide the majority of education and training courses in topics such as contracts, project management, purchasing, job growth skills, sexual harassment, business writing, upward mobility, and many other topics that apply to the state's work environment and careers. As such, the Board has budgeted to spend approximately $500 - $1,000 each year for training staff utilizing external vendors focused on enforcement, but most of the needed training topics that are used daily are covered by SOLID. Management is also very flexible in approving training courses or new project opportunities for staff, so long as there is adequate coverage in the office to maintain operations.

Section 4 – Licensing Program

18. What are the board's performance targets/expectations for its licensing[2] program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The Board's performance targets/expectations for its licensing program meets the guidelines pursuant to California Code of Regulations (CCR) § 1069 Permit Reform Act of 1981, pertaining to application processing times. This regulation provides a detailed timeline for the processing of permits, applications, certifications, registrations, or other form of authorization required by a dental state agency to engage in a particular activity or act. The Board follows these timelines to process its applications and maintains a processing period that is less than the maximum.

As stated in the regulation, the maximum time allotted to notify an applicant that their application is complete or deficient is 90 days. The Board is currently processing applications within 45 business days, which is well within the specified timeframe of 120 days.

19. Describe any increase or decrease in the board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

With the addition of a Licensing Analyst in 2020 to assist with the review of the Applications for Licensure, the processing times have remained steady and have not increased or decreased. With additional staff, one would expect a decrease in the processing times; however, with the implementation of the BreEZe computer system in 2016, it forced the Board to change its business practices from only reviewing complete applications for licensure to allowing the

[2] The term "license" in this document includes a license certificate or registration.

submission of licensure requirements on a flow basis. Prior to BreEZe, if an application was submitted with a licensure requirement missing, the entire application was returned to the applicant to resubmit later after the requirement was fulfilled. This efficient process allowed the Board's processing times and potential backlog to remain steady even with an influx of applications because they were submitted complete and ready for review. Today, applicants are allowed to apply even if all their licensure requirements are not fulfilled. An applicant record is created in the computer system and our Licensing staff sends Deficiency Letters to the applicant for the requirements that are missing. Then, staff must wait for the applicant to either complete or submit the deficient requirements to continue the review of the application. This wait time can be short or it can be lengthy and is dependent on the applicant to submit their fulfilled requirement(s) in a timely manner. Other than notifying applicants of their application deficiencies, there's not much Board staff can do to increase the expediency of the application review. Complete applications that are submitted can be reviewed and approved quickly to qualify the applicant to take the law and ethics examination which is the last step prior to obtaining the license.

The number of pending applications has grown and is more numerous than the completed applications due to the change in business practices to where applicants may submit their licensure requirements on a flow basis instead of everything completed. This causes applications to remain open or pending until the Board receives the deficient requirements from the applicant to move applications forward in the review process. The Board has communicated with applicants and DHEPs to inform them of the licensing process and expected processing times for their applications. Since the Board is now forced to wait on applicants to submit their requirements timely, it's the applicant's responsibility to submit their licensing requirements so their processing time is as short as possible. All applications, barring special circumstances like a military person, are reviewed on a first-received, first-reviewed basis to be fair to all applicants.

If there is a performance barrier to reviewing applications where the backlog increases substantially, the Board could request an additional analyst position to review applications but that's still to be determined. This may be considered in the future when the Board can afford additional positions to address the workload. This would assist with application reviews in addition to address any performance issues that are currently minimal since the application review times are well within our allotted time of 90 days pursuant to California Code of Regulations section 1069.

20. How many licenses or registrations has the board denied over the past four years based on criminal history that is determined to be substantially related to the qualifications, functions, or duties of the profession, pursuant to BPC § 480? Please provide a breakdown of each instance of denial and the acts the board determined were substantially related.

The Board has denied four (4) licenses over the past four years based on criminal history.

FY18/19 – 0 denials.

FY19/20 – 1 denial(s).

Denial #1

Application Date: 06/03/2019

Background: Applicant disclosed DUI conviction; however, they did not disclose that they had additional charges for which they were convicted.

6/17/2017: Conviction of Vehicle Code Section(s) 23152(b), 23578, 20002(A) and Penal Code Section(s) 148(a)(1) Misdemeanor(s). According to court records, the Applicant was convicted for

two separate Driving Under the Influence (DUI) incidents, one that took place on 8/25/16, and another on January 9, 2017.

5/26/2019: Arrest for violation of Penal Code (PC) Section(s) 664 – Attempt to Commit Crime; PC Section(s) 245(A)(1) – Assault with a Deadly Weapon; PC Section(s) 242 PC – Battery.

Acts Substantially Related: Assaultive of abusive conduct as defined in Penal Code section 11160(d) (California Code of Regulations [CCR] Section 1135(c)(7)); Conviction for driving under the influence of drugs or alcohol (CCR Section 1135(c)(9)).

Application Denied: 09/27/2019

FY20/21 – 1 denial(s).

Denial #1

Application Date: 08/27/2020

Background: 08/10/2020: Conviction of Vehicle Code section(s) 23103.5 per 23103 – Wet and Reckless, Misdemeanor.

Acts Substantially Related: Conviction for driving under the influence of drugs or alcohol (CCR Section 1135(c)(9)).

Application Denied: 08/17/2021

FY21/22 – 2 denial(s).

Denial #1

Application Date: 07/26/2021

Background: 09/18/2014: Conviction of Vehicle Code section(s) 23152(A)/23152(B) – DUI Alcohol/.08 Percent or more, Misdemeanor.

10/05/2020: Conviction of Vehicle Code section(s) 23152(A)/23152(B) – DUI Alcohol/.08 Percent or more, Misdemeanor.

Acts Substantially Related: Conviction for driving under the influence of drugs or alcohol (CCR Section 1135(c)(9)).

Application Denied: 10/22/2021

Denial #2

Application Date: 11/18/2021

Background: 06/18/2019: Arrest for Vehicle Code Section(s) 23153(a) – Driving under the influence of alcohol causing injury, Felony; 23153(b) – DUI with BAC .08% or more causing injury; 20001(a)/(b)(2) – Hit and Run with permanent and serious injury, Felony; and Penal Code Section(s) 12022.7(a) – Enhancement-Inflict great bodily injury, Felony; 12022.7(b) – Enhancement-Cause great bodily injury; comatose or Paralysis, Felony.

Acts Substantially Related: Driving under the influence of drugs or alcohol and causing permanent and serious injury (CCR Section 1135(c)(9)).

Application Denied: 04/20/2022

Table 6. Licensee Population					
		FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Registered Dental Hygienist (RDH)	Active[3]	18,185	18,195	18,201	17,863
	Out of State	0	0	0	0
	Out of Country	0	0	0	0
	Delinquent/Expired	3,295	3,430	3,638	3,911
	Retired Status *if applicable*	34	34	41	34
	Inactive	1,738	1,645	1,666	1,876
	Other[4]	8,479	9,059	9,610	10,096
Registered Dental Hygienist in Alternative Practice (RDHAP)	Active	580	598	655	691
	Out of State	0	0	0	0
	Out of Country	0	0	0	0
	Delinquent/Expired	92	105	109	111
	Retired Status *if applicable*	0	0	1	0
	Inactive	50	43	38	45
	Other	20	26	39	66
Registered Dental Hygienist In Extended Functions (RDHEF)	Active	23	24	22	21
	Out of State	0	0	0	0
	Out of Country	0	0	0	0
	Delinquent/Expired	6	5	5	6
	Retired Status *if applicable*	0	0	0	0
	Inactive	2	2	2	1
	Other	1	3	4	4
Fictitious Name Permits (FNP)	Active	127	126	116	126
	Out of State	0	0	0	0
	Out of Country	0	0	0	0
	Delinquent/Expired	69	75	94	77
	Retired Status *if applicable*	0	0	0	0
	Inactive	0	0	0	0
	Other	42	50	55	80
Note: 'Out of State' and 'Out of Country' are two mutually exclusive categories. A licensee should not be counted in both.					

[3] Active status is defined as able to practice. This includes licensees that are renewed, current, and active.

[4] Other is defined as a status type that does not allow practice in California, other than retired or inactive.

Table 7a. Licensing Data by Type

	Application Type	Received	Approved/Issued	Closed	Pending Applications			Cycle Times		
					Total (Close of FY)	Complete (within Board control)*	Incomplete (outside Board control)*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2019/20	WREB/CRDTS	476	559	10			45	32	37	35
	Licensure By Credential (LBC)	38	30	4			15	101	71	78
	(License) WREB/CRDTS	558	633	5				28	26	27
	(License) LBC	31	26	0			26	63	28	50
	Total RDH Licenses	-	659	-	907		11	-	-	-
	(Renewal)	10,392	9,648	593			5,839	6	0	6
	RDHAP	26	31	2			3	34	68	44
	(License)	29	31	5			24	165	727	184
	(Renewal)	368	339	6			186	12	-	12
	RDHEF	-	-	-	-	-	-	-	-	-
	(License)	-	-	-	-	-	-	-	-	-
	(Renewal)	19	16	-			7	5	0	5
	FNP	12	13	0			0	24	28	24
	(License)		13							
	(Renewal)		74				105	80	-	80
FY 2020/21	WREB/CRDTS	915	801	20			139	24	33	31
	Licensure By Credential (LBC)	45	34	6			20	28	71	64
	(License) WREB/CRDTS	802	766	3			59	22	19	20
	(License) LBC	34	36	1			8	60	35	48
	Total RDH Licenses		802							
	(Renewal)	10,416	9,590	560			5,968	8	-	8
	RDHAP	91	81	4			9	36	406	40
	(License)	82	71	4			190			190
	(Renewal)	317	296	14			194	14		14
	RDHEF	-	-	-	-	-	-	-	-	-
	(License)	-	-	-	-	-	-	-	-	-
	(Renewal)	6	6	1			13	55		55
	FNP Initial App	18	14	0			4	24		24
	Renewal	68	36	4			136	51		51
FY 2021/22	WREB/CRDTS	803	725	43			171	28	39	36
	LBC	51	48	8			15	27	68	62
	(License) WREB/CRDTS	724	724	2			57	27	25	26
	(License) LBC	48	41	2			13	51	26	40
	Total RDH Licenses		765							
	(Renewal)	10,397	9,505	581			5,433	10		10
	RDHAP	83	76	6			10	30		30
	(License)	75	68	1			37	95		95
	(Renewal)	384	365	21			169	32		32
	RDHEF	-	-	-	-	-	-	-	-	-

	(License)	-	-	-	-	-	-	-	-	-
	(Renewal)	17	17	0			6	0		0
	FNP Initial App	21	19	1			5	49		49
	Renewal	78	82	29			93	58		58

* Optional. List if tracked by the board. **NOTE:** RDHEF Licenses are no longer issued by the Board.

Table 7b. License Denial

	FY 2019/20	FY 2020/21	FY 2021/22
License Applications Denied (no hearing requested)	1	1	2
SOIs Filed	2	0	7
Average Days to File SOI (from request for hearing to SOI filed)	100	0	270
SOIs Declined	0	0	0
SOIs Withdrawn	0	0	3
SOIs Dismissed (license granted)	0	0	0
License Issued with Probation / Probationary License Issued	1	0	3
Average Days to Complete (from SOI filing to outcome)	72	0	120

21. How does the board verify information provided by the applicant?

The Board verifies information provided by the applicant by thoroughly reviewing all the required documentation received whether in hard copy, electronic form, or obtained through direct online access to another agency. Licensing staff ensure in their review of the documents that they are official and show watermarks, stamps, seal, or other official identifier of the agency, educational program, or examination administrator providing the information. Verifications from other states or jurisdiction where the applicant may have possessed a license also requires an official signature or seal to ensure acceptance.

a. What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant? Has the board denied any licenses over the last four years based on the applicant's failure to disclose information on the application, including failure to self-disclose criminal history? If so, how many times and for what types of crimes (please be specific)?

The Board requires all applicants to submit electronic fingerprints (LiveScan) or hard fingerprint cards to be processed by the Department of Justice and the Federal Bureau of Investigations for any prior criminal history or disciplinary actions. If there is a history, the Board requests the submission of any pertinent court documents, and a letter of explanation about the unlawful act from the applicant.

b. Does the board fingerprint all applicants?

Yes, the Board requires fingerprints be submitted by everyone applying for a California dental hygiene license.

c. Have all current licensees been fingerprinted? If not, explain.

Yes, all current licensees have been fingerprinted.

d. Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?

Yes, there is a national practitioner's databank for dental hygienists related to disciplinary actions. The Board participates in this databank and checks it prior to the issuance of a dental hygiene license. The Board does not have a requirement to check the databank for a licensee renewing their dental hygiene license.

e. Does the board require primary source documentation?

Yes, the Board requires primary source documentation be submitted pursuant to BPC § 1917, to obtain a California dental hygiene license. The documentation consists of:

• Proof of satisfactory completion directly from the NDHBE (National Dental Hygiene Board Examination).

• Proof of graduation directly from a dental hygiene educational program approved by the Board and accredited by American Dental Association's Commission on Dental Accreditation (CODA).

• Proof of satisfactory completion of a clinical examination administered by WREB or CRDTS and due to the COVID-19 pandemic, temporarily the examination administered by CDCA/ADEX; and

• Proof of satisfactory completion of the Board's Law and Ethics Examination.

22. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

The Board does not differentiate between out-of-state, out-of-country, and in-state applicants. The legal requirements and process for licensure for all applicants are the same pursuant to BPC §§ 1917 and 1917.1. The only exception is the implementation of BPC § 115.5 whereby these individuals are granted priority during the application process due to their spouse or domestic partner's military status.

23. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

a. Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?

Yes, the Board identifies applicants who are veterans in compliance with BPC § 114.5.

b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?

Over the years, the Board has not received any applications attempting to use their military education, training, or experience to qualify for a California dental hygiene license. This is because the military primarily focuses on educating and training dentists and not dental hygienists. The majority or possibly all the applications for licensure submitted to the Board is from the active military person's spouse, significant other, or family member that has traveled with them to California due to the transfer of assignment. If the military did change to educate and train dental hygienists, the Board would be open to review the curriculum for acceptance to be applied toward a dental hygiene license.

c. What regulatory changes has the board made to bring it into conformance with BPC § 35?

To date, no regulatory changes have been proposed due to the existing statutory requirements required for licensure as a dental hygienist. In conducting some research, it appears that the military focuses on dental training and not dental hygiene training where individuals could be considered for a dental/dentist license and not a dental hygiene license.

d. How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?

To date, no licensees have requested to waive renewal fees or continuing education requirements to renew their dental hygiene license.

e. How many applications has the board expedited pursuant to BPC § 115.5?

The DHBC has expedited the licensure process for a total of 62 applications for military spouses for the fiscal years 2017/18 – 2021/22 to comply with this section of law. The break down for each fiscal year is as follows:

FY 2017/18 - 12 applicants.

FY 2018/19 - 18 applicants.

FY 2019/20 - 6 applicants.

FY 2020/21 - 11 applicants.

FY 2021/22 - 5 applicants.

24. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

Yes, the Board sends No Longer Interested notifications to the DOJ for licenses that have been revoked. The Board sends them to the DOJ electronically through the BreEZe computer system. An individual who's had a license revoked and petitions the Board for reinstatement, must apply as a new applicant including the submission of electronic fingerprints or hardcopy fingerprint cards. Currently, there is no backlog in sending these notifications to the DOJ.

Examinations

Table 8. Examination Data[5]

California Examination (include multiple language) if any:				
	License Type	RDH	RDHAP	-
	Exam Title	Registered Dental Hygienist Law and Ethics Written Examination	CA Registered Dental Hygienist in Alternative Practice Law and Ethics Written Examination	-
FY 2018/19	Number of Candidates	988	53	-
	Overall Pass %	82	82	-
	Overall Fail %	18	18	-
FY 2019/20	Number of Candidates	811	39	-
	Overall Pass %	80	69	-
	Overall Fail %	20	31	-
FY 2020/21	Number of Candidates	917	97	-
	Overall Pass %	89	81	-
	Overall Fail %	11	19	-

[5] This table includes all exams for all license types as well as the pass/fail rate. Include as many examination types as necessary to cover all exams for all license types.

Table 8. Examination Data[5]				
California Examination (include multiple language) if any:				
	License Type	RDH	RDHAP	-
	Exam Title	Registered Dental Hygienist Law and Ethics Written Examination	CA Registered Dental Hygienist in Alternative Practice Law and Ethics Written Examination	-
FY 2021/22	Number of Candidates	895	95	-
	Overall Pass %	85	66	-
	Overall Fail %	15	34	-
	Date of Last OA	August 2019	September 2019	-
	Name of OA Developer	DCA Office of Professional Examination Services (OPES)	DCA Office of Professional Examination Services (OPES)	-
	Target OA Date	2026	2026	-

***NOTE:** OPES = DCA Office of Professional Examination Services

National Examination (include multiple language) if any:				
	License Type	RDH	-	-
	Exam Title	NDHBE*	-	-
FY 2018/19	Number of Candidates	N/A*	-	-
	Overall Pass %	N/A*	-	-
	Overall Fail %	N/A*	-	-
FY 2019/20	Number of Candidates	N/A*	-	-
	Overall Pass %	N/A*	-	-
	Overall Fail %	N/A*	-	-
FY 2020/21	Number of Candidates	N/A*	-	-
	Overall Pass %	N/A*	-	-
	Overall Fail %	N/A*	-	-
FY 2021/22	Number of Candidates	N/A*	-	-
	Overall Pass %	N/A*	-	-
	Overall Fail %	N/A*	-	-
	Date of Last OA	N/A*	-	-
	Name of OA Developer	N/A*	-	-
	Target OA Date	N/A*	-	-

***NOTE:** The National Board Dental Hygiene Examination (NBDHE) only allows the Board to electronically obtain exam scores for individual applicants and does not provide any group or bulk data per year for their examination.

25. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required? Are examinations offered in a language other than English?

There are three examinations that are required for licensure: The NBDHE (National Board Dental Hygiene Examination), a clinical examination administered by WREB (Western Regional Examination Board) and/or CRDTS (Central Regional Dental Testing Services) or temporarily, unless acceptance is extended by the Board, the CDCA/ADEX (Commission on Dental Competency Assessments/ADEX) Mannequin, and the Board's California Law and Ethics Examination that all candidates must pass. The CDCA/ADEX examination series consists of computer simulations and clinical examinations performed on patients and manikins. Temporary acceptance of the exam was from August 29, 2020, until July 31, 2023, unless extended due to the COVID-19 pandemic and cancellation or postponement of the live, patient-based clinical examinations.

The purpose of the NBDHE is to ensure that each examination candidate and applicant for licensure has achieved the level of knowledge, skill, and judgment necessary to practice in a safe and responsible manner. Accordingly, all candidates are expected to pass the examination on their own merit without assistance and are expected to maintain the confidentiality of the examination. Members of the public who entrust dental hygienists with their well-being expect that they are trustworthy and competent individuals.

The NBDHE is a comprehensive examination consisting of 350 multiple-choice examination items. The examination has two components: a discipline-based component and a case-based component. The discipline-based component includes 200 items addressing three major areas: 1) Scientific Basis for Dental Hygiene Practice; 2) Provision of Clinical Dental Hygiene Services; and 3) Community Health/Research Principles.

The case-based component includes 150 case-based items that refer to 12 to 15 dental hygiene patient cases. These cases presented in this component contain information dealing with adult and child patients by means of patient histories, dental charts, radiographs, and clinical photographs. Information about the American Dental Association NBDHE is available in their 2017 Guide on their website at: www.ada.org under the Education/Careers tab.

The purpose of the WREB and CRDTS regional clinical examinations is to evaluate an applicant's ability to utilize professional judgment and clinical competency in providing oral health care to patients. By completing a regional examination, the results are portable should the licensee choose to move to another state or jurisdiction and obtain a license there. The exam results, if accepted by the new state or jurisdiction, can be used to fulfill the clinical requirement for licensure.

Prior to issuance of a license, an applicant for licensure as a dental hygienist shall successfully complete a supplemental written examination approved by the Board in Law and Ethics. The Board's Law and Ethics Examination, as stated in CCR § 1082.3, requires:

(a) The examination shall test the applicant's knowledge of California Law as it relates to the practice of dental hygiene.

(b) The examination on ethics shall test the applicant's ability to recognize and apply ethical principles as they relate to the practice of dental hygiene.

(c) An examinee shall be deemed to have passed the examination if his/her score is at least 75% in each examination.

All of the above examinations (national boards, clinical, and law and ethics examinations) are only available in English.

26. What are pass rates for first time vs. retakes in the past 4 fiscal years? *(Refer to Table 8: Examination Data)* Are pass rates collected for examinations offered in a language other than English?

The Board only administers the California Law and Ethics Examination for RDH and RDHAPs in English. The first chart shows the pass rates for first time takers over the past four years is and the second shows the data of first-time takers versus applicants retaking the examination.

Pass Rates for First Time Takers of the CA Law and Ethics Examination*				
Fiscal Year	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
RDH	82%	80%	89%	85%
RDHAP	82%	69%	79%	66%

Pass Rates for First Time Takers vs. Retakes of the CA Law and Ethics Examination					
RDH Applicants					
Fiscal Year	Number of First Timers	Percentage	Number of Retakers	Percentage	Total Passed
FY 2018/19	810	82%	178	18%	988
FY 2019/20	649	80%	162	20%	811
FY 2020/21	816	89%	101	11%	917
FY 2021/22	761	85%	134	15%	895
RDHAP Applicants					
Fiscal Year	Number of First Timers	Percentage	Number of Retakers	Percentage	Total Passed
FY 2018/19	43	82%	10	18%	53
FY 2019/20	27	69%	12	31%	39
FY 2020/21	79	81%	18	19%	97
FY 2021/22	63	66%	32	34%	95

27. Is the board using computer-based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

The Board's RDH and RDHAP Law and Ethics Examinations are computer-based tests. The law and ethics exams are available at multiple testing centers in CA and nationwide and are administered on a continuous basis once an applicant is qualified by the Board. Applicants schedule their own examination appointments at their convenience. The Board uses a secured vendor, Psychological Services, Incorporated (PSI Services, Inc.), as part of the department-wide contract to administer the law and ethics examinations.

28. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

Currently, there are no existing statutes that hinder the efficient and effective processing of the Board's licensing applications. The application process is direct and efficient where there are several requirements applicants must complete and submit to the Board prior to being deemed eligible for the California Law and Ethics written examination. Once the applicant passes the exam, which is the last requirement to be completed, the dental hygiene license is issued.

School approvals

29. Describe legal requirements regarding school approval.

The Board's statutory authority regarding dental hygiene educational program (DHEP) approval may be found in the Business and Professions Code (BPC) in the following sections:

- **BPC section 1905, subdivisions (a)(1) – (a)(2).**

(1) Evaluate all registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions educational programs that apply for approval and grant or deny approval of those applications in accordance with regulations adopted by the dental hygiene board. Any such educational programs approved by the dental board on or before June 30, 2009, shall be deemed approved by the dental hygiene board. Any dental hygiene program accredited by the Commission on Dental Accreditation (CODA) may be approved.

(2) Withdraw or revoke its prior approval of a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions educational program in accordance with regulations adopted by the dental hygiene board. The dental hygiene board may withdraw or revoke a dental hygiene program approval if the Commission on Dental Accreditation has indicated an intent to withdraw approval or has withdrawn approval.

- **BPC section 1941.**

(a) The dental hygiene board shall grant or renew approval of only those educational programs for RDHs that continuously maintain a high-quality standard of instruction and, where appropriate, meet the minimum standards set by the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the dental hygiene board.

(b) A new educational program for RDHs shall submit a feasibility study demonstrating a need for a new educational program and shall apply for approval from the dental hygiene board before seeking any required approval for initial accreditation from the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the dental hygiene board. The dental hygiene board may approve, provisionally approve, or deny approval of a new educational program for RDHs.

(c) For purposes of this section, a new or existing educational program for RDHs means a program provided by a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education and that has as its primary purpose providing college level courses leading to an associate or higher degree, that is either affiliated with or conducted by a dental school approved by the dental board, or that is accredited to offer college level or college parallel programs by the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the dental hygiene board.

(d) For purposes of this section, "RDHs" means registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

- **BPC section 1941.5.**

(a) The dental hygiene board shall renew approval of educational programs for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions that certify to the dental hygiene board on a form prescribed by the dental hygiene board that the program continues to meet the requirements prescribed by the dental hygiene board.

(b) The dental hygiene board may conduct periodic surveys, evaluations, and announced and unannounced site visits to existing and new educational programs for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions to ensure continued compliance of educational program requirements and Commission on Dental Accreditation standards for continued approval.

(c) An existing or new educational program for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions that is found to be noncompliant with the educational program requirements and Commission on Dental Accreditation standards may be placed on probation with terms, issued a citation and fine, or have its approval withdrawn if compliance is not met within reasonable specified timelines.

(d) The dental hygiene board, or through an authorized representative, may issue a citation containing fines and orders of abatement for any approved educational program for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions for any violation of this section or the regulations adopted pursuant to this section.

The Board's regulatory authority regarding school approval may be found in Title 16 of the California Code of Regulations (CCR) in the following sections:

- **16 CCR section 1104.**

(a) A new educational program shall obtain Dental Hygiene Board approval prior to admission of students.

(b) The Dental Hygiene Board shall review the approval of all approved educational programs in accordance with accreditation renewal standards set by the Commission on Dental Accreditation of the American Dental Association (CODA), or an equivalent accrediting body, as determined by the Dental Hygiene Board. If an equivalent body has not been established by the Dental Hygiene Board, the standards shall be set by CODA.

(1) All educational programs accredited by CODA, or an equivalent accrediting body, as determined by the Dental Hygiene Board, shall submit to the Dental Hygiene Board after each accreditation site visit an electronic copy of the Self-Study Report prepared for CODA (https://www.ada.org/en/coda), or the equivalent accrediting body, as determined by the Dental Hygiene Board, and a copy of the final report of the findings within thirty (30) days of the final report issuance.

(2) If the educational program is granted CODA's, or an equivalent accrediting body's, as determined by the Dental Hygiene Board, status of "Approval with Reporting Requirements", the program shall submit to the Dental Hygiene Board copies of any and all correspondence received from or submitted to CODA, or an equivalent accrediting body, as determined by the Dental Hygiene Board, until such time as the status of "Approval without Reporting Requirements" is granted.

(3) If the educational program is granted CODA's, or an equivalent accrediting body, as determined by the Dental Hygiene Board, status of “Approval with Reporting Requirements with Intent to Withdraw”, the program shall notify the Dental Hygiene Board within ten (10) days, and the Dental Hygiene Board shall withdraw approval until such time as the status of “Approval without Reporting Requirements” is granted. Students enrolled in a program where approval has been withdrawn will not be considered graduates of an approved program and shall be ineligible for licensure. The program shall notify the students of the withdrawal of approval and the potential for ineligibility for licensure on the basis of not having graduated from an approved program. The program shall copy the Dental Hygiene Board on the notification to students and any correspondence submitted to CODA, or an equivalent accrediting body, as determined by the Dental Hygiene Board, regarding accreditation status.

(4) If the educational program is withdrawn from accredited status by CODA, or an equivalent accrediting body, as determined by the Dental Hygiene Board, the program shall notify the Dental Hygiene Board in writing of such status within 10 days and the Dental Hygiene Board shall withdraw approval. The program shall submit copies of any and all correspondence received from or submitted to CODA, or an equivalent accrediting body, as determined by the Dental Hygiene Board. Students enrolled in a program where accreditation has been withdrawn will not be considered graduates of an accredited program and shall be ineligible for licensure.

(5) Continuation of approval of all educational programs shall be contingent upon compliance with the requirements described in this Article. Written notification of continuation of approval shall be provided.

(c) All Dental Hygiene Board-approved programs shall maintain current accreditation by CODA, or an equivalent accrediting body, as determined by the Dental Hygiene Board.

(d) All Dental Hygiene Board-approved sponsoring and affiliated institutions shall maintain current institutional accreditation pursuant to Business and Professions Code section 1941(c).

(e) A material misrepresentation of fact by a new educational program or an approved educational program in any information required to be submitted to the Dental Hygiene Board is grounds for denial of approval or revocation of the program's approval.

- **16 CCR section 1104.1.**

(a) A college or an institution of higher education applying for approval of a new educational program for registered dental hygienists shall comply with the requirements specified in the Dental Hygiene Board's document entitled, “Instructions for Institutions Seeking Approval of a New RDH Educational Program”, (EDP-I-01 Rev 03/2022), (“Instructions”), which is hereby incorporated by reference, including:

(1) Notify the Dental Hygiene Board in writing of its intent to offer a new educational program that complies with Dental Hygiene Board requirements;

(2) Submit a feasibility study in accordance with the requirements specified in the “Instructions” for approval as referenced in Business and Professions Code (BPC) section 1941(b);

(3) The Dental Hygiene Board shall review the feasibility study and approve or deny approval of the study as specified in the “Instructions”.

(b) After approval of the feasibility study by the Dental Hygiene Board, and at least twelve (12) months prior to the proposed date for enrollment of students, the educational program shall submit CODA's, or an equivalent accrediting body's required documents to the Dental Hygiene Board in accordance with the requirements specified in the “Instructions”. This includes a Self-Study Report that delineates how the proposed program plans to comply with the CODA accreditation standards

contained in CODA's “Accreditation Standards for Dental Hygiene Education Programs” (As Last Revised: February 6, 2015) which is hereby incorporated by reference.

(c) The required documents shall be reviewed by the Dental Hygiene Board and site visit shall be scheduled in accordance with the requirements specified in the “Instructions”.

(d) The Dental Hygiene Board may approve, provisionally approve, or deny approval of the educational program in accordance with the requirements specified in the “Instructions”.

(e) The educational program shall notify the Dental Hygiene Board in writing of any substantive or major change in information contained in the required approval documents within 10 days of such change. A substantive or major change is one that affects the original submission, where without the submission of the new information the request for approval for a new educational program would be false, misleading, or incomplete.

- **16 CCR section 1104.2.**

(a) Any new educational program whose approval is denied may request an informal conference before the Executive Officer or his or her designee. The program shall be given at least ten days notice of the time and place of such informal conference.

(b) The education program may contest the denial of approval by either:

(1) Appearing at the informal conference. The Executive Officer shall notify the educational program of the final decision of the Executive Officer within ten days of the informal conference. Based on the outcome of the informal conference, the educational program may then request a hearing to contest the Executive Officer's final decision. An educational program shall request a hearing by written notice to the Dental Hygiene Board within 30 calendar days of the postmark date of the letter of the Executive Officer's final decision after informal conference. Hearings shall be held pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Or;

(2) Notifying the Dental Hygiene Board in writing the educational program election to forego the informal conference and to proceed with a hearing pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Such notification shall be made to the Dental Hygiene Board before the date of the informal conference.

- **16 CCR section 1105.**

As of January 1, 2016, educational programs for registered dental hygienists shall comply with the requirements set forth below in order to secure and maintain approval by the Dental Hygiene Board.

(a) Administration and Organization. There shall be a written program mission statement that serves as a basis for curriculum structure. Such statement shall take into consideration the individual difference of students, including their cultural and ethnic background, learning styles, and support systems. It shall also take into consideration the concepts of dental hygiene, which must include the dental hygiene process of care, environment, health-illness continuum, and relevant knowledge from related disciplines.

(b) Instruction.

(1) Instruction upon all levels shall be conducted upon the premise that dental hygiene education must meet the test of a true university discipline and shall include lectures, laboratory experiments and exercises and clinical practice under supervision by the faculty.

(2) For purposes of this section, the term “university discipline” is a level of instruction at least equivalent to that level of instruction represented by college courses in the basic sciences commonly offered or accepted in approved California dental schools.

(3) The length of instruction in the educational program shall include two academic years of fulltime instruction at the postsecondary college level or its equivalent, and a minimum of 1,600 clock hours.

(4) The instructor to student ratio shall meet approved Commission on Dental Accreditation standards referenced in subsection (c) of section 1103 of this article.

(5) Instruction involving procedures that require direct supervision shall be supervised by a faculty dentist who possesses an active California license or special permit with no disciplinary actions in any jurisdiction to practice dentistry.

(c) Standards of Competency. Each educational program shall establish and maintain standards of competency. Such standards shall be available to each student and shall be used to measure periodic progress or achievement in the curriculum.

(d) The policies and procedures by which the educational program is administered shall be in writing, shall reflect the mission and goals of the program, and shall be available to all students.

(e) The educational program shall have a written plan for evaluation of all aspects of the program, including admission and selection policy and procedures, attrition and retention of students, curriculum management, patient care competencies, ethics and professionalism, critical thinking, and outcomes assessment, including means of student achievement. If the program has submitted a written plan to the Commission on Dental Accreditation, which includes each of the elements listed above, a copy of such plan may be submitted to the Committee to meet this requirement.

(f) Admission.

(1) The minimum basis for admission into an educational program shall be the successful completion of all of the following:

(A) A high school diploma or the recognized equivalent, which will permit entrance to a college or university accredited by an agency recognized by the U.S. Department of Education or Council for Higher Education Accreditation; and,

(B) College-level general education courses in the topic areas of:

(i) Oral Communication

(ii) Written Communication *

(iii) Psychology

(iv) Sociology

(v) Mathematics *

(vi) Cultural Diversity **

(vii) Nutrition **

* Advanced Placement (AP) Exam Score Exemption may be accepted in lieu of this course.

** This course is required prior to graduation and may be waived as an admission requirement if included within the dental hygiene program curriculum.

(C) College-level biomedical science courses, each of which must include a wet laboratory component, in:

(i) Anatomy

(ii) Physiology

(iii) Inorganic Chemistry

(iv) Biochemistry or Organic Chemistry with Biochemistry

(v) Microbiology

(D) If a state of emergency is declared by the Governor pursuant to Government Code section 8625, an educational program may accept prerequisite biomedical science coursework completed during the period of the state of emergency in Anatomy, Physiology, Inorganic Chemistry, Biochemistry, Organic Chemistry with Biochemistry, and Microbiology utilizing alternative instruction including, but not limited to, instructional methods such as online tutorials, webinars, or hybrid combination of online and in-person instruction with faculty, as deemed appropriate by the educational institution.

(2) Admission of students shall be based on specific written criteria, procedures, and policies. Previous academic performance and/or performance on standardized national tests of scholastic aptitude or other predictors of scholastic aptitude and ability shall be utilized as criteria in selecting students who have the potential for successfully completing the educational program. Applicants must be informed of the criteria and procedures for selection, goals of the program, curricular content, course transferability and the scope of practice of and employment opportunities for dental hygienists.

(g) The program shall have published student grievance policies.

(h) There shall be an organizational chart that identifies the relationships, lines of authority and channels of communication within the educational program, between the program and other administrative segments of the sponsoring institution, and between the program, the institution and extramural facilities and service-learning sites.

(i) The educational program shall have learning resources, including faculty, library, staff and support services, technology and physical space and equipment, including laboratory and clinical facilities, to support the program's stated mission and goals and in accordance with approved accreditation standards referenced in subsection (c) of section 1103 of this article.

(j) The educational program director shall have the primary responsibility for developing policies and procedures, planning, organizing, implementing, and evaluating all aspects of the program.

(k) The number and distribution of faculty and staff shall be sufficient to meet the educational program's stated mission and goals.

(l) When an individual not employed in the educational program participates in the instruction and supervision of students obtaining educational experience, their name and responsibilities shall be described in writing and kept on file by the dental hygiene program, and they shall have twenty-four (24) months of experience providing direct patient care as a registered dental hygienist or dentist.

(m)As of January 1, 2017, in a two-year college setting, graduates of the educational program shall be awarded an associate degree, and in a four-year college or university, graduates shall be awarded an associate or baccalaureate degree.

Who approves your schools?

The Board maintains sole approval dental hygiene educational programs in California pursuant to BPC section 1941. If a California dental hygiene educational program does not have the Board's approval, graduates of the California dental hygiene educational program are not eligible for licensure in California.

Additionally, all dental hygiene educational programs must be accredited by the Commission on Dental Accreditation of the American Dental Association (CODA). CODA was established in 1975 and is nationally recognized by the United States Department of Education as the sole agency to accredit dental and dental-related education programs conducted at the post-secondary level.

What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?

The Bureau of Private Postsecondary Education (BPPE) is generally responsible for protecting consumers and students against fraud, misrepresentation, or other business practices at private postsecondary institutions that may lead to loss of students' tuition and related educational funds; establishing and enforcing minimum standards for ethical business practices and the health and safety and fiscal integrity of postsecondary education institutions; and establish and enforcing minimum standards for instructional quality and institutional stability for all students in all types of private postsecondary educational and vocational institutions.

BOARD COLLABORATION WITH BPPE IN THE DENTAL HYGIENE EDUCATIONAL PROGRAMS APPROVAL PROCESS

The Board maintains communication with BBPE for possible companion cases if the review of the dental hygiene educational program discovers an issue under BPPE's purview.

The Board utilizes its laws and regulations in conjunction with the American Dental Association's Commission on Dental Accreditation (CODA) Standards to oversee the approval of the California dental hygiene educational programs (DHEP). The BPPE (Bureau for Private Postsecondary Education) has no role in the approval of the DHEPs but does review potential issues forwarded to it by the Board concerning the private DHEPs for any deviation in educational standards.

30. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?

The Board approves 26 DHEPs and three Registered Dental Hygiene in Alternative Practice educational programs for a total of 29 dental hygiene educational programs. The Board began the review of the DHEPs in 2016 and had the intention of reviewing all of them within five years to establish an educational baseline for comparison with any future site visits. Issues at a few of the DHEPs that required Board attention and multiple visits and the COVID-19 pandemic caused delays for the completion of its initial review of all DHEPs. Now that the severity of the pandemic seems to be over, to date, the Board has reviewed all 29 dental hygiene educational programs in 37 separate site visits since the Board's inception of the review program in December of 2016.

For the future, each dental hygiene educational program will be reviewed on a rotational basis based upon their CODA accreditation timeline (every seven years) or sooner if the Board becomes aware of substantive changes to the dental hygiene educational program or complaints about the dental hygiene educational program are received by the Board. Much of the information gathered by the DHEP for the CODA site reviews overlaps with information the Board reviews for its approval so it can be used for both agencies.

The Board may withdraw a DHEP's approval pursuant to BPC section 1902(a)(2) if warranted, but would occur after intermediate steps of probation, citation and fine and possibly after a DHEP's

appeal to the Board's decision to remove its approval. The Board provides ample opportunity for a DHEP to comply with the law and CODA Standards to continue its Board approval before further action is taken. If the Board votes to remove approval from the DHEP, it won't prohibit the DHEP from continuing to teach but would result in its students being deemed ineligible to obtain a dental hygiene license.

31. What are the board's legal requirements regarding approval of international schools?

The Board has no authority to approve international schools. It would need to obtain statutory authority, staff, and all the necessary resources to be able to initiate an international school approval process which the Board is not interested in pursuing at this time.

Continuing Education/Competency Requirements

32. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.

The Board requires licensees to complete a certain number of continuing education (CE) hours to renew the dental hygiene license and to assist with continued competency for the practitioner in the profession. CE hour requirements are as follows:

Registered Dental Hygienists – 25 CE hours.

Registered Dental Hygienists in Alternative Practice – 35 CE hours.

Registered Dental Hygienists in Extended Functions – 25 CE hours.

Pursuant to Business and Professions Code section 1936.1, subsection (a), the Board requires as a condition of license renewal that licensees submit assurances satisfactory to the Board that they will, during the preceding two-year period, inform themselves of the developments in the practice of dental hygiene occurring since the original issuance of their licenses by pursuing one or more courses of study satisfactory to the Board. The Board also requires as a condition of license renewal, specific coursework to be completed in Basic Life Support, Infection Control, and the Dental Practice Act for each renewal. This attestation of CE completion is noted on the licensee's License Renewal Application at each renewal that's completed under the penalty of perjury.

The only change was to the law pertaining to CE since the last review. The Board amended BPC section 1936.1(a) to amend the language to complete the CE requirements for the renewal of the license from "succeeding two-year period" to "preceding two-year period" which is the practice followed by most if not all Department of Consumer Affairs boards that require CE as a condition of license renewal.

a. How does the board verify CE or other competency requirements? Has the Board worked with the Department to receive primary source verification of CE completion through the Department's cloud?

The Board verifies CE completion by its licensees through random CE audits. Pursuant to CCR section 1017(n), licensees are required to retain for three license renewal periods certificates of course completion issued at the completion of CE coursework and shall forward them to the Board upon request for audit purposes. The Board expects licensees to be honest when completing their License Renewal Application where they attest under the penalty of perjury that they have completed the required number and type of CE hours to renew the license. The Board conducts a random subsequent CE audit to verify that licensees are in fact completing their required CE coursework to renew their licenses.

The Board has not collaborated with the Department to receive primary source verification of CE completion through the Department's cloud. Discussions may occur between our two agencies in the future on the aspect to use this method to verify CE completion, if needed.

b. Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.

Yes, the Board conducts random CE audits of its licensees. Licensees are expected to follow the laws and regulations that govern their license including the completion of the required CE hours to renew that license over the 24 months prior to its expiration. Licensees attest under the penalty of perjury at the time of completing the License Renewal Application that they have completed not only the required number of CE hours and method (only a maximum 50% of the completed CE hours can be done through online recorded means), but the Board specific requirements in Basic Life Support, Infection Control, and the Dental Practice Act. The CE hours must also be completed by CE providers approved by the Dental Board of California or approving entities accepted by them. Any deviation discovered through the CE Audit is grounds for failure unless CE documentation can be produced as a result of the audit to show CE compliance for the selected license renewal. The licensee is provided a reasonable amount of time to comply and if additional documentation is not produced to show CE compliance, further administrative action such as a citation and fine may be administered against the license. The licensee does have the right to appeal any administrative action taken against the license for the Board's consideration.

c. What are consequences for failing a CE audit?

If a licensee fails a CE audit, their file is forwarded to the Citation and Fine desk for further administrative action which could possibly result in a citation and fine. The amount of the fine is determined by the extent of the non-compliance as determined by the failed CE audit.

d. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?

The Board obtained the staff resources through a budget change proposal in 2020 and only began to consistently conduct CE audits on a regular basis for the past two years. Within that time of two years, the Board has conducted 1,165 random CE audits. Of those audits conducted, 449 or 38.5% failed. This number and percentage have been consistent over the two-year period and the Board will continue to work to ensure licensees are informed of their CE requirements to renew the license prior to its expiration in the hopes of reducing the audit failure rate.

e. What is the board's CE course approval policy?

CE providers and courses approved by the Dental Board of California are deemed acceptable and approved by the Board to apply toward the CE license renewal requirement.

f. Who approves CE providers? Who approves CE courses? If the board approves them, what is the board application review process?

CE providers and courses approved by the Dental Board of California are deemed acceptable and approved by the Board. Pursuant to Business and Professions Code section 1936.1, subsection (c), the Board has the authority to approve CE providers and courses; however, due to other program demands, the lack of staff and resources to dedicate to this issue, and the currently successful use of the existing CE provider and course approval system, the Board focuses its priorities on other issues than CE provider and course approval.

g. How many applications for CE providers and CE courses were received? How many were approved?

None, as the Board currently does not approve CE providers or courses.

h. Does the board audit CE providers? If so, describe the board's policy and process.

The Board does not audit CE providers so there are no policies and processes in place to complete this function.

i. Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance-based assessments of the licensee's continuing competence.

The Board has not prioritized or had reason to review its current CE policy because indicators and communications received by the Board inform us that dental hygiene practitioners are working within their ethical guidelines and rarely deviate from the standard of care. The Board does receive multiple complaints from consumers each year that are practice related issues; however, most of them are closed due to insufficient evidence of any deviation in the standard of care, non-jurisdictional issues that are referred to the agency with jurisdiction, or they stem from billing discrepancies which is also outside of the Board's purview.

Table 8a. Continuing Education

Type	Frequency of Renewal	Number of CE Hours Required Each Cycle	Percentage of Licensees Audited
Registered Dental Hygienist (RDH)	Biennial (every 2 years)	25	Up to 10%
Registered Dental Hygienist in Alternative Practice (RDHAP)	Biennial (every 2 years)	35	Up to 10%
Registered Dental Hygienist in Extended Functions (RDHEF)	Biennial (every 2 years)	25	Up to 10%

Section 5 – Enforcement Program

33. What are the board's performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The Board's performance targets are consistent with the DCA's Consumer Protection Enforcement Initiative (CPEI) Performance Measures (PM). These measures include the following:

PM1- Complaints Received

PM1 is the total number of complaints and conviction/arrest notices received within the specified period

Complaints Received by FY	
Fiscal Year	Complaints Received
FY 2019/2020	219
FY 2020/2021	507
FY 2021/2022	422

PM 2 – Intake Cycle Time

PM2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint was assigned for investigation or closed

Intake Process			
FY 2019/2020	Average Days	Target # of Days	Target Met
1st Quarter	4	10	Yes
2nd Quarter	2	10	Yes
3rd Quarter	2	10	Yes
4th Quarter	1	10	Yes
FY 2020/2021			
1st Quarter	4	10	Yes
2nd Quarter	2	10	Yes
3rd Quarter	2	10	Yes
4th Quarter	1	10	Yes
FY 2021/2022			
1st Quarter	2	10	Yes
2nd Quarter	2	10	Yes
3rd Quarter	2	10	Yes
4th Quarter	2	10	Yes

PM 3 - Investigation Cycle Time

PM3 is the total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action

Intake and Investigation			
FY 2019/2020	Average Days	Target # of Days	Target Met
1st Quarter	240	270	Yes
2nd Quarter	180	270	Yes
3rd Quarter	233	270	Yes

4th Quarter	98	270	Yes
FY 2020/2021			
1st Quarter	125	270	Yes
2nd Quarter	82	270	Yes
3rd Quarter	78	270	Yes
4th Quarter	255	270	Yes
FY 2021/2022			
1st Quarter	135	270	Yes
2nd Quarter	121	270	Yes
3rd Quarter	141	270	Yes
4th Quarter	145	270	Yes

PM 4 – Formal Discipline Cycle Time

PM4 is the total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline and closures without formal discipline.

Formal Discipline			
FY 2019/2020	Average Days	Target # of Days	Target Met
1st Quarter	974	540	No
2nd Quarter	855	540	No
3rd Quarter	629	540	No
4th Quarter	646	540	No
FY 2020/2021	Average Days	Target # of Days	Target Met
1st Quarter	882	540	No
2nd Quarter	499	540	Yes
3rd Quarter	N/A	540	No
4th Quarter	1287	540	No
FY 2021/2022	Average Days	Target # of Days	Target Met
1st Quarter	666	540	No
2nd Quarter	1018	540	No
3rd Quarter	426	540	Yes
4th Quarter	553	540	No

PM 7 – Probation Intake Cycle Time

PM 7 is the total number of new probation cases and the average number of days from the probation monitor assignment, to the date the monitor makes first contact with the probationer.

The target of PM7 is 10 days. The Board has met this goal averaging 1 day to make first contact with probationers.

PM 8 – Probation Violation Response Cycle Time

PM 8 is the average number of days from the date a violation of probation is reported, to the date the probation monitor initiates any action.

The target of PM 8 is 10 days. The Board has met this goal averaging 1 day to initiate action after discovering violation(s) of probation

The Board consistently met and exceeded the expectations of the enforcement program for the past three fiscal years, with the exception of PM 4, the average number of days to close cases transmitted to the Attorney General for disciplinary action. This performance measure is dependent on outside agencies, such as the Attorney General's Office and the Office of Administrative hearings, which the Board does not have control over. Despite not meeting the performance measure for the last two fiscal years, the Board has made some improvements during the FY 2021/2022 in reducing the average days it took to close a complaint that was transmitted over to the Attorney General's Office.

The Board and staff have worked diligently over the past three fiscal years to ensure cases are reviewed and assigned for investigation within 10 days. Over the past three fiscal years, PM 2 shows that it took an average of two days to review and assigned cases for investigation.

The Board enforcement staff has made significant improvements in the investigation and processing timeframe of cases received by the Board. Over the past three fiscal years, the Board has reduced the Board's timeframe of investigation (PM 3) from FY 2019/2020 of 266 days to the most current data, FY 2021/2022 of 132 days.

The Board's highest priority continues to be the protection of the public and is committed to investigating all cases thoroughly and efficiently.

34. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

The volume of enforcement investigations increased 88% between FY 2019/2020 and FY 2020/2021 — from 182 cases to 342 cases received. The increase in cases is attributed to the rise in the number of Continuing Education (CE) audits the Board conducted. As a result, the Board has been issuing an increasing number of Citation and Fine to licensees for failing their CE audit. The Board's intake statistics show a consistent trend in the volume of cases related to convictions and complaints received by the Board. The Board assigned an average of 842 cases for investigation and closed 1,128 cases (Desk Investigation and Non-Sworn Investigation combined).

One performance barrier the Board may experience is the significant delays of outside agencies involved. For example, each desk investigation related to the conviction of a crime that is substantially related to the functions and duties of hygienists requires the Board to obtain various documents, such as court documents, arrest records, and written responses from the licensee. This can be a lengthy and sometimes difficult process in getting all the required records in a timely matter, especially out-of-state criminal conviction records. In many cases, multiple documents are needed from other agencies, and repeated requests are required. Further delays can be caused when processing fees are required by courts and arresting agencies.

Although the Attorney General's Office has improved significantly in processing the Board's cases, there continue to be delays in the settlement cases and administrative hearings with OAH. There are many factors that may contribute to the AG's delay, such as their caseload numbers, the cooperativeness, and responsiveness of the opposing parties, etc. Some cases can become sedentary for three months to half a year before a settlement can be reached and/or a hearing is scheduled. This affects the Board's Formal Discipline performance measure (PM 4).

In addition, the Board's enforcement program only consists of one Special Investigator, one Enforcement Analyst, one Probation Monitor, and one Citation and Fine Analyst. The Board experienced some staff turnover over the past three years due to staff promotion. The Board is in the process of filling all vacant positions to ensure that the Board continues to operate efficiently.

The Board continues to evaluate the workload data and internal procedures to identify issues or other ways to streamline and improve the enforcement program. In addition, the enforcement staff is working on updating the Board's Disciplinary Guidelines and Uniform Standards Regarding Substance Abuses.

Table 9a. Enforcement Statistics

	FY 2019/20	FY 2020/21	FY 2021/22
COMPLAINTS			
Intake			
Received	182	342	323
Closed without Referral for Investigation	2	3	1
Referred to INV	106	412	324
Pending (close of FY)	74	2	0
Conviction / Arrest			
CONV Received	111	92	98
CONV Closed Without Referral for Investigation	0	0	0
CONV Referred to INV	113	92	98
CONV Pending (close of FY)	0	0	0
Source of Complaint[6]			
Public	7	11	5
Licensee/Professional Groups	0	1	4
Governmental Agencies	0	2	3
Internal	159	288	229
Other	13	34	66
Anonymous	3	6	16
Average Time to Refer for Investigation (from receipt of complaint / conviction to referral for investigation)	3	3	2
Average Time to Closure (from receipt of complaint / conviction to closure at intake)	2	2	3
Average Time at Intake (from receipt of complaint / conviction to closure or referral for investigation)	3	3	2

[6] Source of complaint refers to complaints and convictions received. The summatio3n of intake and convictions should match the total of source of complaint.

Table 9a. Enforcement Statistics			
	FY 2019/20	FY 2020/21	FY 2021/22
INVESTIGATION			
Desk Investigations			
Opened	179	468	377
Closed	221	403	355
Average days to close (from assignment to investigation closure)	140	130	95
Pending (close of FY)	48	115	141
Non-Sworn Investigation			
Opened	42	44	49
Closed	47	44	58
Average days to close (from assignment to investigation closure)	486	368	331
Pending (close of FY)	42	41	
Sworn Investigation	N/A	N/A	N/A
Opened	N/A	N/A	N/A
Closed	N/A	N/A	N/A
Average days to close (from assignment to investigation closure)	N/A	N/A	N/A
Pending (close of FY)	N/A	N/A	N/A
All investigations[7]			
Opened	219	507	422
Closed	269	447	371
Average days for all investigation outcomes (from start investigation to investigation closure or referral for prosecution)	205	152	143
Average days for investigation closures (from start investigation to investigation closure)	194	156	132
Average days for investigation when referring for prosecution (from start investigation to referral for prosecution)	440	226	549
Average days from receipt of complaint to investigation closure	214	155	145
Pending (close of FY)	78	145	162
CITATION AND FINE			
Citations Issued	62	77	154
Average Days to Complete (from complaint receipt / inspection conducted to citation issued)	213	246	115
Amount of Fines Assessed	$30,150	$10,000	$135,900
Amount of Fines Reduced, Withdrawn, Dismissed	$0	$500	$7,000
Amount Collected	$26,737	$8,638	$97,300
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	1	0
ACCUSATION			
Accusations Filed	20	4	13
Accusations Declined	0	0	0
Accusations Withdrawn	1	0	1
Accusations Dismissed	0	0	0
Average Days from Referral to Accusations Filed	78	110	92

[7] The summation of desk, non-sworn, and sworn investigations should match the total of all investigations.

Table 9a. Enforcement Statistics			
	FY 2019/20	FY 2020/21	FY 2021/22
(from AG referral to Accusation filed)			
INTERIM ACTION			
ISO & TRO Issued	0	0	0
PC 23 Orders Issued	0	0	0
Other Suspension/Restriction Orders Issued	0	0	0
Referred for Diversion	0	0	0
Petition to Compel Examination Ordered	0	0	1
DISCIPLINE			
AG Cases Initiated (cases referred to the AG in that year)	26	2	23
AG Cases Pending Pre-Accusation (close of FY)	0	0	0
AG Cases Pending Post-Accusation (close of FY)	171	102	143
DISCIPLINARY OUTCOMES			
Revocation	5	0	0
Surrender	4	1	1
Suspension only	0	0	0
Probation with Suspension	0	0	0
Probation only	5	3	8
Public Reprimand / Public Reproval / Public Letter of Reprimand	0	0	1
Other	0	0	0
DISCIPLINARY ACTIONS			
Proposed Decision	3	2	1
Default Decision	4	1	0
Stipulations	9	4	7
Average Days to Complete After Accusation (from Accusation filed to imposing formal discipline)	186	330	382
Average Days from Closure of Investigation to Imposing Formal Discipline	257	454	402
Average Days to Impose Discipline (from complaint receipt to imposing formal discipline)	694	1,058	736
PROBATION			
Probations Completed	8	8	5
Probationers Pending (close of FY)	34	22	20
Probationers Tolled	3	4	3
Petitions to Revoke Probation / Accusation and Petition to Revoke Probation Filed	14	3	3
SUBSEQUENT DISCIPLINE[8]			
Probations Revoked	9	5	1
Probationers License Surrendered	9	4	2
Additional Probation Only	3	1	0
Suspension Only Added	0	0	0
Other Conditions Added Only	0	0	0
Other Probation Outcome	0	0	0
SUBSTANCE ABUSING LICENSEES			
Probationers Subject to Drug Testing	30	22	21
Drug Tests Ordered	627	656	513
Positive Drug Tests	30	4	10

[8] Do not include these numbers in the Disciplinary Outcomes section above.

Table 9a. Enforcement Statistics			
	FY 2019/20	FY 2020/21	FY 2021/22
PETITIONS			
Petition for Termination or Modification Granted	2	3	0
Petition for Termination or Modification Denied	0	0	0
Petition for Reinstatement Granted	0	0	0
Petition for Reinstatement Denied	0	0	0
DIVERSION			
New Participants	0	0	0
Successful Completions	0	0	0
Participants (close of FY)	0	0	0
Terminations	0	0	0
Terminations for Public Threat	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0

Table 10. Enforcement Aging						
	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22	Cases Closed	Average %
Investigations (Average %)						
Closed Within:						
90 Days	74	144	216	273	707	59.5%
91 - 180 Days	10	18	33	36	97	8%
181 - 1 Year	9	33	171	41	254	21%
1 - 2 Years	8	38	10	49	105	8.5%
2 - 3 Years	5	17	3	8	33	3%
Over 3 Years	2	4	2	3	11	1%
Total Investigation Cases Closed	108	254	435	410	1,207	-
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year	0	6	0	1	7	15%
1 - 2 Years	3	5	2	4	14	31%
2 - 3 Years	4	5	3	2	14	31%
3 - 4 Years	1	2	1	2	6	13%
Over 4 Years	0	1	2	1	4	8%
Total Attorney General Cases Closed	8	19	8	10	45	-

35. What do overall statistics show as to increases or decreases in disciplinary action since last review?

The overall statistics show an increase in disciplinary action taken since the last Sunset Review. The overall increase is attributed to the additional hiring of staff to process enforcement related cases.

36. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.

Complaint Prioritization Guidelines for DCA Health Care Agencies	
When complaints are received by the Board, they are reviewed and prioritized based on the alleged violation(s) of the Dental Practice Act, and the laws and regulations that govern the practice of dental hygiene. The Board prioritizes cases according to the Complaint Prioritization Guidelines for Health Care Agencies (August 31, 2009).	
Priority Level	**Complaint Category**
Urgent (Highest Priority)	• In general, any act resulting in death or serious injury)' • Gross negligence, incompetence or repeated negligent acts that -involve death or serious bodily injury – • Drug or alcohol abuse by the licensee resulting in death or serious bodily injury. • Repeated acts of clearly excessive treatment, repeated acts of negligence or gross negligence • Sexual misconduct with patient during course of treatment or examination • Practicing while under the influence of drugs or alcohol • Physical or mental abuse with injury. • Unlicensed activity alleged to have resulted in patient injuries • Aiding and abetting unlicensed activity -alleged to have resulted in -patient injuries • Arrests or convictions substantially related to the area of practice (Note: may be re-categorized based on the nature of the underlying acts) • Impairments (mental, physical or as a result of alcohol or – drug abuse). • Theft of prescription drugs • Furnishing prescription drugs without a prescription
High	• Negligence or incompetence without serious bodily injury • Physical or mental abuse (without injury) • Complaints about licensees on probation • Prescribing or dispensing drugs without authority • Multiple complaints of the same allegation • Complaints with multiple prior complaints • Unlicensed activities (with no apparent harm) • Aiding and abetting unlicensed activity * with no apparent harm) • When evidence will likely be destroyed or unavailable

Routine	• False/misleading advertising • Patient abandonment • Fraud • Failure to release medical records • Record-keeping violations • Applicant misconduct • National Practitioner Data bank reports • Non-jurisdictional complaints (fee disputes, billing) • Continuing Education • Breach of confidentiality

Cases that are identified as "Urgent Priority" are immediately assigned to the enforcement analyst or investigator to review and prioritize into their existing caseload.

37. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?

    a. What is the dollar threshold for settlement reports received by the board?

- Penal Code (PC) § 11105.2 – This section requires the DOJ to report to the Board whenever a licensee is arrested and convicted of a crime(s).
- BPC section 801 requires insurers providing professional liability insurance to Board licensees to report any settlement or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by that person's negligence, error or omission in practice or by his or her rendering of unauthorized professional services.
- BPC section 802 requires uninsured licensees to report any settlement, judgment, or arbitration award over three thousand dollars ($3,000) of a claim or action for damages for death or personal injury caused by negligence, error or omission in practice or by his or her rendering of unauthorized professional services
- BPC § 803 – This section requires the clerk of a court that renders a judgment that a licensee has committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount of $30,000 caused by the licensee's negligence, error or omission in practice, or his or her rendering of unauthorized professional services, must report that judgment to the Board within 10 days after the judgment is entered.
- BPC § 1950.5(x) – This section requires the licensee to report to the Board in writing within seven days any death of his or her patient during the performance of any dental hygiene procedure or the discovery of the death of a patient which was related to a dental hygiene procedure performed by him or her.
- BPC § 1950.5(y) – This section requires the licensee to report to the Board all deaths occurring in his or her practice with a copy sent to the dental office.
- PC § 11164 et seq. – This section requires the licensee to report any child abuse and neglect

All licensees are required to disclose, at the time of license renewal all convictions since their last license renewal.

Cases involving criminal conviction(s) require the Board to request documentation from law enforcement agencies and various state and federal courts. The Board had issues with some of these agencies not responding to the records request or taking a long time to respond, which causes severe delays in the processing of cases. Furthermore, some agencies require a fee for certified arrest reports or court records, which further delays the Board in processing these cases in a timely manner.

b. What is the average dollar amount of settlements reported to the board?

To date, the Board has not been tracking the dollar amount of settlements reported. However, the Board will start tracking this information and provide them for future reporting.

38. Describe settlements the board, and Office of the Attorney General on behalf of the board, enter into with licensees.

The Board uses its "Disciplinary Guidelines and Uniform Standards for Substance Abuse" as a guideline in determining the appropriate disciplinary action(s) against licensees that violate the DPA and/or any laws and regulations that govern the practice of dental hygiene. However, the Board reviews each case individually, taking into consideration of any mitigating evidence and/or extenuating circumstances to support any deviation from the guidelines.

As outlined in the Board Disciplinary Guidelines, the Board settles disciplinary actions as follows:

- Surrender of license(s) - The licensee has agreed to voluntarily surrendered the license. This is considered a disciplinary action. The individual can no longer practice as a Registered Dental Hygienist in California
- Probation with standard and optional conditions.- This license has been disciplined by the Board and is on probation. The licensee may continue to practice as long as the licensee complies with the specified terms and conditions of probation.
- Public Reproval -This license is publicly reproved resulting from a disciplinary action reproving the licensee for violations of the Dental Practice Act.
- Revocation -The license is revoked as a result of a disciplinary action taken by the Board. The individual can no longer practice as a Registered Dental Hygienist in California.

All cases entering into a Stipulated Settlement requires the approval of the Board's Executive Office and votes of the Board members. In many cases, Stipulated Settlement offers a quicker resolution for both the licensee and the Board, while still ensuring that the Board's priority in ensuring consumer protection is met.

a. What is the number of cases, pre-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?

The Board stopped entering into stipulated settlements prior to the filing of an Accusation, Statement of Issues and/or Petition to Revoke Probation. (Revised to "The Board relies on the AG's office prior to filing an accusation.)

b. What is the number of cases, post-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?

In the past four years, the Board settled thirty-nine (39) cases, compared to fifteen (15) cases that resulted in a hearing.

c. What is the overall percentage of cases for the past four years that have been settled rather than resulted in a hearing?

The overall percentage of cases that were settled over the past four years is 72%.

39. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

The Board does not operate with a statute of limitations. However, Board policy is to triage all complaints and process them as soon as possible.

40. Describe the board's efforts to address unlicensed activity and the underground economy.

In an effort to prevent unlicensed activity, the Board provides information on our website to help educate the general public and our licensees. The Board recommends all dental offices require dental hygienists to provide proof of licensure — either by a valid Board-issued pocket license or wall certificate. In addition, anyone may get up-to-date license status by checking on the DCA's website under the "License Search" function. All licensees are required to complete biannual mandatory continuing education courses related to the Dental Practice Act.

The majority of unlicensed activity cases received by the Board are related to licensees who failed to renew their license and practiced with a "Delinquent" license. These cases are investigated by the enforcement unit, and if substantiated, the licensee may be issued a citation and fine, or referral to the Attorney General's Office for prosecution.

In the last three fiscal years, there had only been two cases related to an individual that truly practiced without a dental hygiene license. The Board issued a cite and fine in the maximum amount of $5,000 statutory limit and ordered the individual to immediately cease and desist from practicing dental hygiene without a license. One case was referred to the local District Attorney's Office for criminal prosecution, which is currently pending.

Cite and Fine

41. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the $5,000 statutory limit?

BPC § 125.9 authorizes the Board to issue citations and fines for violations of the Dental Practice Act. Over the past three fiscal years, the Board has used its authority for cite and fine to address cases that warrant a cite and fine. Since the last Sunset Review, the Board hired a Cite and Fine Analyst and had been working on the backlog of cases requiring a cite and fine. The Cite and Fine program is an efficient and cost-effective mechanism to educate and obtain compliance from licenses who violated the Dental Practice Act. This program provides the Board with an alternative mechanism to address cases that do not rise to the level of formal disciplinary action

BPC § 1955(a) authorizes the Board to issue administrative citations to licensees and healthcare facilities who fail to produce requested patient records within the mandated 15-day period. The Board may issue citations with a $250/day fine, up to a $5,000 maximum. To date, the Board has not needed to issue a citation for failure to produce patient records.

The Board has expanded the scope of its use of cite and fine (beyond record production) to address a wider range of violations that can be more efficiently and effectively addressed through the use of cite and fine process with abatement and/or remedial education outcomes. It is also being used to address licensees who do not complete the continuing education (CE) units required to renew a license. These individuals are discovered to be deficient after a CE audit.

There have been no changes to the Board's citation and fine program regulations since the last Sunset Review.

The Board's citation and fine authority is not to exceed $5,000, so if there is a case that is egregious enough to warrant a $5,000 citation and fine, the Board will impose its maximum charge as determined by the Executive Officer or his or her designee.

42. How is cite and fine used? What types of violations are the basis for citation and fine?

The Board uses the Cite and Fine to address less egregious violations of the Dental Practice Act. In addition, the issuance of cite and fine is used to educate and gain immediate compliance from licensees.

When issuing citations, the Board's goal is to protect California consumers by getting the licensee's attention, re-educating him/her on the applicable laws and emphasizing the importance of following the dental hygiene practices that fall within the profession's standard of care. Considerations when issuing a citation and fine include:

• Nature and severity of the violation;

• Length of time that has elapsed since the violation;

• Consequences of the violation – was there potential harm to the consumer;

• Licensee's history of previous violations: the number and types of violations in licensee's history;

• Evidence that the violation was willful

43. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

In the last four (4) fiscal years, there had been a total of 22 informal office conferences conducted with licensees who requested an informal conference. There have been no Administrative Procedure Act Appeals in the last four (4) fiscal years.

44. What are the five most common violations for which citations are issued?

The five most common violations for which citations are issued are as follow:

- Conviction of crime(s) substantially related to the licensee's qualifications, functions, or duties
- Unprofessional conduct

- Practicing with an inactive or expired license
- Continue Education Audit failure
- Change of Address/Change of Name

45. What is average fine pre- and post- appeal?

The average fine pre-appeal is $656.63, and post-appeal is $643.64.

46. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

The Board started to use the Franchise Tax Board (FTB) to collect outstanding fines in FY 2021/2022. The Board Cite and Fine Analyst notifies the licensee and serves three follow-up notices as necessary before sending the collection request to the FTB.

Cost Recovery and Restitution

47. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

BPC §125.3 authorizes the Board to request reimbursement for reasonable costs incurred as the result of the investigation and prosecution of a formal disciplinary matter, which includes but is not limited to the actual cost of investigation and AG-related costs. The Board seeks cost recovery in all cases where it is authorized. Cost recovery is a standard probation term listed in the Board Disciplinary Guidelines. Cost recovery is always sought when a case is resolved through stipulated settlement or issuance of a Proposed Decision by an Administrative Law Judge after an administrative hearing.

The Board may reduce the amount of cost recovery as an incentive to reach a stipulated settlement. This strategy is beneficial for all parties involved as it reduces adjudication costs and processing timelines. Stipulated settlement also provides greater public protection as the matter is resolved more expeditiously. Furthermore, the respondent is subject to probation monitoring, and the matter is publicly disclosed much earlier than if the matter goes forward to an administrative hearing. As with any other disciplinary decision, the Board members must consider and vote to adopt all stipulated settlements before they become effective.

There have been no changes implemented in the Board cost recovery efforts since the last review.

48. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

The amount ordered for revocations, surrenders, and probation through stipulated settlement varies widely and is dependent on many factors. These factors include the time it took to investigate a case and the cost incurred for the prosecution of the case with the Attorney General's office. In general, cost recovery imposed on probationers is collected as part of their required condition of probation. All probationers are required to satisfy their cost recovery within six months prior to the completion of their probation with the Board.

In cases of revocations or surrenders, the ordered costs are considered uncollectable until the licensee either petitions the Board for reinstatement or reapplies for licensure.

49. Are there cases for which the board does not seek cost recovery? Why?

The Board does not seek cost recovery in cases where a Statement of Issues is filed because these individuals are not yet licensed. A Statement of Issues is initiated when an applicant appeals the denial of their application for licensure pursuant to BPC § 485.

50. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

The Board started to use the Franchise Tax Board (FTB) to collect outstanding fines in FY 2021/2022. The Board Cite and Fine Analyst notifies the licensee and serves three follow-up notices, as necessary before sending the collection request to the FTB.

51. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

Table 11. Cost Recovery[9] (list dollars in thousands)

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Total Enforcement Expenditures	$311,000	$616,000	$595,000	$567,000
Potential Cases for Recovery *	1	5	3	4
Cases Recovery Ordered	1	5	3	4
Amount of Cost Recovery Ordered	$1,652.50	$26,103.70	$20,876.50	$13,860.00
Amount Collected	$17,507.74	$15,480.38	$13,436.85	$21,451.14

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

Table 12. Restitution (list dollars in thousands)

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Amount Ordered*	$0	$0	$0	$0
Amount Collected*	$0	$0	$0	$0

***NOTE**: The Board did not order nor collected restitution.

Section 6 – Public Information Policies

52. How does the board use the internet to keep the public informed of board activities? Does the board post board-meeting materials online? When are they posted? How long do they remain on the board's website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

[9] Cost recovery may include information from prior fiscal years.

Yes, the Board uses the internet to keep the public informed by constantly updating its website with the latest dental hygiene information about news and Board activities. This includes board meeting dates, new laws and regulations, examination updates, educational program information and the normal licensing and examination updates as well. There's also enforcement information posted on our website to assist the consumer on the process to file a complaint against a licensee. The Board does post its meeting materials as quickly as possible prior to the meeting date. Sometimes, last minute items are added to the materials as addendums to the main meeting materials and the Board gets those posted prior to the meeting as well. The meeting materials remain on the website indefinitely and older materials and minutes can be found in the Archive file at the bottom of the Board meeting calendar. The previous meeting's draft minutes are normally approved at the next meeting finalizing them and are posted soon after the Board votes to approve them. The meeting minutes like the meeting materials remain on the Board's website indefinitely and after several years, are moved into the Archive file at the bottom of the Board's meeting page available to the public.

53. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long do webcast meetings remain available online?

The Board had intent on initiating webcasting of its meetings, but then the pandemic occurred, and the plan was postponed. During the pandemic, the Board was able to conduct its meetings through Webex due to the in-person restrictions in place at the time. The Board will initiate a hybrid system of meetings moving forward with a combination of in-person and Webex online participation. Webcasting will also be included for the in-person Board and Committee meetings.

According to the DCA Office of Public Affairs, webcasted board meetings remain available online indefinitely and are also viewable through online sites such as YouTube.

54. Does the board establish an annual meeting calendar, and post it on the board's web site?

Yes, the Board establishes tentative meeting dates for the next calendar year at its November meeting of each year. Once the dates are approved by the Board, the dates are posted on the Board's website for public access. The Board works to ensure the dates listed on the website are maintained but can be subject to change due to meeting logistics or member availability especially if a quorum cannot be established.

55. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

Yes, the Board uses the DCA's Recommended Minimum Standards for Consumer Complaint Disclosure.

56. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

Through the Board's website, the public may conduct a License Search (icon on website homepage) if they know the name of the licensee to be researched. After conducting the search, the following information may be shown:

Name, License Number, License Type, License Status, Expiration Date, Secondary Status (if any, meaning there may be an issue with the license), City, State, County, and Zip Code. There is also further details and information about the licensee if the user clicks on the More Details button to the right of the record, which lists any Additional Qualifications, Previous

Names the licensee may have been known by, License Issuance Date, Expiration Date, and, if applicable, any Enforcement or Disciplinary Action taken on the license.

57. What methods are used by the board to provide consumer outreach and education?

The Board mainly uses its website as a primary source for consumer outreach and education. The Board is also in frequent communication with professional associations, the dental hygiene educational programs, and distributes email blasts to its subscribers for any Board meetings, events, or announcements and updates. In the future, the Board will explore the use of social media for consumer outreach and education to contact more of them to disseminate information.

Section 7 – Online Practice Issues

58. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate internet business practices or believe there is a need to do so?

Dental hygienists work under the general and/or direct supervision of a licensed dentist unless they are employed by a public health agency. The definition of general supervision is the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of these procedures. Direct supervision means that the dentist is required to be physically present in the treatment facility during the performance of these procedures. There are only three dental procedures where direct supervision is required and they are for Soft Tissue Curettage, Local Anesthesia administration, and Nitrous Oxide Analgesia administration. All other dental hygiene procedures may be completed under the general supervision of a licensed dentist. As such, most of the dental hygienists may perform their general supervision services with authorization from a licensed dentist through online means such as telehealth or teledentistry if the patient is a patient of record of the dentist and a comprehensive treatment plan has been previously established. If dental hygienists provide these dental services without the appropriate level of supervision of a licensed dentist whether in the dental office or online, they place their license in jeopardy.

As for unlicensed activity, the Board is not aware of any online practicing other than through telehealth or teledentistry, so we have not experienced any extensive unlicensed activity in this area. Where we have experienced unlicensed activity is either through complaints submitted by the public or other licensees, information from the licensees themselves of self-reporting that they neglected to renew their license, or it's discovered that a licensee is practicing with an Inactive license status which does not allow them to provide any dental hygiene services. This may be a mistake when the licensee last renewed their license; however, it's ultimately the responsibility of the licensee to ensure their license is current and has the proper status to provide dental hygiene services.

Online dental hygiene practice has not been an issue for the Board or at a minimum, it has not been brought to the attention of the Board except for an occasional complaint about a dental hygienist inappropriately advertising dental hygiene services at a specific location. Registered Dental Hygienists must work under the supervision of a licensed dentist and if a licensee is found to be providing dental hygiene services independently, that would be an issue the Board needs to address since it's against the law.

Section 8 – Workforce Development and Job Creation

59. What actions has the board taken in terms of workforce development?

The Board has been very proactive in seeking ways to implement BPC § 1900 which states:

"It is the intent of the Legislature by enactment of this article to permit the full utilization of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions in order to meet the dental care needs of all of the state's citizens."

The primary reasons that restrict full utilization of all categories of dental hygienists and decreases their ability to provide care for all of the state's citizens are restrictive supervision levels, scope of practice restrictions limiting the services that dental hygienists are allowed to provide, and the inability for dental hygiene practitioners such as the RDHAP to obtain full reimbursement payment for the services rendered.

The current law states which dental hygiene services are completed under the direct supervision of a licensed dentist (the dentist employer must be physically present in the office when the service is performed) and general supervision (the dentist employer need not be present when the services are performed). The current laws allow the dentist employer to determine the level of supervision necessary for the performance of the services that dental assistants are legally allowed to provide. This same provision should be extended to dental hygienists where the supervising dentist should be able to determine the level of supervision required for a dental hygienist working in the dental office rather than the law dictating the required level of supervision.

Although BPC §§ 1912 – 1914 allow for general supervision for most services performed by dental hygienists, some services are still only authorized under direct supervision (soft tissue curettage, local anesthesia administration, and nitrous oxide analgesia) which limits the full utilization of the dental hygienist services. The Board has approved for staff to seek legislation to remove the direct supervision restrictions in the current law and amend it for the supervising dentist to indicate the level of supervision needed for these procedures.

60. Describe any assessment the board has conducted on the impact of licensing delays.

In the past, the Board was understaffed with only a single Licensing Analyst that was reviewing applications for licensure that caused occasional backlogs, especially during the summer months when a high number of applications for licensure are received and processed due to many of the dental hygiene educational programs graduating their students. As of 2020, the Board hired a second Licensing Analyst to address applications for licensure and ever since then, the Board has been well within its allowable timeframe by law to initially contact an applicant on the status of their application. Pursuant to the California Code of Regulations section 1069, the Board has 90 days to initially contact an applicant to notify them that the application is complete or there is some deficiency that needs their attention. Currently, the Board is well under two months in making the initial contact to the applicant regarding their application for licensure. In many instances, the application delays are not due to the Board's Licensing staff but because the applicant has delayed submitting the requirements for licensure that are needed to continue the application process to eventually issue a license. Once all the requirements for licensure are fulfilled, the license is issued immediately through the computer system. If the application workload increases to the point where Board staff can

no longer review applications within the time allotted by law, additional Licensing staff may be obtained to address the increased workload to decrease the application processing time.

61. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

The Board has increased its communications with the dental hygiene educational programs immensely to convey the latest information of any licensure changes or new requirements for their students to obtain a dental hygiene license. Since the Board implemented increased oversight of the educational programs over the past few years, the communication has improved dramatically. Schools contact us with inquiries faster and more frequently many times than we reach out to them because the information we want to convey is already known by the schools and they reach out to us for further information or clarity first. Board staff post the latest updated information on our website and the Executive Officer sends email blasts to all the program directors to inform them of any changes or information pertaining to the licensing process.

62. Describe any barriers to licensure and/or employment the board believes exist.

One of the requirements for licensure as an RDH is satisfactory completion of a clinical practical examination given by either the Western Regional Examining Board (WREB) or Central Regional Dental Testing Services (CRDTS) and temporarily through CDCA due to COVID-19. This method of testing has been proven that it is in no way testing for competence, as most dental hygiene students pass with a high score. The DHEPs provide a competency-based dental hygiene education and when the students graduate, they have already experienced well over a year of direct supervised patient care in the completion of their competencies. To have them test on people who may not have specific dental issues needed for testing or manikin tests that have shown that the graduating students are competent in providing dental hygiene services is an additional costly step that is not necessary. Applicants seeking licensure as dentists have the option of completing a portfolio showcasing one's abilities instead of completing a clinical examination. Applicants seeking licensure as a Registered Dental Assistant (RDA) are only required to complete a written exam and a law and ethics exam. The Board will continue to review alternative pathways to licensure in lieu of requiring a clinical practical examination.

63. Provide any workforce development data collected by the board, such as:

The Board collects workforce information data for the California Department of Healthcare Access and Information (HCAI) [formerly OSHPD (Office of Statewide Health Planning and Development)] in a survey required to be completed at the time of the license renewal. This data is forwarded to HCAI on an annual basis for their use and is not shared with the Board. Unfortunately, many dental hygienists could be considered "nomads" because many of them work in several dental locations and don't have typical fulltime jobs at a single office. There is also a consensus in communications with the educational programs and licensees that they prefer to work in the heavier populated areas of the state rather than seeking work in the more rural and underserved areas, as better employment opportunities and higher wages plays a large role in where these licensees choose to work.

a. Workforce shortages

The Board believes there are workforce shortage areas in certain populations of the state as well as the underserved areas where healthcare is neither affordable nor accessible to the population. Registered Dental Hygienists must work under the general and/or direct supervision of a licensed dentist depending on the services provided unless they work in a public health setting. Unfortunately, dentists prefer to establish their practices in the more

heavily populated areas of the state instead of the rural, underserved areas so there's limited locations for dental hygienists to work. However, the Board has a license category titled the Dental Hygienist in Alternative Practice (RDHAP) that is allowed to work more autonomously in schools, institutions, medical and dental offices, for the homebound in addition to the underserved areas of the state. There's also a new provision that allows them to operate a mobile dental hygiene clinic if they can obtain the resources required to start them. The number of RDHAPs in the state (~700 active licensees) is slowly increasing; however, the reimbursement rate on the dental hygiene services they provide for their patients is underwhelming and needs to increase to have more licensees pursue this license category for increased access to dental hygiene care.

There is also a fairly large population of dental hygienists that are of retirement age and are preparing to leave the workforce. Some will reduce their amount of work time as they transition to a retired lifestyle. Many licensees are also determining that California is too expensive to stay and choose to leave and relocate to another state and obtain a license to practice dental hygiene there. The profession's wages have not increased at the same rate as the cost of living has in California.

b. Successful training programs.

The Board has not implemented any training programs in workforce development for the dental hygiene profession.

Section 9 – Current Issues

64. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

The Board implemented its Uniform Standards for Substance Abusing licensees years ago. However, Board staff discovered that the language needed improvement or items added and is currently under revision. The revision is expected to clarify some of the language and incorporate new language that other board programs use that the Board is interested in incorporating into its own Uniform Standards. Once complete, it will be presented to the Board for approval and implementation. Although the revision will be Board approved in the near-future, staff will continue to analyze its effectiveness and make recommendations for revision and improvement as necessary.

65. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

The Board has not promulgated regulations to implement the CPEI but follows its methodology of addressing and prioritizing older enforcement cases to decrease case aging and triages its cases depending on the egregiousness of the complaint. By incorporating the CPEI model into its review processes and obtaining additional staff, the Board has reduced the average timeline to investigate its oldest cases. The Board focused on:

• Administrative improvements, such as focusing on cases one year or older, employing better methods for complaint intake, and developing enhanced training for enforcement staff;

• Increased enforcement resources that included the hiring of a non-sworn investigator, probation monitor, and citation and fine analysts for more effective workload distribution;

• Pursuit of legislation to help the Board better protect consumers in areas where their enforcement authorities needed expansion and were limited.

By changing the Board's enforcement processes to mimic the CPEI, California consumers will benefit with a decrease in the amount of time to review and investigate enforcement cases.

The Board ensures consumer protection is its highest priority and consumers can have increased confidence that the Board's enforcement staff work efficiently and swiftly to resolve complaints or exercise the authority to suspend or limit the practice of violators who may pose a potential threat. The Board works diligently to monitor and prosecute those licensees who choose to not follow the law.

66. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

The Board fully participated in the development of the BreEZe computer system for many years prior to its implementation. The Board also provided initial staff in 2012 to assist and help configure the computer system. That staff eventually obtained a permanent position at the Department of Consumer Affairs' Office of Information Systems (OIS) and was incorporated into their staff as a vital person to assist with the program. For us, we were part of Release Two that was initiated in 2016 and have used the system since that time.

a. Is the board utilizing BreEZe? What Release was the board included in? What is the status of the board's change requests?

The Board is currently utilizing the BreEZe computer system and was one of the board programs in Release Two of the system in 2016. Over the years, the board has submitted multiple change requests to address issues that arise or to implement new changes. These system requests are continually submitted to OIS on an ongoing basis as needed. The Board is in frequent communication with OIS for any issues that arise or to stay abreast of any new coming changes.

b. If the board is not utilizing BreEZe, what is the board's plan for future IT needs? What discussions has the board had with DCA about IT needs and options? What is the board's understanding of Release 3 boards? Is the board currently using a bridge or workaround system?

The Board is currently utilizing the BreEZe computer system and was one of the board programs in Release Two of the system and continue to use it since 2016.

Section 10 – Board Actions and Responses to COVID-19.

67. In response to COVID-19, has the board implemented teleworking policies for employees and staff?

Yes. The Board implemented a hybrid telework schedule for all staff, so they are in the office to work three days per week and telework the other two days per week. Staff are assigned specific days to be in the office for coverage and availability to the public or stakeholders. The only exception is the Board's receptionist who is required to be in the office every day to oversee the public counter for any visitors, guests, or stakeholders that stop by the office to conduct business.

a. How have those measures affected board operations? If so, how?

The hybrid telework schedule initially was difficult and a challenge for management to become accustomed to for the oversight of staff. However, with the implementation of online communications, check in and out requirements, and having frequent discussions on work issues and project statuses with all Board staff, the telework schedule has become much less of a burden and a welcomed process to continue to complete the

board's work. Management is frequently updated on any continuing issues, projects, or problems that arise so that they can be quickly dealt with and resolved. Board staff have adapted to the telework life well and have noted that it provides an improved work/life balance. Some staff still prefer to go to the office to work, as homelife can be excessively distracting at times. Overall, board operations continue to run smoothly, and staff are working well within the accepted timelines for their respective projects and assigned duties.

68. In response to COVID-19, has the board utilized any existing state of emergency statutes?

The Board has not utilized any existing state of emergency statutes due to COVID-19 but is kept abreast of any states of emergencies by notifications disseminated from the Department of Consumer Affairs.

a. If so, which ones, and why?

N/A.

69. Pursuant to the Governor's Executive Orders N-40-20 and N-75-20, has the board worked on any waiver requests with the Department?

Yes. Specific to the Dental Hygiene Board, we requested to exclude the requirement of a wet laboratory component for potential dental hygiene student's prerequisite biomedical science coursework since the schools and educational programs were closed due to COVID-19. Most if not all the schools converted to online course completion due to the pandemic making it difficult to complete the wet laboratory component for the biomedical science courses at the school or home. Some schools used wet laboratory kits at home under faculty guidance to fulfill the wet laboratory component, but it wasn't required during the pandemic due to the approved wet laboratory waiver.

a. Of the above requests, how many were approved?

One was requested and approved.

b. How many are pending?

None.

c. How many were denied?

None.

d. What was the reason for the outcome of each request?

The reason for the outcome of the request was so that the potential dental hygiene students could continue the completion of the prerequisite biomedical science coursework requirements for entrance into the dental hygiene educational program.

70. In response to COVID-19, has the board taken any other steps or implemented any other policies regarding licensees or consumers?

Yes. As of August 29, 2020, through July 31, 2023, unless extended, the Board is temporarily accepting the clinical exam results from the alternative manikin-based clinical examinations administered by the Commission on Dental Competency Acceptance (CDCA), Western Regional Examination Board (WREB which has since merged with CDCA), and the Central Regional Dental Testing Services (CRDTS) in addition to the live, patient-based clinical examinations administered by WREB and CRDTS due to the COVID-19 pandemic. For a short period at the beginning of the pandemic, the live, patient-based clinical exam administrations ceased or were postponed inhibiting the spread of the virus when administering those examinations. The Board determined that another examination method must be considered for acceptance to fulfill the examination requirement to minimally delay the dental hygiene students from obtaining licensure. As a result of the presentations by exam administrators on possible alternatives to live, patient-based clinical examinations, the Board voted to accept the

exam results from the alternative manikin-based clinical exams at its August 29, 2020, Board meeting to continue the student's progression toward licensure and to inhibit the spread of the virus.

The Board also supported the request from the California Dental Hygienists' Association to have dental hygienists assist with the administration of the COVID-19 vaccine to the public. Dental hygienists were allowed to administer the vaccines under appropriate supervision once they completed specific training on the process to administer vaccines as detailed in the approved waiver.

The Board was also very active as a resource for licensees to obtain the latest COVID-19 information, contacts for specific COVID guidelines and procedures like the local county or state public health agencies and provided information on infection control procedures to use upon the return to dental practices to treat the consumer.

71. Has the board recognized any necessary statutory revisions, updates, or changes to address COVID-19 or any future State of Emergency Declarations?

During the lengthy COVID-19 pandemic, the Board had the opportunity to review its laws in statutory language and any issues that arose were able to be resolved without the need for statutory amendments. The Governor's and DCA Director's approved waivers helped immensely to provide reasonable solutions to many of the issues created by the pandemic. However, no extended revisions were identified to be requested due to the pandemic or in preparation of any future State of Emergency Declarations.

Section 11 – Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the board.

   The Board experienced multiple years of staffing shortages due to a relatively small budget and the previous hiring freeze. Once lifted, the Board submitted several budget change proposals for additional positions that were approved and no longer has a staffing issue. As the Board's workload continues to expand, additional BCPs will be submitted for new staff to address to address it.

   At the last Sunset Review legislative hearing, the Committee inquired whether the Board was continually auditing its licensees for continuing education (CE) requirements for license renewal. At the time, the Board had only conducted a few CE audits intermittently due to the staffing shortage. Once staff was obtained to address the CE audit workload, the Board has continually conducted audits of its licensees for license renewal compliance.

2. Short discussion of recommendations made by the Committees during prior sunset review.

   The Joint Legislative Sunset Review Committee recommended that the Board obtain additional staff to conduct regular CE audits of its licensees for license renewal compliance. It suggested for the Board to ask for the Committee's assistance, if needed.

3. What action the board took in response to the recommendation or findings made under prior sunset review.

   With the Committee's recommendation, the Board was able to obtain new staff once a BCP was approved to conduct CE audits on an ongoing basis to ensure license renewal compliance.

4. Any recommendations the board has for dealing with the issue, if appropriate.

The CE audit issue was resolved with the addition of new staff and assistance from the JLSRC.

Section 12 – New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, legislative changes) for each of the following:

1. Issues raised under prior Sunset Review that have not been addressed.

   The Board is fortunate in that only a single issue identified in the prior Sunset Review remains. This is to amend the Direct Supervision requirements as stated in law from having the supervising dentist physically onsite to complete the SLN (soft tissue curettage, local anesthesia administration, and nitrous oxide and oxygen analgesia) dental services. The Board will request to amend the law (BPC section 1909) to have both soft tissue curettage and local anesthesia administration under the direct or general supervision as determined by the supervising licensed dentist and maintain the nitrous oxide analgesia under the direct supervision of a licensed dentist.

2. New issues identified by the board in this report. **Left Items 2 & 3 Open for New Proposals**

   a) A.

   b) E.

   c) T.

   d) Moderate elevation of the executive officer's exempt level to an equivalent of a manager 3 to obtain higher level subordinate management staff to appropriately structure the Board's program staff for current and future growth, efficient program oversight, institutional memory, and succession planning.

3. New issues not previously discussed in this report.

   a) Amend BPC section 1909 regarding SLN supervision to change the procedures to General Supervision rather than Direct Supervision of a licensed dentist.

   b) Elimination of clinical examination requirement for licensure for graduates of California dental hygiene educational programs.

   c) Authority to issue Restrictive Temporary Licenses (no SLN authority/services) for military spouses to practice dental hygiene in California.

   d) Increase the number of Board mandated continuing education (CE) hours ceiling from 7.5 to 10 so the Board has room to add mandated CE hours to renew the license if necessary. The Board is currently at its maximum mandated CE hours of 7.5 per license renewal cycle, so there's no room to add any additional CE requirements if the need arises.

   e) Propose new statutory language that will allow an RDHAP who has opened a stand-alone practice site in a Dental Health Professional Shortage Area (DHPSA) to maintain their practice if in the future, the DHPSA designation is removed. One reason the RDHAP license category was created was to serve the designated shortage areas of the state

where dental hygiene services are scarce. Licensees are wary of opening a dental hygiene practice with the risk that they could lose the business if the DHPSA designation is lifted by the Federal Government due to the dental hygiene services they are providing to the population. With the ability to maintain their practice should the DHPSA designation be lifted, more RDHAPs would be willing to open new practices in these communities where their dental services are vitally needed the most.

4. New issues raised by the Committees.

   No new issues from the Committees have been noted by the Board.

Section 13– Attachments

Please provide the following attachments:

A. Board's administrative manual.

   The draft of the newly revised Board administrative manual is attached for review.

B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).

   The current organizational chart of the Board's committees with their membership is attached for review.

C. Major studies, if any (cf., Section 1, Question 4).

   The Board conducted an Occupational Analysis (OA) with the assistance of the DCA Office of Professional Examination Services in 2019. The final OA report for RDH and RDHAP license categories is attached for review.

D. Performance Measures for the past three years (cf., Section 2, Question 6).

   The Enforcement Performance Measures for the past three years is attached for review.

E. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 3, Question 15).

   Year-end organizational charts for the last four fiscal years is attached for review.

F. Dental Hygiene association's support letter to continue the Board.

   A support letter from the California Dental Hygienists' Association (CDHA) for the Board's Sunset Review is attached.

G. Dental Hygiene association's survey conducted with RDHAP licensees who would open a stand-alone dental hygiene practice in underserved designated areas of the state.

   Copy of CDHA's survey of RDHAP licensees inquiring whether they would open a stand-alone dental hygiene practice if the restrictions on DHPSA designation was lifted from underserved areas of the state is attached for review.

Requested Sunset Amendments to the Business and Professions Code

Section 1917

The dental hygiene board shall grant initial licensure as a registered dental hygienist (RDH) to a person who satisfies all of the following requirements:

~~(a) Completion of an educational program for registered dental hygienists, approved by the dental hygiene board, accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution.~~

~~(b) Within the preceding three years, satisfactory completion of the dental hygiene examination given by the Western Regional Examining Board or any other clinical or dental hygiene examination approved by the dental hygiene board.~~

(a) Completion of either of the following:

(1) Satisfactory completion of a California educational program for RDHs, approved by the dental hygiene board, accredited by the Commission on Dental Accreditation, and conducted by a degree-granting, postsecondary institution. If an applicant fails to apply for licensure within three years of completion of a dental hygiene board-approved California educational program for RDHs, the applicant shall be required to satisfactorily complete a dental hygiene licensure examination approved by the dental hygiene board; or

(2) Satisfactory completion of a non-California educational program for RDHs, accredited by the Commission on Dental Accreditation, recognized by the dental hygiene board, and conducted by a degree-granting, postsecondary institution within the United States or Canada, and within three years of the application date satisfactory completion of a dental hygiene licensure examination approved by the dental hygiene board.

~~(c)~~(b) Satisfactory completion of the National Board Dental Hygiene Examination.

~~(d)~~(c) Satisfactory completion of the examination in California law and ethics as prescribed by the dental hygiene board.

~~(e)~~(d) Submission of a completed application form and all fees required by the dental hygiene board.

~~(f)~~(e) Satisfactory completion of dental hygiene board-approved instruction in gingival soft-tissue curettage, nitrous oxide-oxygen analgesia, and local anesthesia.

Section 1926.06

(a) Notwithstanding any other provision of law except the provisions of 1926.4, a registered dental hygienist in alternative practice may operate a physical dental hygiene facility in a dental health professional shortage area as certified by the Department of Health Care Access and Information, in accordance with existing office guidelines.

(b) Once a registered dental hygienist in alternative practice establishes an independent practice in a dental health professional shortage area as certified by the Department of Health Care Access and Information, the registered dental hygienist in alternative practice shall be authorized to continue to personally operate the practice notwithstanding any subsequent removal of the dental health professional shortage area designation by the Department of Health Care Access and Information.

Section 1962

(a) An association, partnership, corporation, or group of three or more registered dental hygienists in alternative practice engaging in practice under a name that would otherwise be in violation of Section 1960 may practice under that name if the association, partnership, corporation, or group holds an unexpired, unsuspended, and unrevoked permit issued by the dental hygiene board under this section.

(b) An individual registered dental hygienist in alternative practice or a pair of registered dental hygienists in alternative practice who practice dental hygiene under a name that would otherwise violate Section 1960 may practice under that name if the licensees hold a valid permit issued by the dental hygiene board under this section. The dental hygiene board shall issue a written permit authorizing the holder to use a name specified in the permit in connection with the holder's practice if the dental hygiene board finds all of the following:

(1) The applicant or applicants are duly licensed registered dental hygienists in alternative practice.

(2) The place where the applicant or applicants practice is owned or leased by the applicant or applicants, and the practice conducted at the place is wholly owned and entirely controlled by the applicant or applicants and is an approved area or practice setting pursuant to Section 1926.

(3) The name under which the applicant or applicants propose to operate contains at least one of the following designations: "dental hygiene group," "dental hygiene practice," ~~or~~ "dental hygiene office," or "mobile dental hygiene clinic," contains the family name of one or more of the past, present, or prospective associates, partners, shareholders, or members of the group, and is in conformity with Section 651 and not in violation of subdivisions (i) and (l) of Section 1950.5.

(4) All licensed persons practicing at the location designated in the application hold valid licenses and no charges of unprofessional conduct are pending against any person practicing at that location.

(c) A permit issued under this section shall expire and become invalid unless renewed in the manner provided for in this article for the renewal of permits issued under this article.

(d) A permit issued under this section may be revoked or suspended if the dental hygiene board finds that any requirement for original issuance of a permit is no longer being fulfilled by the permitholder. Proceedings for revocation or suspension shall be governed by the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) If charges of unprofessional conduct are filed against the holder of a permit issued under this section, or a member of an association, partnership, group, or corporation to whom a permit has been issued under this section, proceedings shall not be commenced for revocation or suspension of the permit until a final determination of the charges of unprofessional conduct, unless the charges have resulted in revocation or suspension of a license.

DHBC
Dental Hygiene
Board of California

Saturday, October 8, 2022

Dental Hygiene Board of California

Agenda Item 9

Future Agenda Items.

Saturday, October 8, 2022

Dental Hygiene Board of California

Agenda Item 10

Closed Session – Full Board

The Board may meet in Closed Session to deliberate on disciplinary matters pursuant to Government Code section 11126, subdivision (c)(3). If there is no closed session at this meeting, it will be announced.

Saturday, October 8, 2022

Dental Hygiene Board of California

Agenda Item 11

Adjournment.

DHBC
Dental Hygiene
Board of California

Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachments

1) Board's Administrative Manual.
2) Current organizational chart showing relationship of committees to the board and membership of each committee.
3) Major Studies: RDH & RDHAP 2019 Occupational Analysis.
4) Performance Measures from the Past Three Years.
5) Year-end Organizational Charts for Past Four Years.
6) California Dental Hygienists' Association (CDHA) Letter of Support for the Board's Sunset Review.
7) CDHA's RDHAP Survey Results for RDHAPs to Open Dental Hygiene Clinics in Dental Health Professional Shortage Areas (DHPSA).

Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachment A

Board's Administrative Manual

DHBC
Dental Hygiene
Board of California

Member Guidelines & Procedure Manual

September 2022

CONTENTS

Chapter 1
INTRODUCTION

The Dental Hygiene Board of California (DHBC) is the only self-regulating dental hygiene agency of its kind in the United States. The California Legislature established the Dental Hygiene Committee of California in 2008 as an independent committee within the Department of Consumer Affairs (DCA). In 2018 through Senate Bill 1482 (Ch. 858, Statutes of 2018), the Legislature approved for the Committee to become a full autonomous Board (DHBC) under the purview of DCA. In California, the DHBC holds authority to regulate the dental hygiene profession under the guidance of statutes contained in the Business and Professions Code (BPC), Sections 1900 - 1967.4 and sections of the California Code of Regulations (CCR). The following is a summary of the DHBC's responsibilities:

- Pursue legislation;
- Author and enforce regulations;
- Grant, renew, and withdraw approval of dental hygiene educational programs;
- Conduct feasibility studies for new dental hygiene educational programs;
- Develop and maintain the dental hygiene Law and Ethics Examination in conjunction with the Office of Professional Examination Services;
- Issue, suspend, and revoke dental hygiene licenses and permits;
- Oversee licenses placed on probation;
- Conduct investigation of and administer enforcement for licensing violations; and
- Participate in outreach and support of the dental and dental hygiene community.

DHBC members are appointed by the Governor and the Legislature. The Governor appoints seven board members, and the State Assembly Speaker appoints one public member while the Senate Rules Committee appoints a second public member. A standard term of appointment is four years in duration. The Governor and Legislature shall have the power to remove any member from the DHBC for neglect of duty required by law, for incompetence, or for unprofessional or dishonorable conduct. In the event that a member resigns, the resigning member shall send a letter to the Governor notifying the Governor of the member's resignation

and effective last date of service. A copy of the letter of resignation shall be sent to the Director of DCA, the DHBC President, and the DHBC Executive Officer (EO).

This procedure manual is provided to guide members in the discharge of their duties and to ensure DHBC effectiveness and efficiency.

Chapter 2
COMPOSITION

Members - The DHBC shall consist of nine members. There shall be four public members, four registered dental hygienist (RDH) members, and one dentist member. Each licensed member shall possess, at the time of appointment and throughout the member's term on the DHBC, a valid California license in good standing to practice in the member's respective field of dentistry or dental hygiene.

- Public members - No public member shall have been licensed under this chapter within five years of the public member's date of appointment, nor shall the public member possess or acquire any financial interest in a business related to the practice of dentistry or dental hygiene during the public member's term on the DHBC.
- RDH members - Of the RDH members, one shall be licensed either in alternative practice or in extended functions; one shall be a dental hygiene educator; and two shall be RDHs.
- Dentist member - The dentist member shall be licensed either as a general dentist or a public health dentist.

Mid - term vacancies shall be filled by Governor or Legislative appointment depending upon which board member creates the vacancy, and the newly appointed member shall serve the remainder of his or her predecessor's unexpired term.

Member Officers - The DHBC shall elect a President, a Vice President, and a Secretary from its membership. The election shall be held at the final meeting of the calendar year. The newly elected member officers shall assume their respective offices on January 1st of the following year. Each term of service for a member officer position is one year. No person shall serve as

a member officer for more than two consecutive years unless extenuating circumstances prevail, requiring the majority of the members vote in favor of an extension. If an office becomes vacant during the year, an election shall be held at the next meeting.

President - The President is the spokesperson for the DHBC. The President represents the DHBC by attending hearings and other meetings with legislators, DCA, and stakeholders. The President attends Dental Board of California meetings as necessary. The President may testify, sign letters, and address the media on behalf of the DHBC. The President shall copy the EO on all written communications made on behalf of the DHBC and the EO shall forward the communication to all members.

The President is the chief official responsible for DHBC business. The President chairs and facilitates DHBC meetings, approves DHBC meeting agendas, signs specified full Board enforcement orders, establishes committees, appoints the Chairperson and members of each committee, and when necessary, assigns members at large to serve in the absence of committee members. The President may establish task forces to research policy questions or other issues as needed.

The President is the immediate supervisor of the EO. Specific instructions for work on policy matters by the EO from DHBC members shall be coordinated through the President. The President shall meet and communicates with the EO on a regular basis. The President holds approval authority for the EO's timesheets, travel expense claims, and leave requests. The President performs the following duties to lead the EO evaluation process:

- The President shall obtain an Executive Officer Performance Evaluation Guide from DCA Office of Human Resources (DCA OHR).
- The President shall distribute the Executive Officer Performance Evaluation Guide to DHBC members.
- The President shall collect each member's input and creates a draft EO Performance Appraisal and Salary Administration.
- The President shall present a draft EO Performance Appraisal and Salary Administration to the DHBC annually.

- The President shall ensure that discussion of EO Performance Appraisal and Salary Administration is noticed on the DHBC meeting agenda for which it will be deliberated. Deliberation on EO Performance Appraisal and Salary Administration shall be conducted annually. Deliberation on the EO Performance Appraisal and Salary Administration shall be conducted in closed session unless the EO requests to the President in writing that the matter be discussed in open session.
- Before the close of deliberations, the President shall ensure that the DHBC approves an EO Performance Appraisal and Salary Administration Report.
- The President shall provide the EO with a written EO Performance Appraisal and Salary Administration Report annually.
- The President shall initiate the Exempt Position Request (EPR) process through the DCA OHR should the board determine that a salary adjustment or elevation in exempt position level of the EO is warranted.

Vice President - The Vice President assists the President at the President's request and may assume the duties above in the President's absence.

Secretary - The Secretary calls the roll at each DHBC meeting and reports whether a quorum is established. The Secretary also calls the roll vote for each agendized action item voted upon and records the official vote results for the record.

Executive Officer - The EO is the chief administrative officer responsible for implementing the policies and directives of the DHBC.

- Recruitment and Selection - The DHBC shall institute an open recruitment plan to maintain a pool of qualified candidates. The DHBC shall also work with the DCA OHR for recruitment procedures. The selection of an EO shall be included as an item of business which must be noticed in a written agenda and transacted at a public meeting.
- Appointment - The appointed EO is exempt from civil service and serves at the pleasure of the DHBC. Appointment of the EO is subject to approval by the Director of the DCA.
- Supervision – The President is the direct supervisor of the EO. The EO, with the assistance of an Assistant EO, manages and supervises the staff.

- Vacancy – In the event the EO's position becomes vacant, the DHBC shall appoint the Assistant EO to serve as Interim EO until a permanent appointment can be made. The Interim EO's salary shall be set at an amount within the EO's salary range and the salary shall be applied to the first day of service as an Interim EO. The DHBC shall hold a special meeting within 30 days of the EO's vacancy to appoint an Interim EO, confirm the salary amount, and to initiate the selection process for a new EO.

Staff - Employees of the DHBC, with the exception of the EO, are civil service employees. Their conditions of employment (including pay, benefits, discipline, and evaluations) are governed by a myriad of civil service laws and regulations as well as collective bargaining labor agreements. Because of this complexity, it is appropriate that the DHBC delegate all authority and responsibility for managing the DHBC staff to the EO and AEO.

Chapter 3
TRAINING & CERTIFICATION REQUIREMENTS

DHBC members are required to complete the following training. Upon completion of each course, members shall send a copy of their Certificate of Completion to the EO or maintain the record in the online Learning Management System (LMS). The EO shall retain a copy of each certificate in the member's personnel file and shall forward additional copies to the appropriate oversight agencies as required.

- Board Member Orientation
- California Ethics Training for State Officials
- Conflict of Interest Certification
- Defensive Driver Training
- Sexual Harassment Prevention

Board Member Orientation Training - Every newly appointed and/or reappointed member is required to complete a New Board Member Orientation training program presented by the DCA within one year of assuming office. The training covers functions, responsibilities, and

obligations entailed in service as a DHBC member. For more information and assistance with scheduling, please contact:

SOLID Training Solutions
1747 Market Blvd., Ste. 270
Sacramento, CA 95834
(916) 574-8316
SOLID@dca.ca.gov

California Ethics Training for State Officials - Every newly appointed and/or reappointed member is required to complete the California Ethics Training for State Officials course within six months of appointment and every two years thereafter. The Attorney General's Website, http://oag.ca.gov/ethics, contains both an interactive version of the training as well as an accessible text-only version.

Conflict of Interest Certification - Every newly appointed and/or reappointed member is required to certify, within 10 days of appointment, and each year thereafter, specific documents to the general effect that he or she will perform all duties of a DHBC member in an impartial manner, free from bias caused by personal financial interests or the interest of persons who have supported the member. These documents, along with further explanation of conflict-of-interest restrictions and requirements, are available through the Board Member Resource Center on the DCA Website or through the Fair Political Practices Commission (FPPC) at:

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

https://www.fppc.ca.gov/

Defensive Driver Training - Each member who will drive a vehicle in the course of any official function as a DHBC member, including commuting to DHBC meetings, shall complete, within 10 days of appointment, and every four years thereafter, the Department of General Service's (DGS) Defensive Driver Training. This training can be accessed through the DGS Website at:

www.dgs.ca.gov/orim/Programs/DDTOnlineTraining.aspx.

Sexual Harassment Prevention - Every newly appointed and/or reappointed member is required to complete Sexual Harassment Prevention training within six months of appointment and every two years thereafter. DCA's Equal Opportunity Employment Office can provide instructions on how to obtain this training.

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

http://www.dcaboardmembers.ca.gov/training/harassment_prevention.shtml

Chapter 4
BAGLEY-KEENE OPEN MEETING ACT

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

All members are encouraged to read the entire Bagley-Keene Open Meeting Act guide prepared by DCA Legal Affairs and accessible through the DCA Internet Web Site at:

http://www.dca.ca.gov/publications/bagleykeene_meetingact.pdf.

Key points include the following:

- The DHBC shall post notice to the public on the Internet at least 10 calendar days before regular meetings are held. Alternate format notices shall be made available, upon request, for persons with disabilities.
- The notice shall include the agenda.
- During the meeting, the only items that shall be discussed are the items on the noticed agenda, with the exception that the public may raise issues during the Public Comment portion of the meeting.

- Issues raised during the meeting but not agenized may, at the discretion of the President, be placed on a future meeting's agenda for discussion.
- For all action items at DHBC meetings, as well as subcommittee meetings of three or more members, the law now requires the DHBC to conduct a roll call vote for each action item voted upon for the record including the abstention of each member present for that action item. The DHBC shall include this information in its meeting minutes.
- Provision is made to allow special meetings for certain circumstances in which adherence to the 10-day notice requirement would impose a substantial hardship on the state body or where immediate action is required to protect public interest.
- Members shall not contact other members in order to discuss, deliberate, or take action outside the meeting on a matter within the subject matter of the DHBC.
- Members are strongly discouraged from using cell phones during any meeting as this may give the impression of unlawful member-to-member communication.
- Members may seek further clarification and instruction from the EO.
- With the advancement of technology, many meetings are now conducted through online teleconference or video methods. Unless there are new laws that change the parameters of the Open Meetings Act, the same key points must be followed for meetings consisting of two or more board or committee members.

Chapter 5
OPERATIONS

General Rules of Conduct -

- Members shall recognize the valuable contributions of all DHBC members.
- Members shall commit appropriate time and effort to DHBC responsibilities including reviewing meeting notes, administrative cases, and other materials provided by staff.
- Members shall adhere to the principles of fairness and impartiality in the discharge of their duty to protect the public, without bias, through the enforcement of DHBC laws and the creation of regulations to govern the practice of dental hygiene.
- Members shall conduct their business in an open manner so that the public may be both informed and involved in accordance with the Bagley-Keene Open Meeting Act.

- Members shall neither privately nor publicly lobby for, nor shall they publicly endorse, or otherwise engage in any personal efforts that would tend to promote their own personal or political views or goals when those views or goals are in opposition to a position adopted by the DHBC.
- Members shall never participate in making a governmental decision, or in any way attempt to use their official position to influence a governmental decision, in which there is a financial interest to the member or the potential of such. Any DHBC member who feels they are entering into a situation where there is a potential for a conflict of interest shall immediately consult the EO or DHBC's legal counsel.
- Members shall never accept gifts from applicants, licensees, or members of the profession while serving on the DHBC.
- Members shall not disclose or otherwise make known the contents or nature of sensitive, private, or confidential documents or information related to DHBC business.
- Members shall not speak or act on behalf of the DHBC without first notifying the EO and obtaining permission from the President.

Full Committee Meetings - The DHBC shall meet at least two times each calendar year with an option for a third meeting, if necessary, to conduct DHBC business. The DHBC shall make a reasonable effort to vary the location of meetings, as economically feasible, to best serve the public and licensees.

Member attendance and active participation is critical to the success of DHBC meetings; therefore, if at any time a member cannot attend a meeting, it is imperative that the member notify the EO as soon as possible so that the EO can verify that a sufficient number of members will be present at the meeting to establish a quorum. To vote on an item of business, a quorum must be present. The presence of five members is necessary to establish a quorum. When a quorum is not present, but members are in attendance at a noticed meeting, members may discuss items of business but they may not take any action.

The President may ascertain from any member whose level of attendance and active participation at noticed meetings and whose timely submittal of mail votes is below standard whether or not the member is able or willing to continue to serve.

Agendas - Any member may submit items to the EO for consideration for future meeting agendas. The President and EO shall review all proposed agenda items received at least 30 days prior to the noticed meeting and the President shall determine which items shall be placed on that meeting's agenda. The EO shall provide the agenda to all members at least 10 days prior to the meeting and the EO shall provide the meeting packet to all members by email no later than seven days prior to the meeting.

Agendas shall focus on the specific tasks assigned by the DHBC and shall include:

- Time for public comment.
- Time for members to recommend new issues to be brought to the DHBC's attention.
- Time for a lunch break if the meeting is a full day.
- Committee agendas shall only contain items dealing with subjects assigned to the respective committee.
- Teleconference agendas shall include the meeting identification and passcode for the public to access the meeting.

Committees - Committees are advisory groups formed to research and deliberate on specific categories of concern, then recommend actions to the full Board for approval. The President shall appoint members to fill positions on each standing committee. A member may serve on multiple committees. Members who attend a committee meeting when not appointed to that committee may sit in the audience but shall not participate in the meeting discussion or voting. There are four standing committees:

- Licensing and Examination Committee
- Enforcement Committee
- Legislative and Regulatory Committee
- Education Committee

Licensing and Examination Committee - The purpose of the Licensing and Examination Committee is to advise the DHBC on policy matters relating to examination and licensure.

Enforcement Committee - The purpose of the Enforcement Committee is to advise the DHBC on policy matters related to protecting the health and safety of consumers. This includes evaluation of disciplinary statutes and maintenance of regulations and guidelines pertaining to enforcement.

Legislative and Regulatory Committee - The purpose of the Legislative and Regulatory Committee is to review and track legislation that affects the DHBC and to recommend positions on legislation. The committee also provides information and recommendations on regulatory additions or changes.

Education Committee - The purpose of the Education Committee is to advise the DHBC on granting, renewing, or withdrawing approval of educational programs and curriculum content. The committee also provides information and recommendations on feasibility studies for new educational programs.

Ad Hoc Committees - The President may establish ad hoc committees as needed. Any member may request that an ad hoc committee be established. The ad hoc committee is charged with an in-depth review of a specific issue and a recommendation to the DHBC.

Staff Assistance – The DHBC staff are available to provide support and consultation to the DHBC members and committees; however, members must funnel all communications and requests for staff assistance through the EO.

Recordkeeping - All public meetings are recorded using either audio and/or video recording equipment. Recordings shall be maintained until either 30 days from the meeting or until after the minutes are approved or accepted, whichever is later. Teleconferences may also be recorded for the minutes and record.

Minutes - Meeting minutes are a summary, not a transcript, of the proceedings. Only a quorum may approve meeting minutes and when less than a quorum is present, they may accept the minutes. A vote shall be taken regarding whether or not to accept/approve the minutes at the next meeting following the meeting for which the minutes pertain. Approved or accepted minutes for the open session portions of DHBC meetings shall be made available for

distribution to the public and placed on the DHBC's Internet Web Site within 30 working days of approval/acceptance.

Voting - All votes shall be captured in a roll call format pursuant to the Bagley-Keene Open Meeting Act and reflected as such in the minutes.

Chapter 6
DISCIPLINARY MATTERS INVOLVING LICENSEES

When a disciplinary matter involving a licensee arises, the Enforcement Analyst shall prepare a comprehensive report on the issue and provide it to all DHBC members. At the close of the report, the Enforcement Analyst shall propose various positions or stipulations for members to consider regarding the matter and shall provide each member a mail ballot and copy of the voting policy.

Voting on Disciplinary Matters - Each member may vote by mail ballot in favor of one of the proposed disciplinary positions or stipulations, or the member may vote to hold for discussion by writing on his or her ballot "hold for discussion" as well as the reason for the request to hold for discussion. If two or more members vote to hold for discussion, the matter is set aside until it can be discussed during a closed session at the next meeting. Members shall cast new votes after the discussion.

The DHBC shall approve, by a majority vote, any proposed decision or stipulation before the formal discipline becomes final and the penalty can take effect.

For stipulations, a background memorandum from the assigned deputy attorney general accompanies the mail ballot. A two-week deadline is generally given for return of the mail ballot to the DHBC's office.

If the matter is held for discussion, legal counsel will preside over the closed session to assure compliance with the Administrative Procedure Act and Open Meeting Act.

Security Regarding Disciplinary Matters - Members shall not directly participate in complaint handling or investigations. The following guidelines apply but members should contact the EO or DHBC legal counsel for answers to specific questions.

- No member shall access a licensee's or candidate's file.
- Members shall not intervene on behalf of a licensee, candidate for licensure, or respondent for any reason.
- If a member is contacted by a licensee, candidate for licensure, respondent, or by a respondent's attorney, the member shall refer the person making contact to the EO and shall immediately notify the EO of the contact event.

Chapter 7
SALARY PER DIEM

Members fill non-salaried positions but are paid $100 per day for each meeting, training, or other day actually spent in the discharge of official DHBC duties. Members are reimbursed travel and other expenses necessarily incurred in the performance of official duties. They are paid from the DHBC's funds (BPC Section 103). Salary per diem and travel reimbursement shall be rendered in accordance with the following guidelines:

- The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a DHBC or committee meeting until that meeting is adjourned. Travel time is not included in this component.
- No salary per diem or reimbursement for travel-related expenses shall be paid to members except for attendance at official meetings unless a substantial official service is performed by the member. In the event of attendance at gatherings, events, hearings, conferences, or meetings other than official DHBC or committee meetings in which a substantial official service is performed, the member shall notify the EO and gain approval from the DHBC President prior to the member's attendance.
- For DHBC-specified work, members may be compensated for actual time spent performing work authorized by the President. This may include, but is not limited to,

authorized attendance at other gatherings, events, meetings, trainings, hearings, or conferences.

- Reimbursable work does not include miscellaneous reading and information gathering for business not related to any meeting, preparation time for a presentation, or participation at meetings not related to official duties.

Chapter 8
TRAVEL REIMBURSEMENT

Members shall obtain the President's approval prior to embarking on any travel in support of the DHBC except for DHBC meetings and mandatory training.

Rules governing members' reimbursement of authorized travel expenses are consistent with rules that apply to management-level state staff. Members shall coordinate with the EO as soon as possible upon return from travel to file travel expense claims.

Chapter 9
ADDITIONAL RESOURCES

Sample Mail Ballot ***Model with Separate Hold Provisions***

To: All DHBC Members

From: Enforcement Analyst

Date:

RE: Mail Ballot for [First] [Last], License No. _____ Case No. _____

THIS MAIL BALLOT MUST BE RETURNED TO THE DHBC NO LATER THAN _____
(If the ballot does not reach the DHBC by this date your vote may not be counted and the DHBC may lose jurisdiction to act).

Please review the attached documents and vote on the above case. Upon completion of this mail ballot, please return it to me in the enclosed envelope or fax it to me at (916) 263-2688 by the date noted above.

The decision presented is a:

___ Proposed Decision. The DHBC will lose jurisdiction to act on _____ [Government Code Section 11517(d)].

___ Stipulated Decision

___ Default Decision

___ Probationary License

Please choose one option:

___ I vote to adopt (Choose this option if you accept the decision as written).

___ I vote to reject (Choose this option if you have questions or concerns).

___ I vote to recuse myself (Choose this option if you believe you have a conflict).

___ I vote to hold for discussion (Choose this option if you would like to discuss at the next DHBC meeting)

_____ _____

DHBC Member Signature **Date**

If you have procedural questions about the decision, please contact me at (916) 576-5005.

EXPLANATION OF ENFORCEMENT TERMS

Accusation - Charges filed against a licensee alleging violations of the laws and regulations relating to the practice of dental hygiene.

Default Decision - Licensee fails to respond to the Accusation by filing a Notice of Defense or fails to appear at the administrative hearing.

Denied - The application for licensure as a dental hygienist is denied.

Decision - The order of the DHBC in a disciplinary action.

Interim Suspension Order (ISO) - An order issued upon petition by the DHBC, suspending a licensee from all or a part of his or her practice in dental hygiene.

Petition to Revoke Probation - Charges filed against a probationer seeking revocation of their license based upon violation(s) of probation.

Probation - Terms and conditions placed on a licensee for a specific period of time as a result of disciplinary action.

Probationary License - A conditional license issued to an applicant with terms and conditions for a specific period of time.

Public Reprimand - Licensee was reprimanded for a minor violation(s).

Revoked - Licensee's right to practice is ended and the license is taken back.

Revoked, Stayed, Probation - "Stayed" means the revocation is postponed. Professional practice may continue so long as the licensee complies with the specific terms and conditions ordered. Violation of probation may result in the revocation that was postponed.

Statement of Issues - Charges filed against an applicant to deny licensure.

Stipulated Decision - A Settlement agreed to in lieu of a formal hearing to resolve the accusation and impose discipline.

Surrender - Licensee stipulates to surrender the license. The right to practice is ended.

Suspension - Licensee is prohibited from practicing for a specific period of time.

EXPLANATION OF MAIL BALLOT TERMS

Adopt - A vote to adopt the proposed action means that you accept the action as presented.

Default Decision - If an accusation mailed to the last known address is returned by the post office as unclaimed, or if a respondent fails to file a Notice of Defense or fails to appear at the hearing, the respondent is considered in default. The penalty in a case resolved by default is generally revocation of the license. A default decision can be set aside and the case set for hearing if 1) the respondent petitions for reconsideration before the effective date of the decision; and 2) the DHBC grants the petition.

Hold for Discussion - In addition to voting, you should mark this box if you have a question or concern about the decision and would like to discuss the matter with fellow members during a closed session. If you vote to reject, you may also wish to hold the case. TWO votes must be received to hold a case. If the case is a **stipulated decision**, the DHBC staff can explain why they entered into the agreement. If the case is either type, you may contact the DHBC's assigned legal counsel to discuss the merits of the case.

Proposed Decision - Following a hearing, the administrative law judge shall draft a proposed decision recommending an outcome based on the facts and the DHBC's disciplinary guidelines. At its discretion, the DHBC may impose a lesser penalty than that in the proposed decision. If the DHBC desires to increase a proposed penalty, however, it must vote to reject or non-adopt the proposed decision, read the transcript of the hearing, and review all exhibits prior to acting on the case.

Recusal - Mark this box if you believe you cannot participate in making the decision because you have a specific conflict. Common examples are if the person is a member of your family, a close personal friend, or business partner. If you are unsure if you should recuse yourself, you should contact the EO or the assigned DHBC legal counsel.

Reject - A vote to reject (non-adopt) the proposed action means that you disagree with one or more portions of the proposed action and do not want it adopted as the DHBC's decision. This

vote should be used if you believe an additional term or condition of probation should be added (or deleted), or would otherwise modify the proposed penalty.

Stipulated Decision - At any time during the disciplinary process, the parties to the matter (the EO and the respondent) can agree to a disposition of the case. With the EO's consent, the Deputy Attorney General can negotiate a stipulated decision (also referred to as a stipulated agreement) based on the DHBC's disciplinary guidelines. The DHBC may adopt the stipulated decision as proposed, may counter-offer and recommend other provisions, or may reject the agreement. If respondent declines to accept a proposed counteroffer, the case continues in the standard disciplinary process.

Summary of Outcomes - If a proposed decision is rejected, the transcript will be ordered and the case scheduled for argument according to DHBC policy. After reviewing the record, the DHBC will be able to adopt the decision as previously written or modify the decision as it deems appropriate, except that a cost recovery order may not be increased. If a stipulated decision is rejected, the case will be set for hearing unless a counteroffer is made during a closed session. If a default decision is rejected, the case will be set for hearing.

ACRONYMS

Agencies

AGO	Attorney General's Office
DBC	Dental Board of California
DCA	Department of Consumer Affairs
DHBC	Dental Hygiene Board of California
DHCC	Dental Hygiene Committee of California
OAH	Office of Administrative Hearings
OAL	Office of Administrative Law
OPES	Office of Professional Examination Services
PSI	Psychological Services Incorporated

Organizations

ADHA	American Dental Hygienists Association
CDHA	California Dental Hygienists Association
CDA	California Dental Association
CDHEA	California Dental Hygiene Educators Association
CAPS	California Assoc. of Private Post-Secondary Schools
CCC	California Community Colleges
CODA	Commission on Dental Accreditation
CRDTS	Central Regional Dental Testing Services, Inc.
WREB	Western Regional Examination Board

Codes

BPC	Business and Professions Code
CAC	California Administrative Code
CCR	California Code of Regulations
CGCGOV	California Government Code

Titles

AG	Attorney General
ALJ	Administrative Law Judge
DA	District Attorney
DAG	Deputy Attorney General
EO	Executive Officer

Licenses

FNP	Fictitious Name Permit
LBC	Licensure by Credential
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienist in Alternative Practice
RDHEF	Registered Dental Hygienist in Extended Functions
SLN	Soft Tissue Curettage, Local Anesthetic, and Nitrous Oxide and Oxygen Administration

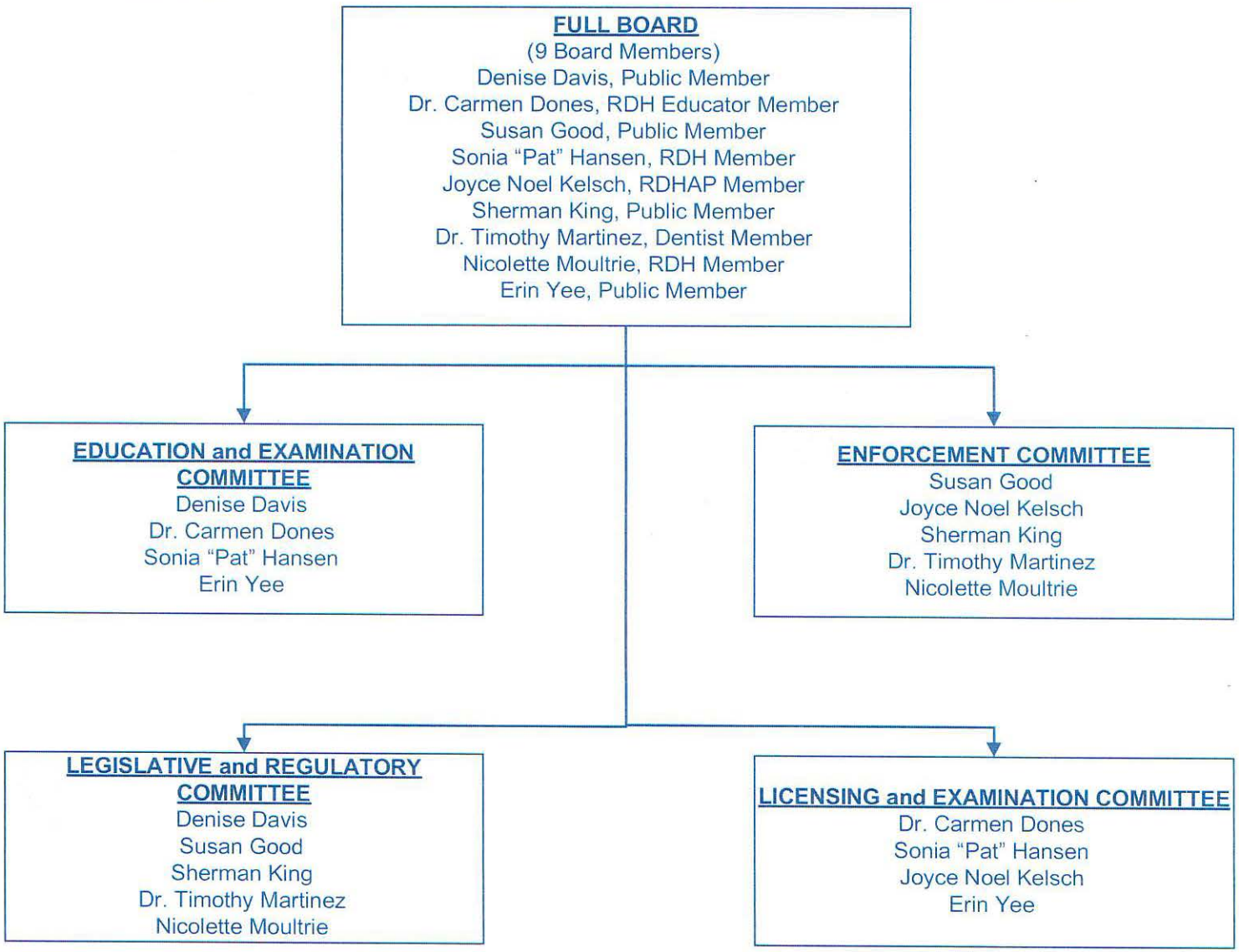
INDEX

Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachment B

Current Organizational Chart of the Board's Committees and Their Membership

DHBC ORG CHART of the BOARD'S COMMITTEE'S and MEMBERSHIP



Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachment C

Major Studies: 2019 RDH and RDHAP Occupational Analysis

DHBC
Dental Hygiene
Board of California

OCCUPATIONAL ANALYSIS OF THE REGISTERED DENTAL HYGIENIST PROFESSION

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

DENTAL HYGIENE BOARD OF CALIFORNIA

OCCUPATIONAL ANALYSIS OF THE REGISTERED DENTAL HYGIENIST PROFESSION

August 2019

Heidi Lincer, Ph.D., Chief

Shana Larrucea, Research Program Specialist

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

EXECUTIVE SUMMARY

The Dental Hygiene Board of California (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct an occupational analysis (OA) of dental hygiene practice in California. The purpose of the OA is to define practice for dental hygienists in terms of the actual tasks that newly licensed dental hygienists must be able to perform safely and competently at the time of licensure. The results of this OA provide a description of practice for the dental hygiene profession that can then be used to review the National Board Dental Hygiene Examination (NBDHE) developed by the Joint Commission on National Dental Examinations (JCNDE); the Western Regional Examination Board (WREB) Clinical Examinations; and the National Dental Hygiene Clinical Examination (NDHCE) developed by Central Regional Dental Testing Services (CRDTS). It can also be used to develop the California Registered Dental Hygienist Laws and Ethics Examination.

OPES test specialists began by researching the profession and conducting semi-structured telephone interviews with licensed Registered Dental Hygienists (RDHs) working in locations throughout California. The purpose of these interviews was to identify the tasks performed by RDHs and to specify the knowledge required to perform those tasks in a safe and competent manner. Using the information gathered from the research and the interviews, OPES test specialists developed a preliminary list of tasks performed in dental hygiene practice along with statements representing the knowledge needed to perform those tasks.

In April 2019, OPES convened a workshop to review and refine the preliminary lists of task and knowledge statements derived from the telephone interviews. The workshop was comprised of licensed RDHs, known as subject matter experts (SMEs), with diverse backgrounds in the profession (i.e., location of practice, years licensed, specialty). These SMEs also identified changes and trends in dental hygiene practice, determined demographic questions for the OA questionnaire, and performed a preliminary linkage of the task and knowledge statements to ensure that all tasks had a related knowledge statement and that all knowledge statements had a related task. Additional task and knowledge statements were created as required to determine the scope of the content areas of the description of practice.

After completing the April 2019 workshop, OPES test specialists developed a three-part OA questionnaire to be completed by RDHs statewide. Development of the OA questionnaire included a pilot study that was conducted using a group of licensed RDHs. The pilot study participants' feedback was incorporated into the final questionnaire.

In the first part of the OA questionnaire, licensed RDHs were asked to provide demographic information relating to their work settings and practice. In the second part, RDHs were asked to rate specific tasks in terms of frequency (i.e., how often the RDH performs the task in the RDH's current practice) and importance (i.e., how important the task is to effective performance of the RDH's current practice). In the third part, RDHs were asked to rate specific knowledge statements in terms of how important each knowledge statement is to performance of the tasks in the RDH's current practice.

In June 2019, on behalf of the Board, OPES distributed an email invitation to 8,584 licensed RDHs in California, inviting them to complete the OA questionnaire online. The invitation was sent to all RDHs with an email address on file with the Board.

A total of 1,712 RDHs, or 19.9%, responded by accessing the online OA questionnaire. The final sample size included in the data analysis was 1,456, or 17% of the sampled population. This response rate reflects two adjustments. First, OPES excluded data from respondents who indicated they were not currently licensed and practicing as RDHs in California. Second, questionnaires containing a large volume of incomplete or unresponsive data were removed. The demographic composition of the respondent sample appears to be representative of the licensed RDH population in California.

OPES test specialists then performed data analyses of the task and knowledge ratings obtained from the OA questionnaire respondents. The task frequency and importance ratings were combined to derive an overall criticality index for each task statement. The mean importance rating was used as the criticality index for each knowledge statement.

Once the data was analyzed, OPES conducted an additional workshop with SMEs in July 2019. The SMEs evaluated the criticality indices and determined whether any task or knowledge statements should be eliminated. The SMEs in this group also established the final linkage between tasks and knowledge statements, wrote additional task and knowledge statements, organized the task and knowledge statements into content areas, and wrote descriptions of those areas. The SMEs then evaluated and confirmed the content area and subarea weights of the examination outline.

The examination outline is structured into six content areas weighted by criticality relative to the other content areas. The outline provides a description of the scope of practice for RDHs, and it also identifies the tasks and knowledge critical to safe and effective RDH practice in California at the time of licensure. Additionally, the examination outline provides a basis for evaluating the degree to which the content of any examination under consideration measures content critical to RDH practice in California.

At this time, California licensure as an RDH is granted by meeting educational and experience requirements and passing the NBDHE; the Western Regional Examination Board (WREB) Clinical Examinations; the National Dental Hygiene Clinical Examination (NDHCE) developed by Central Regional Dental Testing Services (CRDTS); and the California RDH Laws and Ethics Examination.

OVERVIEW OF THE REGISTERED DENTAL HYGIENIST EXAMINATION OUTLINE

Content Area	Content Area Description		Percent Weight
1.	Treatment Preparation	This area assesses the candidate's knowledge of preparing the operatory and patient dental hygiene services.	5
2.	Dental Hygiene Treatment	This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.	40
3.	Patient Education	This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.	10
4.	Infection Control	This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.	15
5.	Documentation	This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental records.	5
6.	Laws, Regulations, and Ethics	This area assesses the candidate's knowledge of licensing requirements, professional conduct, patient confidentiality, use of telehealth methods and technology, and mandated reporting.	25
		Total	100

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER 1 | INTRODUCTION

PURPOSE OF THE OCCUPATIONAL ANALYSIS

The Dental Hygiene Board of California (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct an occupational analysis (OA) as part of the Board's comprehensive review of dental hygiene practice in California. The purpose of the OA is to identify critical activities performed by Registered Dental Hygienists (RDHs) in California. The results of this OA provide a description of practice for the RDH profession that can then be used to review the National Board Dental Hygiene Examination (NBDHE) developed by the Joint Commission on National Dental Examinations (JCNDE); the Western Regional Examination Board (WREB) Clinical Examinations; the National Dental Hygiene Clinical Examination developed by Central Regional Dental Testing Services (CRDTS); and to develop the California Registered Dental Hygienist Laws and Ethics Examination.

CONTENT VALIDATION STRATEGY

OPES used a content validation strategy to ensure that the OA reflected the actual tasks performed by practicing RDHs.

OPES incorporated the technical expertise of California RDHs throughout the OA process to ensure that the identified tasks and knowledge statements directly reflect requirements for safe and effective performance in current practice.

PARTICIPATION OF SUBJECT MATTER EXPERTS

The Board selected California RDHs to participate as subject matter experts (SMEs) during the phases of the OA. The SMEs were selected from a broad range of practice settings, geographic locations, and experience backgrounds. During the development phase of the OA, the SMEs provided information regarding the different aspects of RDH practice. The SMEs also provided technical expertise to evaluate and refine the content of tasks and knowledge statements before administration of the OA questionnaire. After the administration of the OA questionnaire, an additional workshop of SMEs reviewed the results and finalized the examination outline, which ultimately provides the description of practice.

ADHERENCE TO LEGAL STANDARDS AND GUIDELINES

Licensing, certification, and registration programs in the State of California adhere strictly to federal and state laws and regulations, as well as professional guidelines and technical standards. For the purpose of OAs, the following laws and guidelines are authoritative:

- California Business and Professions Code section 139.
- Uniform Guidelines on Employee Selection Procedures (1978), Code of Federal Regulations, Title 29, Section 1607

- California Fair Employment and Housing Act, Government Code section 12944.

- *Principles for the Validation and Use of Personnel Selection Procedures* (2003), Society for Industrial and Organizational Psychology (SIOP).

- *Standards for Educational and Psychological Testing (2014),* American Educational Research Association, American Psychological Association, and National Council on Measurement in Education.

For a licensure program to meet these standards, it must be solidly based upon the activities required for practice.

DESCRIPTION OF OCCUPATION

The RDH occupation is described as follows in section 1908 of the California Business and Professions Code:

> (a) The practice of dental hygiene includes dental hygiene assessment and development, planning, and implementation of a dental hygiene care plan. It also includes oral health education, counseling, and health screenings.
>
> (b) The practice of dental hygiene does not include any of the following procedures:
>
> (1) Diagnosis and comprehensive treatment planning.
>
> (2) Placing, condensing, carving, or removal of permanent restorations.
>
> (3) Surgery or cutting on hard and soft tissue including, but not limited to, the removal of teeth and the cutting and suturing of soft tissue.
>
> (4) Prescribing medication.
>
> (5) Administering local or general anesthesia or oral or parenteral conscious sedation, except for the administration of nitrous oxide and oxygen, whether administered alone or in combination with each other, or local anesthesia pursuant to Section 1909.

Section 1909: A registered dental hygienist is authorized to perform the following procedures under direct supervision of a licensed dentist, after submitting to the hygiene board evidence of satisfactory completion of a course of instruction, approved by the hygiene board, in the procedures:

> (a) Soft-tissue curettage.
> (b) Administration of local anesthesia.
> (c) Administration of nitrous oxide and oxygen, whether administered alone or in combination with each other.

Section 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.

CHAPTER 2 | OCCUPATIONAL ANALYSIS QUESTIONNAIRE

SUBJECT MATTER EXPERT INTERVIEWS

The Board provided OPES with a list of RDHs to contact for telephone interviews. During the semi-structured interviews, nine SMEs were asked to identify all of the activities they perform that are specific to the RDH profession. The SMEs outlined major content areas of their practice and confirmed the tasks performed in each content area. The SMEs were also asked to identify the knowledge necessary to perform each task safely and competently.

TASK AND KNOWLEDGE STATEMENTS

To develop the task and knowledge statements, OPES test specialists integrated the information gathered from literature reviews of profession-related sources (e.g., related OA reports, articles, industry publications) and from the interviews with SMEs.

In April 2019, OPES test specialists facilitated a workshop with eight SMEs from diverse backgrounds (i.e., years licensed, specialty, and practice location) to evaluate the task and knowledge statements for technical accuracy and comprehensiveness. The SMEs assigned each statement to a content area and verified that the content areas were independent and nonoverlapping. In addition, the SMEs performed a preliminary linkage of the task and knowledge statements to ensure that every task had a related knowledge and every knowledge statement had a related task. The SMEs also verified proposed demographic questions for the OA questionnaire, including questions regarding scope of practice and practice setting.

Once the lists of task and knowledge statements and the demographic questions were verified, OPES used this information to develop an online questionnaire that was sent to California RDHs for completion and evaluation.

QUESTIONNAIRE DEVELOPMENT

OPES test specialists developed an online OA questionnaire designed to solicit RDHs' ratings of the tasks and knowledge statements. The surveyed RDHs were instructed to rate each task in terms of how often they perform the task (Frequency) and in terms of how important the task is to effective performance of their current practice (Importance). In addition, they were instructed to rate each knowledge statement in terms of how important the specific knowledge is to performance of their current practice (Importance). The OA questionnaire also included a demographic section for purposes of developing an accurate profile of the respondents. The OA questionnaire can be found in Appendix E.

PILOT STUDY

Before administering the final questionnaire, OPES conducted a pilot study of the online questionnaire. The draft questionnaire was reviewed by the Board and then sent to nine SMEs who had participated in the task and knowledge statement development workshop. OPES received feedback to the pilot study from seven respondents. The respondents provided a final review of the task and knowledge statements, estimated time for completion, online navigation, and ease of use of the questionnaire. OPES used this feedback to develop the final questionnaire.

CHAPTER 3 | RESPONSE RATE AND DEMOGRAPHICS

SAMPLING STRATEGY AND RESPONSE RATE

In June 2019, on behalf of the Board, OPES sent emails to 8,584 RDHs (all RDHs with an email on file with the Board) inviting them to complete the OA questionnaire online. The email invitation can be found in Appendix D.

Of the 8,584 RDHs in the sample group, 1,712 licensed RDHs, or 19.9%, responded by accessing the online questionnaire. The final sample size included in the data analysis was 1,456, or 17.0% of the population that was invited to complete the questionnaire. This response rate reflects two adjustments. First, OPES excluded data from respondents who indicated they were not currently licensed and practicing as RDHs in California. Second, questionnaires containing a large volume of missing or unresponsive data were also excluded. The respondent sample appears to be representative of the population of California RDHs based on the sample's demographic composition.

DEMOGRAPHIC SUMMARY

As shown in Table 1 and Figure 1, 4.6% of the respondents included in the analysis reported having been licensed for 5 years or fewer, 8.0% for 6-10 years, 21.6% for 11-15 years, and 65.2% for more than 16 years.

As shown in Table 2 and Figure 2, 39.6% reported working 31 to 40 hours per week, 31.5% reported working 21 to 30 hours per week, 16.1% reported working 11 to 20 hours per week, and 8.7% reported working 1 to 10 hours per week.

As shown in Table 3 and Figure 3, 61.3% of the respondents reported being employed by one dental office, 28.4% reported being employed by two dental offices, and 10.0% reported being employed by three or more dental offices.

As shown in Table 4 and Figure 4, when asked to indicate their primary practice setting, 86.0% of the respondents reported general, 5.7% reported periodontics, 4.7% reported pedodontics, 2.5% reported endodontics, and 0.9% reported oral surgery.

Respondents were also asked about other dental licenses they hold in California. As shown in Table 5, 38.7% reported also holding an RDA license, 15.5% reported holding RDAEF licenses, and 3.1% reported holding RDHAP licenses.

More detailed demographic information from respondents can be found in Tables 1-7 and Figures 1-6.

TABLE 1 – NUMBER OF YEARS LICENSED AS AN RDH

YEARS	NUMBER (N)	PERCENT
1 to 5 years	67	4.6
6 to 10 years	117	8.0
11 to 15 years	315	21.6
More than 16 years	950	65.2
Missing	7	0.5
Total	1,456	100*

**NOTE: Percentages do not add to 100 due to rounding.*

FIGURE 1 – NUMBER OF YEARS LICENSED AS AN RDH

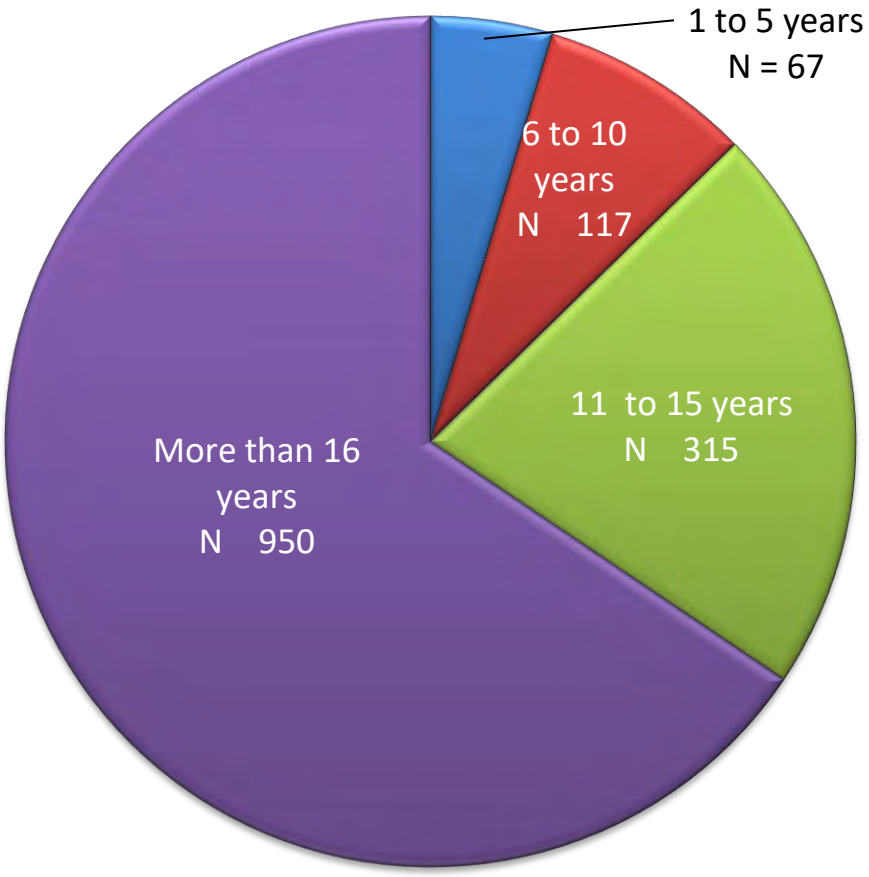


TABLE 2 – HOURS WORKED PER WEEK

HOURS	NUMBER (N)	PERCENT
1 to 10	127	8.7
11 to 20	234	16.1
21 to 30	458	31.5
31 to 40	576	39.6
More than 40 hours	59	4.1
Missing	2	0.1
Total	1,456	100*

**NOTE: Percentages do not add to 100 due to rounding.*

FIGURE 2 – HOURS WORKED PER WEEK

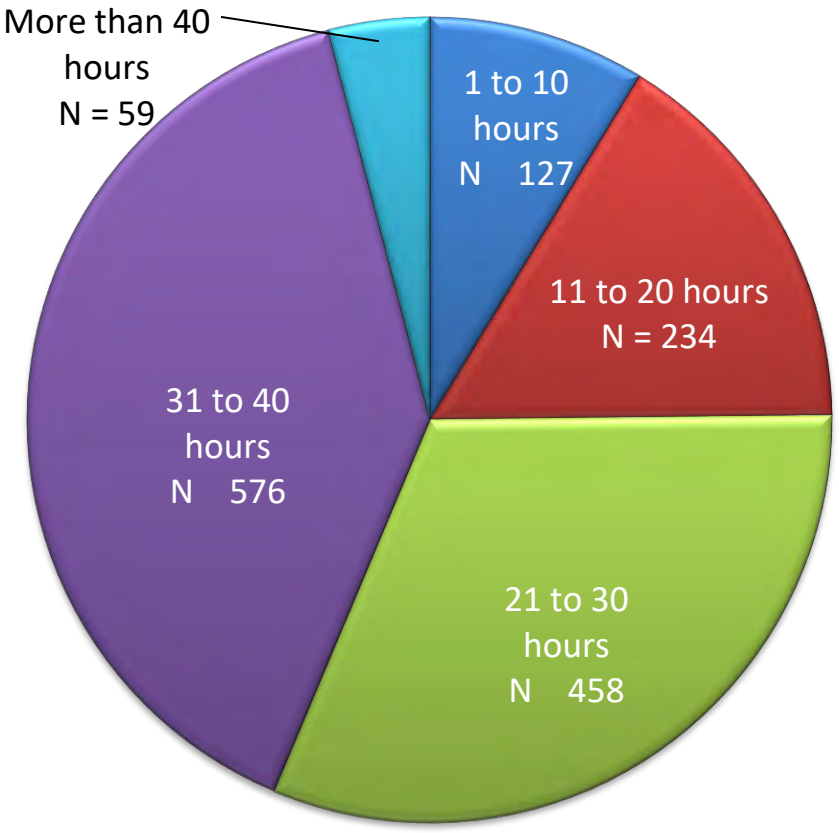


TABLE 3 – NUMBER OF OFFICES IN WHICH RDH IS EMPLOYED

YEARS	NUMBER (N)	PERCENT
1	892	61.3
2	414	28.4
3 or more	145	10.0
Missing	5	0.3
Total	1,456	100

FIGURE 3 – NUMBER OF OFFICES IN WHICH RDH IS EMPLOYED

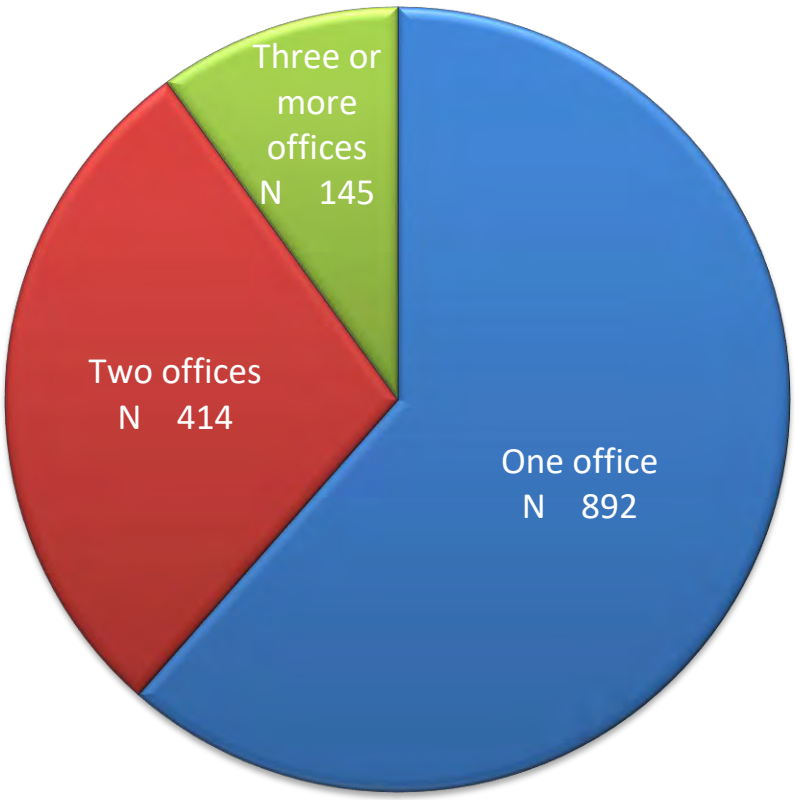


TABLE 4 – PRIMARY PRACTICE SETTING

SETTING	NUMBER (N)	PERCENT
General	1,252	86.0
Periodontics	83	5.7
Pedodontics	68	4.7
Endodontics	36	2.5
Oral Surgery	13	0.9
Missing	4	0.3
Total	1,456	100*

**NOTE: Percentages do not add to 100 due to rounding.*

FIGURE 4 – PRIMARY PRACTICE SETTING

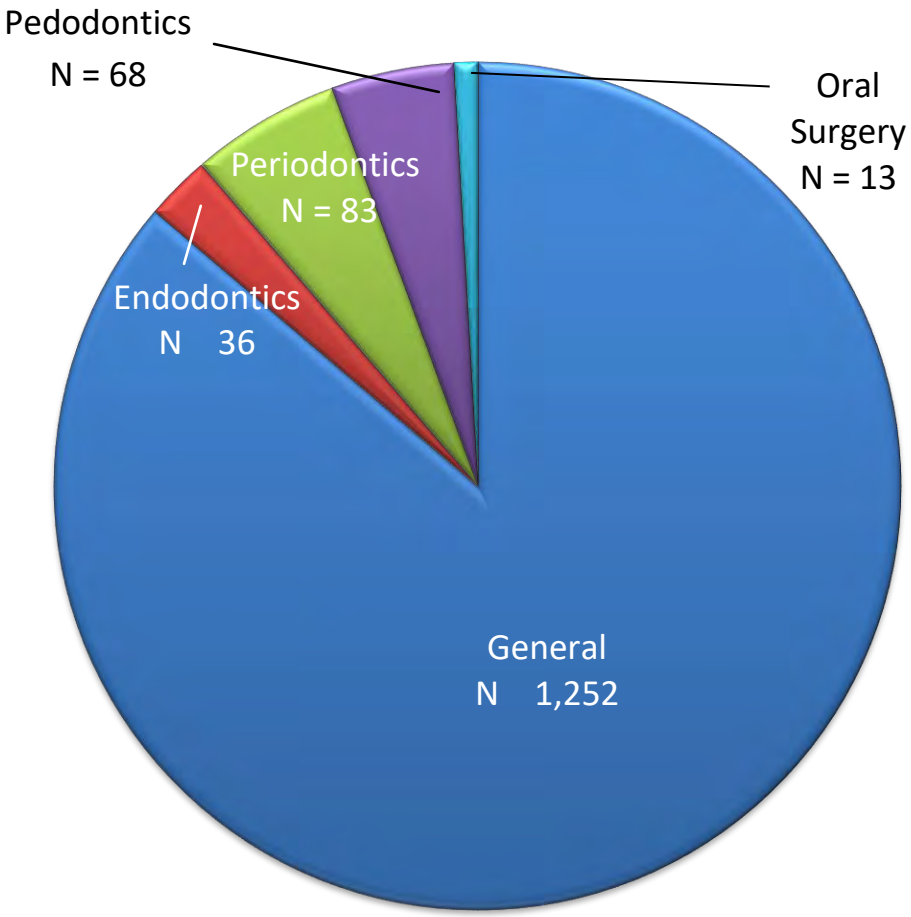


TABLE 5 – OTHER CALIFORNIA DENTAL-RELATED LICENSES HELD*

LICENSE	NUMBER (N)	PERCENT
RDA	564	38.7
RDAEF	226	15.5
RDHAP	45	3.1

**NOTE: Respondents were asked to select all that apply. Percentages indicate the proportion in the sample of respondents.*

FIGURE 5 – OTHER CALIFORNIA DENTAL-RELATED LICENSES HELD

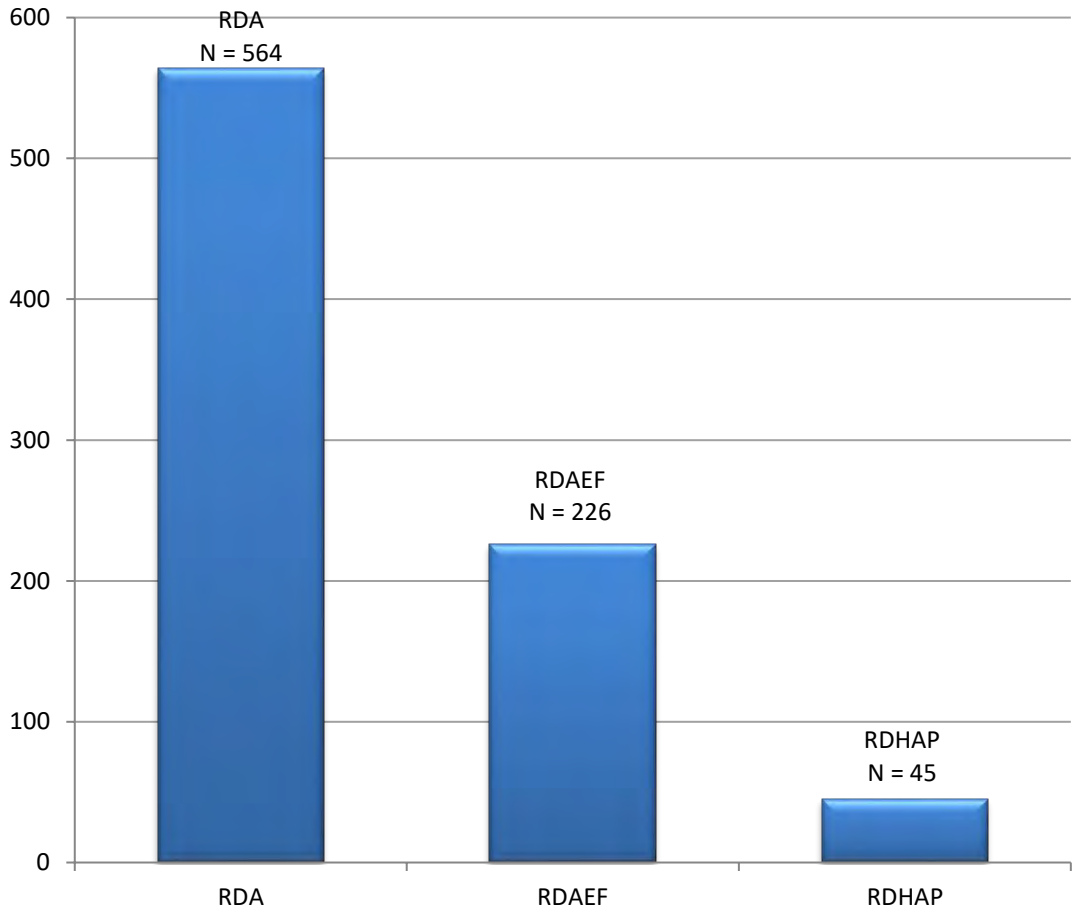
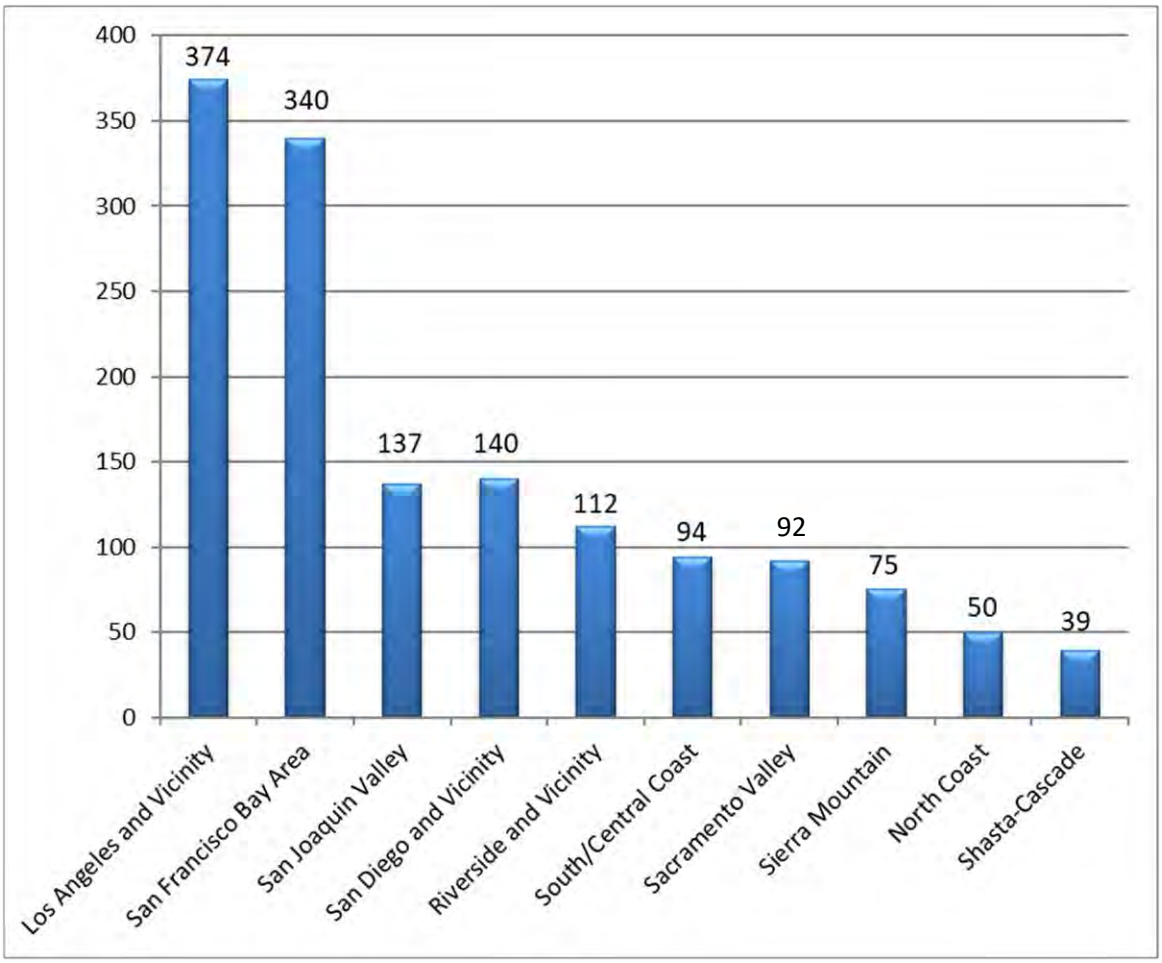


TABLE 6 – RESPONDENTS BY REGION

REGION NAME	NUMBER (N)	PERCENT
Los Angeles County and Vicinity	374	25.7
San Francisco Bay Area	340	23.4
San Joaquin Valley	137	9.4
San Diego County and Vicinity	140	9.6
Riverside and Vicinity	112	7.7
South Coast and Central Coast	94	6.5
Sacramento Valley	92	6.3
Sierra Mountain Valley	75	5.2
North Coast	50	3.4
Shasta and Cascade	39	2.7
Missing	3	0.2
Total	1,456	100*

**NOTE: Percentages do not add to 100 due to rounding.*

FIGURE 6 – RESPONDENTS BY REGION



Appendix A shows a more detailed breakdown of the frequencies by region.

TABLE 7 – LOCATION OF WORK SETTING

LOCATION	NUMBER (N)	PERCENT
Urban (more than 50,000 people)	1,263	86.7
Rural (fewer than 50,000 people)	190	13.0
Missing	3	0.2
Total	1,456	100*

**NOTE: Percentages do not add to 100 due to rounding.*

CHAPTER 4 | DATA ANALYSIS AND RESULTS

RELIABILITY OF RATINGS

OPES evaluated the task and knowledge ratings using a standard index of reliability, coefficient alpha (α), that ranges from 0 to 1. Coefficient alpha is an estimate of the internal consistency of the respondents' ratings of the task and knowledge statements. A higher coefficient value indicates more consistency between respondent ratings. Coefficients were calculated for all respondent ratings.

Table 8 displays the reliability coefficients for the task rating scales in each content area. The overall ratings of task frequency and task importance across content areas were highly reliable (frequency α = .933; importance α = .933). Table 9 displays the reliability coefficients for the knowledge statement rating scale in each content area. The overall ratings of knowledge importance across content areas were also highly reliable (α = .971). These results indicate that the responding RDHs rated the task and knowledge statements consistently throughout the questionnaire.

TABLE 8 – TASK SCALE RELIABILITY

CONTENT AREA	Number of Tasks	α Frequency	α Importance
1. Treatment Preparation	4	.734	.683
2. Dental Hygiene Treatment	19	.831	.868
3. Patient Education	4	.779	.798
4. Infection Control	5	.811	.655
5. Documentation	5	.768	.766
6. Laws, Regulations, and Ethics	10	.817	.835
Total	47	.933*	.933

**Note: The total shown is not the sum of the individual area rating of task frequency and importance but rather the overall rating of task frequency and task importance.*

TABLE 9 – KNOWLEDGE SCALE RELIABILITY

CONTENT AREA	Number of Knowledge Statements	α Importance
1. Treatment Preparation	4	.852
2. Dental Hygiene Treatment	28	.936
3. Patient Education	4	.893
4. Infection Control	5	.837
5. Documentation	6	.890
6. Laws, Regulations, and Ethics	10	.920
Total	57	.971

TASK CRITICALITY INDICES

In July 2019, OPES convened a workshop consisting of eight SMEs. The purpose of this workshop was to evaluate the survey results to identify the essential tasks and knowledge statements required for safe and effective RDH practice at the time of licensure. The SMEs reviewed the mean frequency, mean importance, and criticality index for each task. They also evaluated the mean importance ratings for each knowledge statement.

To calculate the criticality indices of the tasks, OPES test specialists used the formula below. For each respondent, the frequency rating (Fi) and the importance rating (Ii) were multiplied for each task. Next, the multiplication products were averaged across respondents as shown below.

Task criticality index = mean [(Fi) X (Ii)]

The tasks were sorted in descending order by criticality index and by content area. The tasks, their mean frequency and importance ratings, and their associated criticality indices are presented in Appendix B.

The SMEs who participated in the July 2019 workshop evaluated the task criticality indices derived from the questionnaire results. OPES test specialists instructed the SMEs to identify a cutoff value to determine if any of the tasks did not have a high enough criticality index to be retained. Based on their review, the SMEs determined that one task should be deleted from the content outline based on a low criticality index value (T20). The SMEs determined that another task (T34) should be deleted from the content outline because it was very similar to another task. These task statements are identified in Appendix B.

Additionally, SMEs determined that four tasks (T48, T49, T50, T51) should be added. Tasks 48, 49, and 50 were added to ensure a complete description of dental hygiene practice. Task 51 was added to further clarify a task statement that included multiple subjects.

KNOWLEDGE IMPORTANCE RATINGS

To determine the criticality of each knowledge statement, the mean importance (K Imp) rating for each knowledge statement was calculated. The knowledge statements and their mean importance ratings, sorted by descending order of mean importance and grouped by content area, are presented in Appendix C.

The SMEs who participated in the July 2019 workshop that evaluated the task criticality indices also reviewed the knowledge statement mean importance ratings. Based on their review, the SMEs determined that one knowledge statement should be deleted from the content outline (K29). The eliminated knowledge statement is identified in Appendix C. The exclusion of a knowledge statement from the examination outline does not mean that the knowledge stated is not used in dental hygiene practice; it means that the SMEs determined that the knowledge statement was not critical for testing relative to other knowledge statements within the scope of RDH practice.

Additionally, SMEs determined that four knowledge statements (K60, K61, K62, K63) should be added to further clarify other knowledge statements that included multiple subjects.

CHAPTER 5 | EXAMINATION OUTLINE

TASK-KNOWLEDGE LINKAGE

The SMEs who participated in the July 2019 workshop reviewed the preliminary assignments of the tasks and knowledge statements to content areas from the April 2019 workshop. The SMEs established the final linkage of specific knowledge statements to tasks. The SMEs reviewed the content areas and wrote descriptions for each content area.

CONTENT AREAS AND WEIGHTS

The SMEs in the July 2019 workshop were also asked to finalize the weights for content areas on the RDH examination outline. OPES test specialists presented the SMEs with preliminary weights of the content areas that were calculated by dividing the sum of the criticality indices for the tasks in each content area by the overall sum of the criticality indices for all tasks, as shown below.

$$\frac{\textit{Sum of Criticality Indices for Tasks in Content Area}}{\textit{Sum of Criticality Indices for All Tasks}} = \textit{Percent Weight of Content Area}$$

The SMEs evaluated the preliminary weights by reviewing the following elements for each content area: the group of tasks and knowledge statements, the linkage established between the tasks and knowledge statements, and the relative importance of the tasks to dental hygiene practice in California. The SMEs adjusted the preliminary weights based on what they perceived as the relative importance of the tasks' content to dental hygiene practice in California. A summary of the preliminary and final content area weights for the RDH examination outline is presented in Table 10.

TABLE 10 – CONTENT AREA WEIGHTS

CONTENT AREA	Preliminary Weights Percent	Final Weights Percent
1. Treatment Preparation	15	5
2. Dental Hygiene Treatment	30	40
3. Patient Education	9	10
4. Infection Control	11	15
5. Documentation	13	5
6. Laws, Regulations, and Ethics	22	25
Total	100	100

The examination outline for the RDH profession is presented in Table 11.

TABLE 11 – EXAMINATION OUTLINE: RDH

1. Treatment Preparation (5%) - This area assesses the candidate's knowledge of preparing the operatory and patient dental hygiene services.

Tasks	*Associated Knowledge Statements*
T1. Prepare operatory for dental hygiene treatment.	K1. Knowledge of procedures and protocols to prepare and breakdown operatory.
T2. Review patient dental records and medical history.	K2. Knowledge of conditions related to oral-systemic health (e.g., diabetes, cardiovascular disease).
T3. Select instruments, equipment, and materials for dental hygiene treatment.	K4. Knowledge of instruments, equipment, and materials used for dental hygiene treatment.
T6. Take patient vital signs.	K3. Knowledge of techniques for assessing vital signs.

2. Dental Hygiene Treatment (40%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.

Tasks	*Associated Knowledge Statements*
T7. Perform visual oral health screening.	K7. Knowledge of procedures for assessing the oral cavity. K8. Knowledge of assessing periodontal conditions using clinical and radiographic findings.
T8. Complete a comprehensive periodontal assessment.	K7. Knowledge of procedures for assessing the oral cavity. K8. Knowledge of assessing periodontal conditions using clinical and radiographic findings.
T9. Expose dental radiographs to assist with diagnosis of caries or periodontal conditions.	K9. Knowledge of techniques for exposing and developing dental radiographs.
T10. Develop dental hygiene care plan that correlates with findings from periodontal assessment.	K10. Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment. K11. Knowledge of methods to develop dental hygiene care plans to assess patient needs.

2. Dental Hygiene Treatment (40%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.

Tasks	*Associated Knowledge Statements*
T11. Modify dental hygiene treatment plan based on current information.	K10. Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment. K11. Knowledge of methods to develop dental hygiene care plans to assess patient needs.
T12. Perform non-surgical periodontal procedures (e.g., scaling, root planing).	K13. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using hand instruments. K14. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using power instruments.
T13. Perform oral prophylaxis to remove hard and soft deposits and stain.	K15. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using hand instruments. K16. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using power instruments.
T14. Administer topical anesthetic to patients.	K17. Knowledge of procedures to administer topical anesthetic. K18. Knowledge of conditions that require application of topical anesthesia. K19. Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.

2. Dental Hygiene Treatment (40%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.

Tasks	*Associated Knowledge Statements*
T14. Administer topical anesthetic to patients.	K17. Knowledge of procedures to administer topical anesthetic. K18. Knowledge of conditions that require application of topical anesthesia. K19. Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.
T15. Administer nitrous oxide under direct supervision of a dentist.	K19. Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment. K20. Knowledge of indications, contraindications, and side effects for administering nitrous oxide during dental hygiene treatment. K22. Knowledge of procedures to administer nitrous oxide.
T51. Administer local anesthetic under direct supervision of a dentist.	K21. Knowledge of indications, contraindications, and side effects for administering local anesthesia during dental hygiene treatment. K60. Knowledge of procedures to administer local anesthetic.
T16. Perform soft tissue curettage under direct supervision of a dentist.	K23. Knowledge of soft tissue curettage procedure.

2. Dental Hygiene Treatment (40%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.

Tasks	*Associated Knowledge Statements*
T17. Perform air polishing to remove supragingival and subgingival biofilm and stain.	K24. Knowledge of methods to perform air polishing to remove supragingival and subgingival biofilm and stain.
T18. Evaluate the presence or absence of biofilm and calculus before and after instrumentation.	K25.Knowledge of techniques for detecting the presence or absence of biofilm and calculus.
T19. Apply fluorides and other caries-preventing agents to patients.	K26. Knowledge of application techniques for fluoride and caries-preventing agents. K28. Knowledge of application of agents used for control of caries (e.g., pit and fissure sealants, interim therapeutic restorations (ITRs). K61. Knowledge of agents used for control of caries.
T21. Apply topical, therapeutic, and subgingival agents for the management of periodontal disease.	K27. Knowledge of agents used for the management of periodontal disease. K30. Knowledge of application of agents used for the management of periodontal disease (e.g., antimicrobials).
T22. Place ITR after diagnosis by dentist.	K31. Knowledge of procedures to place ITRs.

2. Dental Hygiene Treatment (40%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment.

Tasks	*Associated Knowledge Statements*
T21. Apply topical, therapeutic, and subgingival agents for the management of periodontal disease.	K27. Knowledge of agents used for the management of periodontal disease. K30. Knowledge of application of agents (e.g., antimicrobials) used for the management of periodontal disease.
T22. Place ITR after diagnosis by dentist.	K31. Knowledge of procedures to place ITRs
T23. Clean and polish removable appliances.	K32. Knowledge of procedures for cleaning and polishing removable appliances (e.g., dentures).
T24. Recognize oral health conditions resulting from personal habits (e.g., tobacco, substance abuse, eating disorders).	K33. Knowledge of personal habits that affect oral health conditions (e.g., tobacco, substance abuse, eating disorders).
T48. Remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.	K12. Knowledge of procedures to remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.
T32. Maintain hand instruments for dental hygiene treatment.	K41. Knowledge of sharpening techniques of hand instruments.

3. Patient Education (10%) - This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.

Tasks	*Associated Knowledge Statements*
T25. Discuss scheduled dental hygiene treatment with patient.	K34. Knowledge of methods for communicating a dental hygiene care plan with patient.
T26. Communicate assessment findings and dental hygiene care plan to patient.	K34. Knowledge of methods for communicating a dental hygiene care plan with patient. K37. Knowledge of individualized oral hygiene instructions to address specific patient needs.
T27. Provide patients with individualized oral hygiene instructions.	K37. Knowledge of individualized oral hygiene instructions to address specific patient needs.
T28. Provide nutritional counseling to improve oral health.	K36. Knowledge of nutritional counseling related to oral health.
T49. Provide postoperative care instructions to patients.	K35. Knowledge of instructions for postoperative care.

4. Infection Control (15%) - This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.

Tasks	*Associated Knowledge Statements*
T4. Provide patient with eyewear and bib to protect patient during dental hygiene treatment.	K5. Knowledge of standard precautions required to protect patients during dental hygiene treatment.
T5. Wear personal protective equipment (PPE) before providing treatment to help prevent spread of disease.	K5. Knowledge of standard precautions required to protect patients during dental hygiene treatment. K6. Knowledge of standard precautions required to protect health care workers during dental hygiene treatment.
T29. Maintain a safe and clean work environment.	K62. Knowledge of Cal/OSHA laws and regulations pertaining to dental settings.
T30. Adhere to infection-control policies and protocols for performing dental hygiene treatment.	K38. Knowledge of standards for infection control.
T31. Sterilize instruments in accordance with California infection control guidelines.	K40. Knowledge of techniques for sterilizing dental hygiene instruments.
T50. Disinfect or sterilize equipment in accordance with California infection control guidelines.	K39. Knowledge of techniques for disinfecting and sterilizing dental hygiene equipment.

5.Documentation (5%) - This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental records.

Tasks	*Associated Knowledge Statements*
T33. Document patient oral health status.	K44. Knowledge of different types of periodontal conditions. K45. Knowledge of basic characteristics of normal and abnormal oral conditions. K46. Knowledge of the characteristics of caries, defective restorations, temporomandibular joint disorders (TMD), and occlusal disorders for referral to dentist.
T35. Document existing and recommended restorative treatment as diagnosed by the dentist.	K46. Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist. K48. Knowledge of methods and protocol for documenting in patient dental records.
T36. Update patient dental records and medical history, including chief complaints and concerns.	K47. Knowledge of methods and protocol for updating patient medical history. K48. Knowledge of methods and protocol for documenting in patient dental records.
T37. Record in patient records the dental services performed.	K49. Knowledge of protocol for documenting dental hygiene services performed.

6. Laws, Regulations, and Ethics (25%) - This area assesses the candidate's knowledge of licensing requirements, professional conduct, patient confidentiality, use of telehealth methods and technology, and mandated reporting.

Tasks	*Associated Knowledge Statements*
T38. Communicate with other dental professionals using telehealth methods and technology.	K50. Knowledge of methods for communicating with health care providers using telehealth. K52. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K53. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T39. Obtain informed consent from patient in accordance with laws and regulations.	K51. Knowledge of laws and regulations related to informed consent.
T40. Maintain confidentiality of patient records in accordance with laws and regulations.	K52. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.
T41. Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.	K52. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K53. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T42. Maintain security of patient records in accordance with laws and regulations.	K52. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K53. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.

6. Laws, Regulations, and Ethics (25%) - This area assesses the candidate's knowledge of licensing requirements, professional conduct, patient confidentiality, use of telehealth methods and technology, and mandated reporting.

Tasks	*Associated Knowledge Statements*
T43. Adhere to laws and regulations regarding professional conduct.	K54. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting. K63. Knowledge of RDH allowable duties.
T44. Adhere to laws and regulations regarding excessive treatment.	K54. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting. K55. Knowledge of laws and regulations regarding excessive treatment.
T45. Report reasonable suspicion of child, elder, or dependent adult abuse or neglect as legally mandated.	K56. Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse or neglect.
T46. Maintain dental hygiene license according to laws and regulations.	K57. Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California dental hygiene license. K58. Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.
T47. Maintain required continuing education units for license renewal.	K59. Knowledge of laws and regulations regarding continuing education requirements to maintain dental hygiene license.

CHAPTER 6 | CALIFORNIA REGISTERED DENTAL HYGIENIST LAWS AND ETHICS EXAMINATION OUTLINE

CALIFORNIA RDH LAWS AND ETHICS EXAMINATION

At this time, California licensure as an RDH is granted by meeting educational and experience requirements and passing the NBDHE; the Western Regional Examination Board (WREB); the National Dental Hygiene Clinical Examination developed by Central Regional Dental Testing Services (CRDTS); and the California RDH Laws and Ethics Examination.

The SMEs who participated in the July 2019 workshop were asked to develop a preliminary examination outline for the California RDH Laws and Ethics Examination by identifying the tasks and knowledge that they believed were California-specific. The SMEs determined that all tasks and knowledge statements within the Laws and Ethics content area should remain in the examination outline for the California RDH Laws and Ethics Examination.

CONTENT AREAS AND WEIGHTS

In July 2019, OPES facilitated a workshop with eight SMEs. Before the workshop, OPES organized the tasks and knowledge statements from the preliminary California RDH Laws and Ethics Examination Outline into a proposed examination outline with five content areas. The SMEs determined the final content area names, descriptions, and content area weights. After the examination outline was finalized, OPES renumbered the tasks and knowledge statements. The final examination outline for the California RDH Laws and Ethics Examination consists of five content areas and is presented in Table 12. Tables 13 and 14 provide a conversion chart indicating the new tasks and knowledge statement numbers in the California RDH Laws and Ethics Examination Outline and the original task and knowledge numbers in the California RDH Examination Outline.

TABLE 12 – EXAMINATION OUTLINE FOR THE CALIFORNIA RDH LAWS AND ETHICS EXAMINATION

1. Licensing Requirements (40%) - This area assesses the candidate's knowledge of the California laws and regulations governing the RDH's license maintenance.

Tasks	*Associated Knowledge Statements*
T1. Maintain dental hygiene license according to laws and regulations.	K1. Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California dental hygiene license. K2. Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.
T2. Maintain required continuing education units for license renewal.	K3. Knowledge of laws and regulations regarding continuing education requirements to maintain dental hygiene license.

2. Professional Conduct (36%) - This area assesses the candidate's knowledge of the California laws and regulations governing the RDH professional conduct.

Tasks	*Associated Knowledge Statements*
T3. Adhere to laws and regulations regarding professional conduct.	K4. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting. K5. Knowledge of RDH allowable duties.
T4. Adhere to laws and regulations regarding excessive treatment.	K4. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting. K6. Knowledge of laws and regulations regarding excessive treatment.

3. Patient Confidentiality (10%) - This area assesses the candidate's knowledge of the California laws and regulations governing patient confidentiality.

Tasks	*Associated Knowledge Statements*
T5. Obtain informed consent from patient in accordance with laws and regulations.	K7. Knowledge of laws and regulations related to informed consent.
T6. Maintain confidentiality of patient records in accordance with laws and regulations.	K8. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.
T7. Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.	K8. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K9. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T8. Maintain security of patient records in accordance with laws and regulations.	K8. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K9. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.

4. Mandated Reporting (10%) - This area assesses the candidate's knowledge of the California laws and regulations governing mandated reporting.

Task	*Associated Knowledge Statement*
T9. Report reasonable suspicion of child, elder, or dependent adult abuse or neglect as legally mandated.	K10. Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse or neglect.

5. Telehealth (4%) - This area assesses the candidate's knowledge of the California laws and regulations governing telehealth.

Tasks	*Associated Knowledge Statements*
T10. Communicate with other dental professionals using telehealth methods and technology.	K8. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K9. Knowledge of laws and regulations regarding maintaining physical and electronic patient records. K11. Knowledge of methods for communicating with health care providers using telehealth.

TABLE 13 – RENUMBERING OF TASKS

Original Task Number in California RDH Examination Outline	New Task Number in California RDH Laws and Ethics Examination Outline
46	1
47	2
43	3
44	4
39	5
40	6
41	7
42	8
45	9
38	10

TABLE 14 – RENUMBERING OF KNOWLEDGE STATEMENTS

Original Knowledge Statement Number in California RDH Examination Outline	New Knowledge Statement Number in California RDH Laws and Ethics Examination Outline
57	1
58	2
59	3
54	4
63	5
55	6
51	7
52	8
53	9
56	10
50	11

CHAPTER 7 | CONCLUSION

The OA of the dental hygienist profession described in this report provides a comprehensive description of current practice in California. The procedures employed to perform the OA were based upon a content validation strategy to ensure that the results accurately represent RDH practice. Results of this OA can be used to ensure that national examinations under consideration for acceptance or already accepted by the Dental Hygiene Board measure content critical to optometry practice in California.

By adopting the Registered Dental Hygienists (RDH) outline contained in this report, the Board ensures that its California RDH Laws and Ethics Examination reflects current practice.

This report provides all documentation necessary to verify that the analysis has been completed in accordance with legal, professional, and technical standards.

APPENDIX A | RESPONDENTS BY REGION

LOS ANGELES COUNTY AND VICINITY

County of Practice	Frequency
Los Angeles	237
Orange	137
TOTAL	374

NORTH COAST

County of Practice	Frequency
Del Norte	2
Humboldt	4
Mendocino	8
Sonoma	36
TOTAL	50

RIVERSIDE AND VICINITY

County of Practice	Frequency
Riverside	53
San Bernardino	59
TOTAL	112

SACRAMENTO VALLEY

County of Practice	Frequency
Butte	9
Glenn	2
Lake	1
Sacramento	66
Sutter	4
Yolo	8
Yuba	2
TOTAL	92

SAN DIEGO COUNTY AND VICINITY

County of Practice	Frequency
Imperial	2
San Diego	138
TOTAL	140

SAN FRANCISCO BAY AREA

County of Practice	Frequency
Alameda	67
Contra Costa	51
Marin	17
Napa	9
San Francisco	36
San Mateo	27
Santa Clara	89
Santa Cruz	26
Solano	18
TOTAL	340

SAN JOAQUIN VALLEY

County of Practice	Frequency
Fresno	36
Kern	18
Kings	6
Madera	3
Merced	5
San Joaquin	29
Stanislaus	30
Tulare	10
TOTAL	137

SHASTAAND CASCADE

County of Practice	Frequency
Lassen	4
Plumas	1
Shasta	22
Siskiyou	5
Tehama	6
Trinity	1
TOTAL	39

SIERRA MOUNTAIN VALLEY

County of Practice	Frequency
Amador	2
Calaveras	3
El Dorado	11
Mariposa	2
Nevada	9
Placer	43
Tuolumne	5
TOTAL	75

SOUTH COAST AND CENTRAL COAST

County of Practice	Frequency
Monterey	14
San Benito	2
San Luis Obispo	20
Santa Barbara	23
Ventura	35
TOTAL	94

MISSING

TOTAL	3

APPENDIX B | CRITICALITY INDICES FOR ALL TASKS BY CONTENT AREA

Content Area 1: Treatment Preparation

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
2	Review patient dental records and medical history.	4.83	4.87	23.68
1	Prepare operatory for dental hygiene treatment.	4.69	4.47	21.19
3	Select instruments, equipment, and materials for dental hygiene treatment.	4.07	4.29	20.72
6	Take patient vital signs.	4.15	4.21	10.96

Content Area 2: Dental Hygiene Treatment

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
13	Perform oral prophylaxis to remove hard and soft deposits and stains.	4.80	4.59	22.18
32	Maintain instruments to ensure efficient functioning for dental hygiene treatment.	4.55	4.61	21.23
7	Perform visual oral health screening.	4.52	4.52	20.85
8	Complete a comprehensive periodontal assessment.	4.39	4.49	20.14
10	Develop dental hygiene care plan that correlates with findings from periodontal assessment.	4.42	4.44	20.08
18	Evaluate the presence or absence of biofilm and calculus before and after instrumentation.	4.37	4.21	19.20
9	Expose dental radiographs to assist with diagnosis of caries or periodontal conditions.	4.13	4.32	18.75
12	Perform nonsurgical periodontal procedures (e.g., scaling, root planing).	4.06	4.53	18.72
11	Modify dental hygiene treatment plan based on current information.	4.20	4.18	18.13
24	Recognize oral health conditions resulting from personal habits (e.g., tobacco, substance abuse, eating disorders).	4.11	4.30	18.13
19	Apply fluorides and other caries-preventing agents to patients.	3.73	3.66	14.35
14	Administer topical anesthetic to patients.	3.34	3.44	12.12
23	Clean and polish removable appliances.	3.41	3.08	11.34
21	Apply topical, therapeutic, and subgingival agents for the control of caries and periodontal disease.	2.76	3.10	9.92
16	Perform soft tissue curettage under direct supervision of a dentist.	2.55	3.07	9.26

15	Administer nitrous oxide and local anesthetic under direct supervision of a dentist.	2.26	2.91	8.43
17	Perform air polishing to remove supragingival and subgingival biofilm and stain.	1.32	1.42	4.20
20	Take impressions for nondiagnostic cast models.	0.60	0.89	1.20
22	Place ITR after diagnosis by dentist.	0.32	0.63	0.76

**Note: Shaded task statement was deleted by SMEs. (See Chapter 4).*

Content Area 3: Patient Education

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
27	Provide patients with individualized oral hygiene instructions.	4.61	4.49	20.99
26	Communicate assessment findings and dental hygiene care plan to patient.	4.57	4.46	20.74
25	Discuss scheduled dental hygiene treatment with patient.	4.42	4.25	19.27
28	Provide nutritional counseling to improve oral health.	3.24	3.56	12.49

Content Area 4: Infection Control

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
30	Adhere to infection control policies and protocols for performing dental hygiene treatment.	4.86	4.93	24.04
5	Wear personal protective equipment (PPE) before providing treatment to help prevent spread of disease.	4.84	4.85	23.63
29	Maintain a safe and clean work environment.	4.83	4.86	23.57
31	Sterilize instruments in accordance with California infection control guidelines.	4.66	4.88	23.12
4	Provide patient with eyewear and bib to protect patient during dental hygiene treatment.	4.48	4.26	19.63

Content Area 5: Documentation

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
37	Document in patient record the dental services performed.	4.76	4.72	22.77
36	Update patient dental records and medical history, including chief complaints and concerns.	4.67	4.61	21.79
34	Report abnormalities of the oral cavity to the dentist.	4.45	4.65	20.88
33	Document patient oral health status.	4.48	4.47	20.43
35	Document existing and recommended restorative treatment as diagnosed by the dentist.	3.77	3.93	16.34

**Note: Shaded task statement was deleted by SMEs. (See Chapter 4).*

Content Area 6: Laws, Regulations, and Ethics

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
46	Maintain dental hygiene license according to laws and regulations.	4.78	4.82	23.12
47	Maintain required continuing education units for license renewal.	4.77	4.73	22.65
43	Adhere to laws and regulations regarding professional conduct.	4.78	4.68	22.60
40	Maintain confidentiality of patient records in accordance with laws and regulations.	4.71	4.61	22.10
41	Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.	4.73	4.61	22.10
42	Maintain security of patient records in accordance with laws and regulations.	4.38	4.36	20.34
44	Adhere to laws and regulations regarding excessive treatment.	4.32	4.35	20.17
39	Obtain informed consent from patient in accordance with laws and regulations.	3.51	3.88	15.64
45	Report reasonable suspicion of child, elder, or dependent adult abuse or neglect as legally mandated.	1.52	4.21	6.87
38	Communicate with other dental professionals using telehealth methods and technology.	1.36	1.80	4.55

APPENDIX C | KNOWLEDGE STATEMENT IMPORTANCE RATINGS

Content Area 1: Treatment Preparation

Number	Knowledge Statement	Mean Importance
4	Knowledge of instruments, equipment, and materials used for dental hygiene treatment.	4.37
2	Knowledge of conditions related to oral-systemic health (e.g., diabetes, cardiovascular disease).	4.30
1	Knowledge of procedures and protocols to prepare and break down operatory.	4.30
3	Knowledge of techniques for assessing vital signs.	4.24

Content Area 2: Dental Hygiene Treatment

Number	Knowledge Statement	Mean Importance
13	Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using hand instruments.	3.75
15	Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using hand instruments.	3.75
21	Knowledge of indications, contraindications, and side effects for administering local anesthesia during dental hygiene treatment.	3.72
8	Knowledge of methods to assess periodontal conditions using clinical and radiographic findings.	3.71
41	Knowledge of methods to maintain the integrity (sharpening or sterilizing) of hand instruments for dental hygiene treatment.	3.68
7	Knowledge of procedures for assessing the oral cavity.	3.64
14	Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using power instruments.	3.63
16	Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using power instruments.	3.60
19	Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.	3.60
25	Knowledge of techniques for detecting the presence or absence of biofilm and calculus.	3.50
11	Knowledge of methods to develop dental hygiene care plans to assess patient needs.	3.44
10	Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment.	3.40
22	Knowledge of procedures to administer nitrous oxide and local anesthetic.	3.38
33	Knowledge of personal habits that affect oral health conditions (e.g., tobacco, substance abuse, eating disorders).	3.36
17	Knowledge of procedures to administer topical anesthetic.	3.35
27	Knowledge of agents used for the management of periodontal disease.	3.33
18	Knowledge of conditions that require application of topical anesthesia.	3.31
26	Knowledge of application techniques for fluoride and caries-preventing agents.	3.26
20	Knowledge of indications, contraindications, and side effects for administering nitrous oxide during dental hygiene treatment.	3.17
9	Knowledge of techniques for exposing and developing dental radiographs.	3.15
23	Knowledge of soft tissue curettage procedure.	3.05
30	Knowledge of application of agents (e.g., antimicrobials) used for the management of periodontal disease.	3.04
28	Knowledge of application of agents used for control of caries (e.g., pit and fissure sealants, ITR).	2.70
12	Knowledge of procedures to remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.	2.54
32	Knowledge of procedures for cleaning and polishing removable appliances (e.g., dentures).	2.47

Content Area 2: Dental Hygiene Treatment, continued

Number	Knowledge Statement	Mean Importance
24	Knowledge of methods to perform air polishing to remove supragingival and subgingival biofilm and stain.	1.78
31	Knowledge of procedures to place interim therapeutic restorations.	1.20
29	Knowledge of techniques for taking impressions.	1.13

**Note: Shaded knowledge statement was deleted by SMEs. (See Chapter 4).*

Content Area 3: Patient Education

Number	Knowledge Statement	Mean Importance
37	Knowledge of individualized oral hygiene instructions to address specific patient needs.	3.46
34	Knowledge of methods for communicating a dental hygiene care plan with patient.	3.42
35	Knowledge of instructions for postoperative care.	3.39
36	Knowledge of nutritional counseling related to oral health.	2.90

Content Area 4: Infection Control

Number	Knowledge Statement	Mean Importance
38	Knowledge of standards for infection control.	3.89
39	Knowledge of techniques for disinfecting and sterilizing dental hygiene equipment.	3.87
40	Knowledge of techniques for sterilizing dental hygiene instruments.	3.86
5	Knowledge of standard precautions required to protect patients during dental hygiene treatment.	3.81
6	Knowledge of standard precautions required to protect health care workers during dental hygiene treatment.	3.80

Content Area 5: Documentation

Number	Knowledge Statement	Mean Importance
45	Knowledge of basic characteristics of normal and abnormal oral conditions.	3.70
44	Knowledge of different types of periodontal conditions.	3.65
47	Knowledge of methods and protocol for updating patient medical history.	3.61
49	Knowledge of protocol for documenting dental hygiene services performed.	3.61
48	Knowledge of methods and protocol for documenting in patient dental records.	3.39
46	Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist.	3.38

Content Area 6: Laws, Regulations, and Ethics

Number	Knowledge Statement	Mean Importance
57	Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California dental hygiene license.	3.60
59	Knowledge of laws and regulations regarding continuing education requirements to maintain dental hygiene license.	3.54
54	Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting.	3.53
52	Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.	3.43
55	Knowledge of laws and regulations regarding excessive treatment.	3.32
53	Knowledge of laws and regulations regarding maintaining physical and electronic patient records.	3.31
56	Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse or neglect.	3.28
51	Knowledge of laws and regulations related to informed consent.	3.22
58	Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.	3.12
50	Knowledge of methods for communicating with health care providers using telehealth.	1.16

APPENDIX D | EMAIL INVITATION TO PRACTITIONERS

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Dear Licensee,

The Dental Hygiene Board of California is requesting your assistance with an important study that will define the entry-level job tasks of the Registered Dental Hygienist (RDH) in California. The results of the study will serve to inform the content of the RDH Licensing Examination in California.

Please complete the questionnaire by July 1, 2019.

Thank you for your participation!

[redacted]
California Department of Consumer Affairs
Office of Professional Examination Services (OPES)
2420 Del Paso Road, Suite 265, Sacramento, CA 95834
[redacted]

Begin Survey

Please do not forward this email as its survey link is unique to you.
Privacy | Unsubscribe

Powered by SurveyMonkey

APPENDIX E | QUESTIONNAIRE

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Occupational Analysis of the Registered Dental Hygienist Profession

Dear Licensed Registered Dental Hygienist,

Thank you for participating in this study of the dental hygiene profession in California, a project of the Dental Hygiene Board of California (Board).

The Board is conducting an occupational analysis of the dental hygiene profession. The purpose of the occupational analysis (OA) is to identify the important tasks performed by registered dental hygienists in their current work and the knowledge required to perform those tasks effectively. Results of the OA will be used to ensure that the examinations required for licensure as a registered dental hygienist in California reflect current practice. Your participation in the OA is essential. The Board requires responses from many licensees to achieve representation from different geographic regions of the state and from different work settings.

Please take the time to complete the questionnaire as it relates to your current work. Your responses will be kept confidential and will not be tied to your license or any other personal information. Individual responses will be combined with the responses of other dental hygienists and only group data will be analyzed.

For your convenience, you do not have to complete the questionnaire in a single session. Before you exit, complete the page that you are on. You can resume where you stopped as long as you reopen the questionnaire from the same computer and use the same web browser. The web link is available 24 hours a day, 7 days a week.

To begin the questionnaire, please click Next. Any question marked with an asterisk must be answered before you can progress through the questionnaire. Please submit the completed questionnaire by July 1, 2019.

If you have any questions or need assistance, please contact [redacted] at [redacted]@dca.ca.gov.

The Board welcomes your feedback and appreciates your time!

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part I - Personal Data

The information you provide here is voluntary and confidential. It will be treated as personal information subject to the Information Practices Act (Civil Code, Section 1798 et seq.), and will be used only for the purpose of analyzing the information from this questionnaire.

* 1. Are you currently practicing as a California-licensed dental hygienist?

- ◯ Yes
- ◯ No

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part I - Personal Data (Continued)

2. How many years have you been practicing in California as a licensed dental hygienist?

- ◯ 0 to 5 years
- ◯ 6 to 10 years
- ◯ 11 to 15 years
- ◯ 16 or more years

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part I - Personal Data (continued)

3. How many hours per week do you work as a licensed dental hygienist?

- ◯ 0 to 10 hours
- ◯ 11 to 20 hours
- ◯ 21 to 30 hours
- ◯ 31 to 40 hours
- ◯ 41 or more hours

4. What describes the location of your primary work setting?

- ◯ Urban (more than 50,000)
- ◯ Rural (50,000 or fewer)

5. How many different offices employ you as a registered dental hygienist?

- ◯ One
- ◯ Two
- ◯ Three or more

6. How would you describe your primary/current work setting?

- ◯ General
- ◯ Endodontic
- ◯ Orthodontic
- ◯ Periodontic
- ◯ Pedodontic
- ◯ Oral surgery
- ◯ Other (please specify)

7. What other California licenses or certifications do you hold?

- ◯ None
- ◯ RDA
- ◯ RDAEF
- ◯ Periodontal soft tissue curettage
- ◯ Administration of local anesthesia
- ◯ Administration of nitrous oxide and oxygen
- ☐ Other (please specify)

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part I - Personal Data (continued)

8. In what California county do you perform the majority of your work?

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- Del Norte
- El Dorado
- Fresno
- Glenn
- Humboldt
- Imperial
- Inyo
- Kern
- Kings
- Lake
- Lassen
- Los Angeles
- Madera
- Marin
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono
- Monterey
- Napa
- Nevada
- Orange
- Placer
- Plumas
- Riverside
- Sacramento
- San Benito
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Sierra
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tehama
- Trinity
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba

Part II - Task Rating Instructions

In this part of the questionnaire, you will be presented with 47 tasks reflecting the nature of dental hygiene practice in California.

Please rate each task as it relates to your current practice.

Your frequency and importance ratings should be separate and independent ratings. Therefore, the ratings that you assign on one rating scale should not influence the ratings that you assign on the other rating scale. For example, you may perform a task frequently, but that task may not be important. Or you may perform a task infrequently, but that task may be very important.

If the task is NOT part of your current practice, rate the task "0" (zero) frequency and "0" (zero) importance. Tasks that you perform frequently should be rated high on the frequency scale and tasks that are important to your work as a dental hygienist should be rated high on the importance scale.

Choose the rating that best fits each task.

Please use the scales below to rate the tasks on the following pages.

FREQUENCY SCALE

HOW OFTEN do you perform this task in your current practice? Consider all of the practice tasks you have performed over the past year and make your judgment relative to all other tasks you perform.

0 – DOES NOT APPLY. I do not perform this task in my current practice.
1 – RARELY. I perform this task the least often in my current practice relative to other tasks I perform.
2 – SELDOM. I perform this task less often than most other tasks I perform in my current practice.
3 – REGULARLY. I perform this task as often as other tasks I perform in my current practice.
4 – OFTEN. I perform this task more often than most other tasks I perform in my current practice.
5 – VERY OFTEN. This task is one of the tasks I perform most often in my current practice relative to other tasks I perform.

IMPORTANCE SCALE

HOW IMPORTANT is performance of this task for effective performance in your current practice? Consider all of the job tasks you have performed over the past year and make your judgment relative to all other tasks you perform.

0 – DOES NOT APPLY. I do not perform this task in my current practice.

1 – NOT IMPORTANT. This task is not important for effective performance in my current practice.
2 – FAIRLY IMPORTANT. This task is somewhat important for effective performance in my current practice.
3 – IMPORTANT. This task is important for effective performance in my current practice.
4 – VERY IMPORTANT. This task is very important for effective performance in my current practice.
5 – CRITICALLY IMPORTANT. This task is extremely important for effective performance in my current practice.

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part II - Treatment Preparation

9. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
1. Prepare operatory for dental hygiene treatment.		
2. Review patient dental records and medical history.		
3. Select instruments, equipment, and materials for dental hygiene treatment.		
4. Provide patient with eyewear and bib to protect patient during dental hygiene treatment.		
5. Wear personal protective equipment (PPE) before providing treatment to help prevent spread of disease.		
6. Take patient vital signs.		

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part II - Dental Hygiene Treatment

10. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
7. Perform oral health screening.		
8. Complete a comprehensive periodontal assessment.		
9. Expose dental radiographs to assist with diagnosis of caries or periodontal conditions.		
10. Develop dental hygiene care plan that correlates with findings from periodontal assessment.		
11. Modify dental hygiene treatment plan based on current information.		
12. Perform nonsurgical periodontal procedures (e.g., scaling, root planing).		
13. Perform oral prophylaxis to remove hard and soft deposits, and stains.		
14. Administer topical anesthetic to patients.		
15. Administer nitrous oxide and local anesthetic under direct supervision of a dentist.		
16. Perform soft tissue curettage under direct supervision of a dentist.		
17. Perform air polishing to remove supragingival and subgingival biofilm and stain.		
18. Evaluate the presence or absence of biofilm and calculus before and after instrumentation.		
19. Apply fluorides and other caries-preventing agents to patients.		
20. Take impressions for nondiagnostic cast models.		
21. Apply topical, therapeutic, and subgingival agents for the control of caries and periodontal disease.		
22. Place interim therapeutic restoration after diagnosis by dentist.		
23. Clean and polish removable appliances.		
24. Recognize oral health conditions resulting from personal habits (e.g., tobacco, substance abuse, eating disorders).		

Part II - Patient Education

11. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
25. Discuss scheduled dental hygiene treatment with patient.		
26. Communicate assessment findings and dental hygiene care plan to patient.		
27. Provide instructions to patients for oral hygiene and postoperative care.		
28. Provide nutritional counseling to improve oral health.		

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part II - Infection Control

12. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
29. Maintain a safe and clean work environment.		
30. Adhere to infection control policies and protocols for performing dental hygiene treatment.		
31. Sterilize instruments in accordance with California infection control guidelines.		
32. Maintain instruments to ensure efficient functioning for dental hygiene treatment.		

Part II - Documentation and Recordkeeping

13. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
33. Record conditions of the oral cavity.		
34. Report abnormalities of the oral cavity to the dentist.		
35. Record existing and recommended restorative treatment as diagnosed by the dentist.		
36. Update patient dental records and medical history, including chief complaints and concerns.		
37. Document in patient record the dental services performed.		

Part II - Laws and Regulations

14. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
38. Communicate with other dental professionals using telehealth methods and technology.		
39. Obtain informed consent from patient in accordance with laws and regulations.		
40. Maintain confidentiality of patient records in accordance with laws and regulations.		
41. Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.		
42. Maintain security of patient records in accordance with laws and regulations.		
43. Adhere to laws and regulations regarding professional conduct.		
44. Adhere to laws and regulations regarding excessive treatment.		
45. Report reasonable suspicion of child, elder, or dependent adult abuse, or neglect as legally mandated.		
46. Maintain dental hygiene license according to laws and regulations.		
47. Maintain required continuing education units for license renewal.		

Part III - Knowledge Rating Instructions

In this part of the questionnaire, you will be presented with 59 knowledge statements. Please rate each knowledge statement based on how important you feel the knowledge is to the effective performance of your tasks.

If a knowledge is NOT a part of your current practice, rate the statement "0" (zero)importance and go on to the next statement.

Use the following scale to rate each knowledge statement's importance.

IMPORTANCE SCALE

HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?
0 – DOES NOT APPLY. This knowledge is not required for effective performance of tasks in my current practice.
1 – NOT IMPORTANT. This knowledge is not important for effective performance of tasks in my current practice.
2 – FAIRLY IMPORTANT. This knowledge is somewhat important for effective performance of tasks in my current practice.
3 – IMPORTANT. This knowledge is important for effective performance of tasks in my current practice.
4 – VERY IMPORTANT. This knowledge is very important for effective performance of tasks in my current practice.
5 – CRITICALLY IMPORTANT. This knowledge is extremely important for effective performance of tasks in my current practice.

Part III - Treatment Preparation

15. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
1. Knowledge of procedures and protocols to prepare and break down operatory.	◯	◯	◯	◯	◯	◯
2. Knowledge of conditions related to oral-systemic health (e.g., diabetes, cardiovascular disease).	◯	◯	◯	◯	◯	◯
3. Knowledge of techniques for assessing vital signs.	◯	◯	◯	◯	◯	◯
4. Knowledge of instruments, equipment, and materials used for dental hygiene treatment.	◯	◯	◯	◯	◯	◯
5. Knowledge of standard precautions required to protect patients during dental hygiene treatment.	◯	◯	◯	◯	◯	◯
6. Knowledge of standard precautions required to protect health care workers during dental hygiene treatment.	◯	◯	◯	◯	◯	◯

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part III - Dental Hygiene Treatment

16. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
7. Knowledge of procedures for assessing the oral cavity.	○	○	○	○	○	○
8. Knowledge of methods to assess periodontal conditions.	○	○	○	○	○	○
9. Knowledge of techniques for exposing and developing dental radiographs.	○	○	○	○	○	○
10. Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment.	○	○	○	○	○	○
11. Knowledge of methods to develop dental hygiene care plans to assess patient needs.	○	○	○	○	○	○
12. Knowledge of procedures to remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.	○	○	○	○	○	○
13. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using hand instruments.	○	○	○	○	○	○
14. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using power instruments.	○	○	○	○	○	○
15. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using hand instruments.	○	○	○	○	○	○
16. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using power instruments.	○	○	○	○	○	○
17. Knowledge of procedures to administer topical anesthetic.	○	○	○	○	○	○
18. Knowledge of conditions that require application of topical anesthesia.	○	○	○	○	○	○
19. Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.	○	○	○	○	○	○

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
20. Knowledge of indications, contraindications, and side effects for administering nitrous oxide during dental hygiene treatment.	○	○	○	○	○	○
21. Knowledge of indications, contraindications, and side effects for administering local anesthesia during dental hygiene treatment.	○	○	○	○	○	○
22. Knowledge of procedures to administer nitrous oxide and local anesthetic.	○	○	○	○	○	○
23. Knowledge of soft tissue curettage procedure.	○	○	○	○	○	○
24. Knowledge of methods to perform air polishing to remove supragingival and subgingival biofilm and stain.	○	○	○	○	○	○
25. Knowledge of techniques for detecting the presence or absence of biofilm and calculus.	○	○	○	○	○	○
26. Knowledge of application techniques for fluoride and other caries-preventing agents.	○	○	○	○	○	○
27. Knowledge of agents used for control of caries and periodontal disease.	○	○	○	○	○	○
28. Knowledge of application of agents used for control of caries (e.g., pit and fissure sealants, ITR).	○	○	○	○	○	○
29. Knowledge of techniques for taking impressions.	○	○	○	○	○	○
30. Knowledge of application of agents used for control of periodontal disease (e.g., antimicrobials).	○	○	○	○	○	○
31. Knowledge of procedures to place interim therapeutic restorations.	○	○	○	○	○	○
32. Knowledge of procedures for cleaning and polishing removable appliances (e.g., dentures).	○	○	○	○	○	○
33. Knowledge of personal habits that affect oral health conditions (e.g., tobacco, substance abuse, eating disorders).	○	○	○	○	○	○

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part III - Patient Education

17. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
34. Knowledge of methods for communicating a dental hygiene care plan with patient.	○	○	○	○	○	○
35. Knowledge of instructions for post-operative care.	○	○	○	○	○	○
36. Knowledge of nutritional counseling related to oral health.	○	○	○	○	○	○
37. Knowledge of individualized oral hygiene instructions to address specific patient needs.	○	○	○	○	○	○

Part III - Infection Control

18. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
38. Knowledge of standards for infection control.	○	○	○	○	○	○
39. Knowledge of techniques for disinfecting dental hygiene equipment.	○	○	○	○	○	○
40. Knowledge of techniques for sterilizing dental hygiene instruments.	○	○	○	○	○	○
41. Knowledge of methods to maintain the integrity (sharpening or sterilizing) of hand instruments for dental hygiene treatment.	○	○	○	○	○	○
42. Knowledge of procedures for maintaining (i.e., replacing filter) dental hygiene power instruments.	○	○	○	○	○	○
43. Knowledge of protocols to maintain dental hygiene equipment in working condition.	○	○	○	○	○	○

Part III - Documentation and Recordkeeping

19. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
44. Knowledge of different types of periodontal conditions.	○	○	○	○	○	○
45. Knowledge of basic characteristics of normal and abnormal oral conditions.	○	○	○	○	○	○
46. Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist.	○	○	○	○	○	○
47. Knowledge of methods and protocol for updating patient medical history.	○	○	○	○	○	○
48. Knowledge of methods and protocol for charting patient dental records.	○	○	○	○	○	○
49. Knowledge of protocol for documenting dental hygiene services performed.	○	○	○	○	○	○

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

Part III - Laws and Regulations

20. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
50. Knowledge of methods for communicating with health care providers using telehealth.	○	○	○	○	○	○
51. Knowledge of laws and regulations related to informed consent.	○	○	○	○	○	○
52. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.	○	○	○	○	○	○
53. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.	○	○	○	○	○	○
54. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting.	○	○	○	○	○	○
55. Knowledge of laws and regulations regarding excessive treatment.	○	○	○	○	○	○
56. Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse and neglect.	○	○	○	○	○	○
57. Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California dental hygiene license.	○	○	○	○	○	○
58. Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.	○	○	○	○	○	○
59. Knowledge of laws and regulations regarding continuing education requirements to maintain dental hygiene license.	○	○	○	○	○	○

2019 Registered Dental Hygienist Occupational Analysis Questionnaire

THANK YOU!

You have completed this questionnaire! Thank you for participating!

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DHBC
Dental Hygiene
Board of California

OCCUPATIONAL ANALYSIS OF THE REGISTERED DENTAL HYGIENIST IN ALTERNATIVE PRACTICE PROFESSION

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

DENTAL HYGIENE BOARD OF CALIFORNIA

OCCUPATIONAL ANALYSIS OF THE REGISTERED DENTAL HYGIENIST IN ALTERNATIVE PRACTICE PROFESSION

September 2019

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
OFFICE OF PROFESSIONAL EXAMINATION SERVICES

EXECUTIVE SUMMARY

The Dental Hygiene Board of California (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct an occupational analysis (OA) of the registered dental hygienist in alternative practice (RDHAP) profession in California. The purpose of the OA is to define practice for RDHAPs in terms of the actual tasks that newly licensed RDHAPs must be able to perform safely and effectively at the time of licensure.

OPES test specialists began by researching the profession (e.g., related OA reports, articles, industry publications) and conducting semi-structured telephone interviews with licensed RDHAPs working in locations throughout California. The purpose of these interviews was to identify the tasks performed by RDHAPs and to specify the knowledge required to perform those tasks in a safe and effective manner. Using the information gathered from the research and the interviews, OPES test specialists developed a preliminary list of tasks performed in the RDHAP profession along with knowledge statements representing the knowledge needed to perform those tasks.

In April 2019, OPES convened a workshop to review and refine the preliminary lists of tasks and knowledge statements derived from the telephone interviews. The workshop was comprised of licensed RDHAPs, or subject matter experts (SMEs), with diverse backgrounds in the profession (i.e., location of practice, years licensed, specialty). These SMEs also identified changes and trends in the RDHAP profession, determined demographic questions for the OA questionnaire, and performed a preliminary linkage of the tasks and knowledge statements to ensure that all tasks had a related knowledge statement and all knowledge statements had a related task. Additional tasks and knowledge statements were created as needed to complete the scope of the content areas of the description of practice.

After completing the April 2019 workshop, OPES test specialists developed a three-part OA questionnaire to be completed by RDHAPs statewide. Development of the OA questionnaire included a pilot study that was conducted using a group of licensed RDHAPs. The feedback from those participants was incorporated into the final questionnaire.

In the first part of the OA questionnaire, RDHAPs were asked to provide demographic information relating to their work settings and practice. In the second part, RDHAPs were asked to rate specific tasks in terms of frequency (i.e., how often the RDHAP performs the task in the RDHAP's current practice) and importance (i.e., how important the task is to effective performance of the RDHAP's current practice). In the third part, RDHAPs were asked to rate specific knowledge statements in terms of how important each knowledge statement is to performance of the RDHAP's current practice.

In June 2019, on behalf of the Board, OPES distributed an email invitation to all 507 licensed RDHAPs in California, inviting them to complete the OA questionnaire online. A total of 88 RDHAPs, or 17.4%, responded by accessing the online OA questionnaire. The final sample size included in the data analysis was 68, or 13.4% of the sampled population. This response rate

reflects two adjustments. First, OPES excluded data from respondents who indicated they were not currently licensed and practicing as RDHAPs in California. Second, questionnaires containing a large volume of incomplete or unresponsive data were removed. The demographic composition of the respondent sample appears to be representative of the licensed RDHAP population in California.

OPES test specialists then performed data analyses of the task and knowledge ratings obtained from the OA questionnaire respondents. The task frequency and importance ratings were combined to derive an overall criticality index for each task statement. The mean importance rating was used as the criticality index for each knowledge statement.

Once the data was analyzed, OPES conducted an additional workshop with SMEs in July 2019. The SMEs evaluated the criticality indices and determined whether any tasks or knowledge statements should be eliminated. The SMEs in this group also established the final linkage between tasks and knowledge statements, organized the tasks and knowledge statements into content areas, and defined those areas. The SMEs then evaluated and confirmed the content area weights of the examination outline. During the July 2019 workshop, the SMEs also determined the content areas and weights for the California RDHAP Laws and Ethics Examination Outline. The examination outline is structured into five content areas.

The examination outline for the RDHAP examination is structured into six content areas weighted by criticality relative to the other content areas. The outline provides a description of the scope of practice for RDHAPs, and it also identifies the tasks and knowledge critical to safe and effective RDHAP practice in California at the time of licensure. Additionally, the examination outline provides a basis for evaluating the degree to which the content of any examination under consideration measures content critical to RDHAP practice in California.

At this time, California licensure as an RDHAP is granted by meeting educational and experience requirements and by passing the California RDHAP Laws and Ethics Examination.

OVERVIEW OF THE RDHAP EXAMINATION OUTLINE

Content Area		Content Area Description	Percent Weight
1.	Treatment Preparation	This area assesses the candidate's knowledge of preparing equipment and patients for dental hygiene services in alternative settings, including coordinating treatment with other health care professionals.	15
2.	Dental Hygiene Treatment	This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment in alternative settings.	25
3.	Patient Education	This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.	9
4.	Infection Control	This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.	10
5.	Documentation	This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental and medical records in alternative settings.	11
6.	Laws, Regulations, and Ethics	This area assesses the candidate's knowledge of operating as an RDHAP, submitting claims for services performed, licensing requirements, professional conduct, patient confidentiality, using telehealth methods and technology, and mandated reporting.	30
		Total	**100**

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER 1 | INTRODUCTION

PURPOSE OF THE OCCUPATIONAL ANALYSIS

The Dental Hygiene Board of California (Board) requested that the Department of Consumer Affairs' Office of Professional Examination Services (OPES) conduct an occupational analysis (OA) as part of the Board's comprehensive review of the registered dental hygienist in alternative practice (RDHAP) profession in California. The purpose of the OA is to identify critical activities performed by RDHAPs in California and to develop the California RDHAP Laws and Ethics Examination.

CONTENT VALIDATION STRATEGY

OPES used a content validation strategy to ensure that the OA reflected the actual tasks performed by practicing RDHAPs. OPES incorporated the technical expertise of California RDHAPs throughout the OA process to ensure that the identified tasks and knowledge statements directly reflect requirements for performance in the current RDHAP profession.

PARTICIPATION OF SUBJECT MATTER EXPERTS

The Board selected California RDHAPs to participate as subject matter experts (SMEs) during the phases of the OA. The SMEs were selected from a broad range of practice settings, geographic locations, and experience backgrounds. During the development phase of the OA, the SMEs provided information regarding the different aspects of current dental hygiene practice. The SMEs also provided technical expertise during the workshop that was convened to evaluate and refine the content of tasks and knowledge statements before administration of the OA questionnaire. After the administration of the OA questionnaire, OPES convened an additional group of SMEs to review the results and finalize the examination outline, which ultimately provides the basis of the description of practice.

ADHERENCE TO LEGAL STANDARDS AND GUIDELINES

Licensing, certification, and registration programs in the State of California adhere strictly to federal and state laws and regulations, as well as professional guidelines and technical standards. For the purpose of OAs, the following laws and guidelines are authoritative:

- California Business and Professions Code section 139.
- Uniform Guidelines on Employee Selection Procedures (1978), Code of Federal Regulations, Title 29, Section 1607.
- California Fair Employment and Housing Act, Government Code section 12944.

- *Principles for the Validation and Use of Personnel Selection Procedures* (2003), Society for Industrial and Organizational Psychology (SIOP).

- *Standards for Educational and Psychological Testing* (2014), American Educational Research Association, American Psychological Association, and National Council on Measurement in Education.

For a licensure examination to meet these standards, it must be solidly based upon RDHAP activities required for practice.

DESCRIPTION OF OCCUPATION

The RDHAP occupation is described as follows in sections 1907, 1908, 1910, and 1926 of the California Business and Professions Code:

Section 1907:

(a) All functions that may be performed by a registered dental assistant.

Section 1908:

(a) The practice of dental hygiene includes dental hygiene assessment and development, planning, and implementation of a dental hygiene care plan. It also includes oral health education, counseling, and health screenings.

Section 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.

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

(a) Residences of the homebound.
(b) Schools.
(c) Residential facilities and other institutions.
(d) Dental health professional shortage areas, as certified by the Office of Statewide Health Planning and Development in accordance with existing office guidelines.

CHAPTER 2 | OCCUPATIONAL ANALYSIS QUESTIONNAIRE

SUBJECT MATTER EXPERT INTERVIEWS

The Board provided OPES with a list of RDHAPs to contact for telephone interviews. During the semi-structured interviews, six SMEs were asked to identify all of the activities they perform that are specific to the RDHAP profession. The SMEs outlined major content areas of their practice and confirmed the tasks performed in each content area. The SMEs were also asked to identify the knowledge necessary to perform each task safely and competently.

TASKS AND KNOWLEDGE STATEMENTS

To develop tasks and knowledge statements, OPES test specialists integrated the information gathered from literature reviews of profession-related sources (e.g., related OA reports, articles, industry publications) and from interviews with SMEs.

In April 2019, OPES test specialists facilitated a workshop with eight SMEs from diverse backgrounds (i.e., years licensed, specialty, and practice location) to evaluate the task and knowledge statements for technical accuracy and comprehensiveness. The SMEs also assigned each statement to a content area and verified that the content areas were independent and nonoverlapping. In addition, the SMEs performed a preliminary linkage of the tasks and knowledge statements to ensure that every task had a related knowledge statement and every knowledge statement had a related task. The SMEs also verified proposed demographic questions for the OA questionnaire, including questions regarding scope of practice and practice setting.

Once the lists of task and knowledge statements and the demographic questions were verified, OPES used this information to develop an online questionnaire that was sent to California RDHAPs for RDHAPs to complete.

QUESTIONNAIRE DEVELOPMENT

OPES test specialists developed an online OA questionnaire designed to solicit RDHAPs' ratings of the tasks and knowledge statements. The surveyed RDHAPs were instructed to rate each task in terms of how often they perform the task (Frequency) and in terms of how important the task is to effective performance of their current practice (Importance). In addition, they were instructed to rate each knowledge statement in terms of how important that specific knowledge is to performance of their current practice (Importance). The OA questionnaire also included a demographic section for purposes of developing an accurate profile of the respondents. The OA questionnaire can be found in Appendix E.

PILOT STUDY

Before administering the final questionnaire, OPES conducted a pilot study of the online questionnaire. The draft questionnaire was reviewed by the Board and then sent to seven SMEs who had participated in the tasks and knowledge statement development workshop. OPES received feedback to the pilot study from five respondents. The respondents reviewed the tasks and knowledge statements, provided the estimated time for completion, and reviewed the online navigation and ease of use of the questionnaire. OPES used this feedback to develop the final questionnaire.

CHAPTER 3 | RESPONSE RATE AND DEMOGRAPHICS

SAMPLING STRATEGY AND RESPONSE RATE

In June 2019, on behalf of the Board, OPES sent emails to all 507 licensed RDHAPs in California inviting them to complete the OA questionnaire online. The email invitation can be found in Appendix D.

Of the 507 RDHAPs in the sample group, 88 licensed RDHAPs, or 17.4 percent responded by accessing the online questionnaire. The final sample size included in the data analysis was 68, or 13.4 percent of the population that was invited to complete the questionnaire. This response rate reflects two adjustments. First, OPES excluded data from respondents who indicated they were not currently licensed and practicing as RDHAPs in California. Second, questionnaires containing a large volume of missing or unresponsive data were also excluded. The respondent sample appears to be representative of the population of California RDHAPs based on the sample's demographic composition.

DEMOGRAPHIC SUMMARY

As shown in Table 1 and Figure 1, 41.2% of the respondents included in the analysis reported having been licensed for 5 years or less, 29.4% for 6-10 years, 22.1% for 11-15 years, and 7.4% for more than 16 years.

As shown in Table 2 and Figure 2, 61.8% reported working 1 to 10 hours per week, 13.2% reported working 11 to 20 hours per week, 11.8% reported working 31 to 40 hours per week, 10.3% reported working 21 to 30 hours per week, and 2.9% of the respondents reported working 41 or more hours per week,

As shown in Table 4 and Figure 4, 51.5% of the respondents reported being employed by one dental office, 17.6% reported being employed by three or more dental offices, 8.8% reported being employed by two dental offices, and 22.1% reported operating a mobile site.

When asked to indicate their primary practice setting, 45.6% of the respondents reported general dentistry, 26.5% reported working in public health, 16.2% reported geriatrics, 5.9% reported periodontics dentistry, and 5.9% reported working in skilled nursing facilities (see Table 5 and Figure 5).

More detailed demographic information from respondents can be found in Tables 1-6 and Figures 1-6.

TABLE 1 – NUMBER OF YEARS LICENSED AS AN RDHAP

YEARS	NUMBER (N)	PERCENT
0 to 5 years	28	41.2
6 to 10 years	20	29.4
11 to 15 years	15	22.1
More than 16 years	5	7.4
Total	68	100*

**NOTE: Percentages do not add to 100 due to rounding.*

FIGURE 1 – NUMBER OF YEARS LICENSED AS AN RDHAP

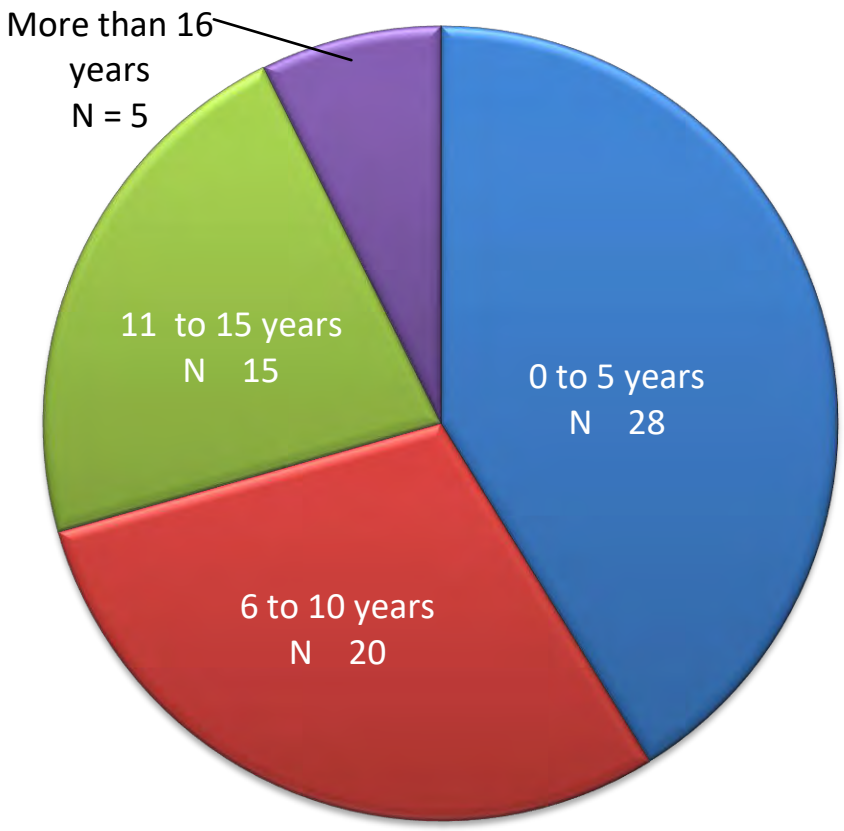


TABLE 2 – HOURS WORKED PER WEEK

HOURS	NUMBER (N)	PERCENT
1 to 10	42	61.8
11 to 20	9	13.2
21 to 30	7	10.3
31 to 40	8	11.8
More than 40 hours	2	2.9
Total	1,456	100

FIGURE 2 – HOURS WORKED PER WEEK

TABLE 3 – LOCATION OF WORK SETTING

LOCATION	NUMBER (N)	PERCENT
Urban (more than 50,000 people)	53	77.9
Rural (fewer than 50,000 people)	15	22.1
Total	68	100

TABLE 4 – NUMBER OF OFFICES IN WHICH RDHAP IS EMPLOYED

YEARS	NUMBER (N)	PERCENT
1	35	51.5
2	6	8.8
3 or more	12	17.6
Mobile site	15	22.1
Total	68	100

FIGURE 3 – NUMBER OF OFFICES IN WHICH RDHAP IS EMPLOYED

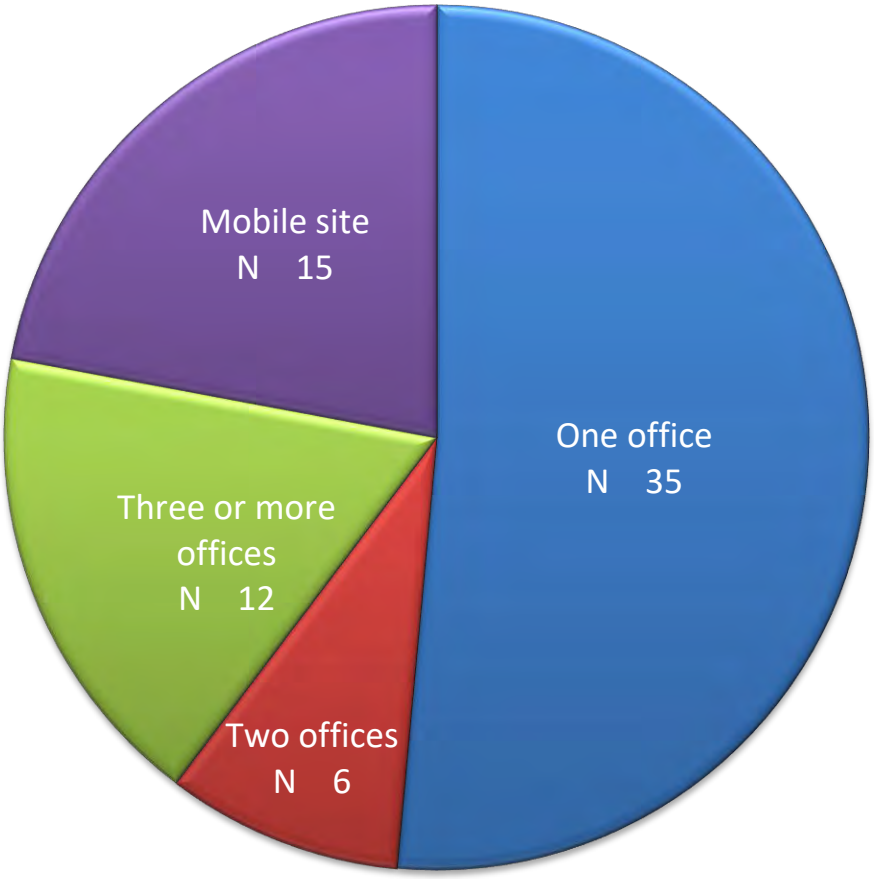


TABLE 5 – PRIMARY PRACTICE SETTING

SETTING	NUMBER (N)	PERCENT
General	31	45.6
Geriatric	11	16.2
Periodontics	4	5.9
Skilled nursing facility	4	5.9
Public health	18	26.5
Total	68	100*

**NOTE: Percentages do not add to 100 due to rounding.*

FIGURE 4 – PRIMARY PRACTICE SETTING

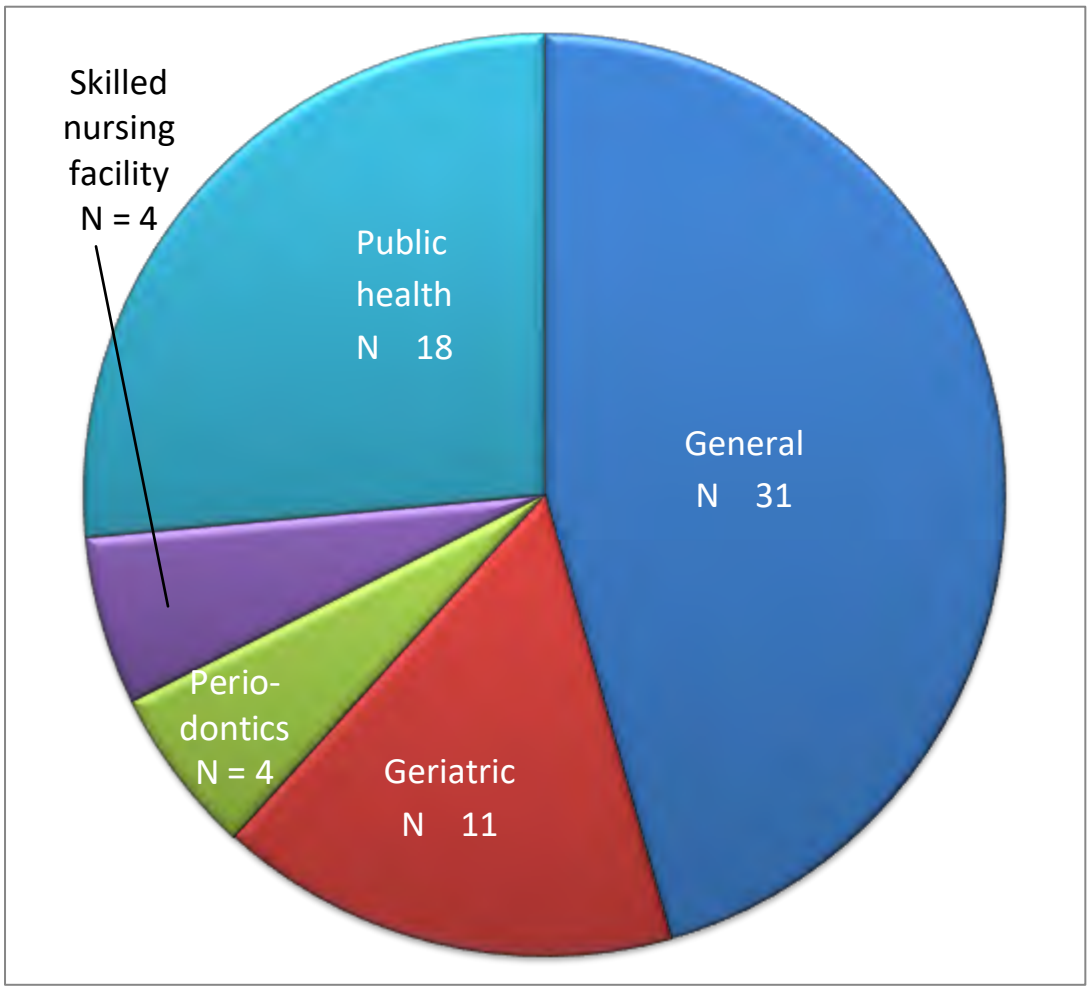
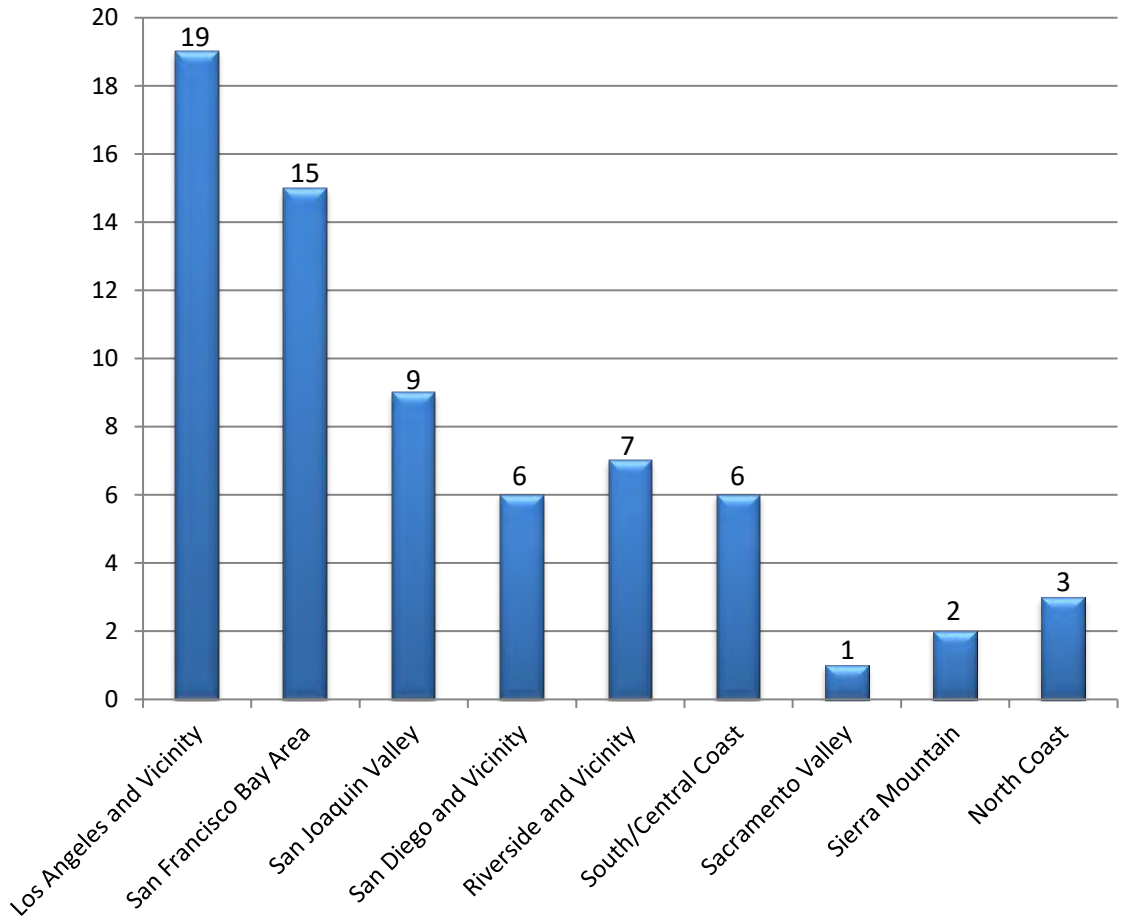


TABLE 6 – RESPONDENTS BY REGION

REGION NAME	NUMBER (N)	PERCENT
Los Angeles County and Vicinity	19	27.9
San Francisco Bay Area	15	22.1
San Joaquin Valley	9	13.2
San Diego County and Vicinity	6	8.8
Riverside and Vicinity	7	10.3
South Coast and Central Coast	6	8.8
Sacramento Valley	1	1.5
Sierra Mountain	2	2.9
North Coast	3	4.4
Total	68	100.0

Appendix A shows a more detailed breakdown of the frequencies by region.

FIGURE 5 – RESPONDENTS BY REGION



CHAPTER 4 | DATA ANALYSIS AND RESULTS

RELIABILITY OF RATINGS

OPES evaluated the task and knowledge statement ratings using a standard index of reliability, coefficient alpha (α), that ranges from 0 to 1. Coefficient alpha is an estimate of the internal consistency of the respondents' ratings of the tasks and knowledge statements. A higher coefficient value indicates more consistency between respondent ratings. Coefficients were calculated for all respondent ratings.

Table 7 displays the reliability coefficients for the task rating scales in each content area. The overall ratings of task frequency and task importance across content areas were highly reliable (frequency α = .952; importance α = .942). Table 8 displays the reliability coefficients for the knowledge statement rating scale in each content area. The overall ratings of knowledge importance across content areas were also highly reliable (α = .974). These results indicate that the responding RDHAPs rated the tasks and knowledge statements consistently throughout the questionnaire.

TABLE 7 – TASK SCALE RELIABILITY

CONTENT AREA	NUMBER OF TASKS	α FREQUENCY	α IMPORTANCE
1. Treatment Preparation	7	.893	.762
2. Dental Hygiene Treatment	17	.879	.912
3. Patient Education	4	.928	.855
4. Infection Control	4	.948	.918
5. Documentation	5	.833	.681
6. Laws, Regulations, and Ethics	16	.869	.829
Total	53	.952*	.942*

**NOTE: The total shown is not the sum of the individual content area rating of task frequency and importance but rather the overall rating of task frequency and task importance.*

TABLE 8 – KNOWLEDGE STATEMENT SCALE RELIABILITY

CONTENT AREA	NUMBER OF KNOWLEDGE STATEMENTS	α IMPORTANCE
1. Treatment Preparation	6	.862
2. Dental Hygiene Treatment	25	.933
3. Patient Education	4	.938
4. Infection Control	6	.837
5. Documentation	6	.925
6. Laws, Regulations, and Ethics	16	.933
Total	63	.974*

**NOTE: The total shown is not the sum of the individual content area rating of task frequency and importance but rather the overall rating of task frequency and task importance.*

TASK CRITICALITY INDICES

In July 2019, OPES convened a workshop consisting of five SMEs. The purpose of this workshop was to identify the essential tasks and knowledge required for safe and effective dental hygiene practice at the time of licensure. The SMEs reviewed the mean frequency, mean importance, and criticality index for each task. They also reviewed the mean importance rating for each knowledge statement.

To calculate the criticality indices of the task statements, OPES test specialists used the following formula below. For each respondent, the frequency rating (Fi) and the importance rating (Ii) were multiplied for each task. Next, the multiplication products were averaged across respondents as shown below.

Task criticality index = mean [(Fi) X (Ii)]

The tasks were sorted in descending order by criticality index and by content area. The tasks, their mean frequency and importance ratings, and their associated criticality indices are presented in Appendix B.

The SMEs who participated in the July 2019 workshop evaluated the task criticality indices derived from the questionnaire results. OPES test specialists instructed the SMEs to identify a cutoff value to determine if any of the tasks did not have a high enough criticality index to be retained. Based on their review, the SMEs determined that two tasks should be deleted from the content outline (T17 and T20). The SMEs determined that task T34 should also be deleted from the content outline because it was very similar to another task. These task statements are identified in Appendix B.

Additionally, the SMEs determined that three tasks (T54, T55, T56) should be added. These tasks were added to provide linkages with three knowledge statements.

KNOWLEDGE IMPORTANCE RATINGS

To determine the criticality of each knowledge statement, the mean importance (K Imp) rating for each knowledge statement was calculated. The knowledge statements and their mean importance ratings, sorted by descending order of mean importance and grouped by content area, are presented in Appendix C.

The SMEs who participated in the July 2019 workshop that evaluated the task criticality indices also reviewed the knowledge statement mean importance ratings. Based on their review, the SMEs determined that two knowledge statements should be deleted from the content outline (K22 and K27). The eliminated knowledge statements are identified in Appendix C. The exclusion of a knowledge statement from the examination outline does not mean that the knowledge is not used in dental hygiene practice; it means that the SMEs determined that the knowledge was not critical for testing relative to other knowledge within the RDHAP scope of practice.

Additionally, SMEs determined that two knowledge statements (K64, and K65) should be added to further clarify knowledge statements that included multiple subjects.

CHAPTER 5 | EXAMINATION OUTLINE

TASK-KNOWLEDGE LINKAGE

The SMEs who participated in the July 2019 workshop reviewed the preliminary assignments of the tasks and knowledge statements to content areas developed in the April 2019 workshop. The SMEs established the final linkage of specific knowledge statements to task statements. The SMEs reviewed the content areas and wrote descriptions for each content area.

CONTENT AREAS AND WEIGHTS

The SMEs in the July 2019 workshop were also asked to finalize the weights for content areas on the RDHAP examination outline. OPES test specialists presented the SMEs with preliminary weights of the content areas that were calculated by dividing the sum of the criticality indices for the tasks in each content area by the overall sum of the criticality indices for all tasks, as shown below.

$$\frac{\textit{Sum of Criticality Indices for Tasks in Content Area}}{\textit{Sum of Criticality Indices for All Tasks}} = \textit{Percent Weight of Content Area}$$

The SMEs evaluated the preliminary weights by reviewing the following elements for each content area: the group of tasks and knowledge statements, the linkage established between the tasks and knowledge statements, and the relative importance of the tasks to the RDHAP profession in California. The SMEs adjusted the preliminary weights based on what they perceived as the relative importance of the tasks' content to the RDHAP profession in California. A summary of the preliminary and final content area weights for the RDHAP examination outline is presented in Table 9.

TABLE 9 – CONTENT AREA WEIGHTS

CONTENT AREA	Percent Preliminary Weights	Percent Final Weights
1. Treatment Preparation	15	15
2. Dental Hygiene Treatment	25	25
3. Patient Education	9	9
4. Infection Control	10	10
5. Documentation	11	11
6. Laws, Regulations, and Ethics	30	30
Total	100	100

The examination outline for the RDHAP profession is presented in Table 10.

TABLE 10 – EXAMINATION OUTLINE: RDHAP

1. Treatment Preparation (15%) - This area assesses the candidate's knowledge of preparing equipment and patients for dental hygiene services in alternative settings, including coordinating treatment with other health care professionals.

Tasks	*Associated Knowledge Statements*
T1. Prepare operatory for dental hygiene treatment.	K1. Knowledge of procedures and protocols to prepare and breakdown operatory.
T2. Review patient dental records and medical history.	K2. Knowledge of conditions related to oral-systemic health (e.g., diabetes, cardiovascular disease).
T3. Select instruments, equipment, and materials for dental hygiene treatment.	K4. Knowledge of instruments, equipment, and materials used for dental hygiene treatment.
T6. Coordinate treatment and referral with dentist and other health care professionals.	K21. Knowledge of procedures needed for practicing dental hygiene treatment outside of a dental office.
T7. Take patient vital signs.	K3. Knowledge of techniques for assessing vital signs.

2. Dental Hygiene Treatment (25%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment in alternative settings.

Tasks	*Associated Knowledge Statements*
T8. Perform visual oral health screening.	K7. Knowledge of procedures for assessing the oral cavity. K8. Knowledge of assessing periodontal conditions using clinical and radiographic findings.
T9. Complete a comprehensive periodontal assessment.	K7. Knowledge of procedures for assessing the oral cavity. K8. Knowledge of assessing periodontal conditions using clinical and radiographic findings.
T10. Expose dental radiographs to assist with diagnosis of caries or periodontal conditions.	K9. Knowledge of techniques for exposing and developing dental radiographs.
T11. Develop dental hygiene care plan that correlates with findings from periodontal assessment.	K10. Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment. K11. Knowledge of methods to develop dental hygiene care plans to assess patient needs.
T12. Modify dental hygiene treatment plan based on current information.	K10. Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment. K11. Knowledge of methods to develop dental hygiene care plans to assess patient needs.
T13. Provide dental hygiene services in settings outside of a dental office.	K20. Knowledge of work conditions necessary to provide dental hygiene treatment outside of a dental office.
T14. Perform non-surgical periodontal procedures (e.g., scaling, root planing).	K13. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using hand instruments. K14. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using power instruments.
T15. Perform oral prophylaxis to remove hard and soft deposits, and stains.	K15. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using hand instruments. K16. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using power instruments.

2. Dental Hygiene Treatment (25%) - This area assesses the candidate's knowledge of completing a comprehensive oral health assessment, dental hygiene treatment planning, and dental hygiene treatment in alternative settings.

Tasks	*Associated Knowledge Statements*
T16. Administer topical anesthetic to patients.	K17. Knowledge of procedures to administer topical anesthetic. K18. Knowledge of conditions that require application of topical anesthesia. K19. Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.
T18. Evaluate the presence or absence of biofilm and calculus before and after instrumentation.	K23. Knowledge of techniques for detecting the presence or absence of biofilm and calculus.
T19. Apply fluorides and other caries-preventing agents to patients.	K24. Knowledge of application techniques for fluoride and caries-preventing agents. K26. Knowledge of application of agents used for control of caries (e.g., pit and fissure sealants, interim therapeutic restorations). K64. Knowledge of agents used for control of caries.
T21. Apply topical, therapeutic, and subgingival agents for the management of periodontal disease.	K25. Knowledge of agents used for the management of periodontal disease. K28. Knowledge of application of agents (e.g., antimicrobials) used for the management of periodontal disease.
T22. Place interim therapeutic restoration after diagnosis by dentist.	K29. Knowledge of procedures to place ITRs.
T23. Clean and polish removable appliances.	K30. Knowledge of procedures for cleaning and polishing removable appliances (e.g., dentures).
T24. Recognize oral health conditions resulting from personal habits (e.g., tobacco, substance abuse, eating disorders).	K31. Knowledge of personal habits that affect oral health conditions (e.g., tobacco, substance abuse, eating disorders).
T32. Maintain hand instruments for dental hygiene treatment.	K41. Knowledge of sharpening techniques of hand instruments.
T54. Remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.	K12. Knowledge of procedures to remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.

3. Patient Education (9%) - This area assesses the candidate's knowledge of educating patients regarding oral health and individualized oral hygiene instructions.

Tasks	*Associated Knowledge Statements*
T25. Discuss scheduled dental hygiene treatment with patient.	K32. Knowledge of methods for communicating a dental hygiene care plan with patient.
T26. Communicate assessment findings and dental hygiene care plan to patient.	K32. Knowledge of methods for communicating a dental hygiene care plan with patient. K35. Knowledge of individualized oral hygiene instructions to address specific patient needs.
T27. Provide patients with individualized oral hygiene instructions.	K35. Knowledge of individualized oral hygiene instructions to address specific patient needs.
T28. Provide nutritional counseling to improve oral health.	K34. Knowledge of nutritional counseling related to oral health.
T55. Provide postoperative care instructions to patients.	K33. Knowledge of instructions for postoperative care.

4. Infection Control (10%) - This area assesses the candidate's knowledge of maintaining a safe and clean work environment and adhering to infection control protocols and standard precautions.

Tasks	*Associated Knowledge Statements*
T4. Provide patient with eyewear and bib to protect patient during dental hygiene treatment.	K5. Knowledge of standard precautions required to protect patients during dental hygiene treatment.
T5. Wear personal protective equipment (PPE) before providing treatment to help prevent spread of disease.	K5. Knowledge of standard precautions required to protect patients during dental hygiene treatment. K6. Knowledge of standard precautions required to protect health care workers during dental hygiene treatment.
T29. Maintain a safe and clean work environment.	K65. Knowledge of Cal/OSHA laws and regulations pertaining to dental settings.
T30. Adhere to infection control policies and protocols for performing dental hygiene treatment.	K36. Knowledge of standards for infection control.
T31. Sterilize instruments in accordance with California infection control guidelines.	K38. Knowledge of techniques for sterilizing dental hygiene instruments.
T56. Disinfect or sterilize equipment in accordance with California infection control guidelines.	K37. Knowledge of techniques for disinfecting and sterilizing dental hygiene equipment.

5.Documentation (11%) - This area assesses the candidate's knowledge of documenting patient oral health status, procedures performed, and updating patient dental and medical records in alternative settings.

Tasks	*Associated Knowledge Statements*
T33. Document patient oral health status.	K42. Knowledge of different types of periodontal conditions. K43. Knowledge of basic characteristics of normal and abnormal oral conditions. K44. Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist.
T35. Document existing and recommended restorative treatment as diagnosed by the dentist.	K44. Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist. K46. Knowledge of methods and protocol for documenting in patient dental records.
T36. Update patient dental records and medical history, including chief complaints and concerns.	K45. Knowledge of methods and protocol for updating patient medical history. K46. Knowledge of methods and protocol for documenting in patient dental records.
T37. Document in patient records the dental services performed.	K47. Knowledge of protocol for documenting dental hygiene services performed.

6. Laws, Regulations, and Ethics (30%) - This area assesses the candidate's knowledge of operating as an RDHAP, submitting claims for services performed, licensing requirements, professional conduct, patient confidentiality, using telehealth methods and technology, and mandated reporting.

Tasks	*Associated Knowledge Statements*
T38. Communicate with other dental professionals using telehealth methods and technology.	K48. Knowledge of methods for communicating with health care providers using telehealth. K50. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K51. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T39. Obtain written prescription by dental provider for dental hygiene treatment within 18 months of patient care.	K63. Knowledge of laws and regulations regarding written prescriptions from medical and dental providers.
T40. Obtain informed consent from patient in accordance with laws and regulations.	K49. Knowledge of laws and regulations related to informed consent.
T41. Maintain confidentiality of patient records in accordance with laws and regulations.	K50. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.
T42. Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.	K50. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K51. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T43. Maintain security of patient records in accordance with laws and regulations.	K50. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K51. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T44. Adhere to laws and regulations regarding professional conduct.	K52. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting.
T45. Adhere to laws and regulations regarding excessive treatment.	K52. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting. K53. Knowledge of laws and regulations regarding excessive treatment.
T46. Report reasonable suspicion of child, elder, or dependent adult abuse or neglect as legally mandated.	K54. Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse and neglect.
T47. Maintain dental hygiene in alternative practice license according to laws and regulations.	K55. Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California dental hygiene in alternative practice license. K56. Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.

6. Laws, Regulations, and Ethics (30%) - This area assesses the candidate's knowledge of operating as an RDHAP, submitting claims for services performed, licensing requirements, professional conduct, patient confidentiality, using telehealth methods and technology, and mandated reporting.

Tasks	*Associated Knowledge Statements*
T48. Maintain required continuing education units for license renewal.	K57. Knowledge of laws and regulations regarding continuing education requirements to maintain dental hygiene license.
T49. Submit claims to third party providers for dental hygiene services performed.	K59. Knowledge of documentation required to submit claims to third party providers for dental hygiene services performed.
T50. Employ an RDHAP or DA to assist in practice.	K62. Knowledge of laws and regulations related to managing dental hygiene in alternative practice businesses.
T51. Operate a mobile dental hygiene clinic registered as a dental hygiene office or facility.	K62. Knowledge of laws and regulations related to managing dental hygiene in alternative practice businesses.
T52. Adhere to regulations regarding billing, billing codes, and documentation.	K60. Knowledge of procedures for receiving insurance reimbursements. K61. Knowledge of laws and regulations regarding discounted fees and services.
T53. Own and manage an RDHAP business in accordance with laws and regulations.	K62. Knowledge of laws and regulations related to managing an RDHAP business.

CHAPTER 6 | CALIFORNIA REGISTERED DENTAL HYGIENIST IN ALTERNATIVE PRACTICE LAWS AND ETHICS EXAMINATION OUTLINE

At this time, California licensure as an RDHAP is granted to RDHs who have completed the requisite RDHAP education and experience and passed the California RDHAP Laws and Ethics Examination.

The SMEs who participated in the July 2019 workshop were asked to develop a new examination outline for the California RDHAP Laws and Ethics Examination by identifying the tasks and knowledge that they believed were California-specific. The SMEs determined that all task and knowledge statements within the Laws, Regulations, and Ethics content area should remain in the examination outline for the California RDHAP Laws and Ethics Examination.

CONTENT AREAS AND WEIGHTS

In July 2019, OPES facilitated a workshop with five SMEs. Before the workshop, OPES organized the tasks and knowledge statements from the preliminary California RDHAP Laws and Ethics Examination Outline into a proposed examination outline with five content areas. The SMEs determined the final content area names, descriptions, and content area weights. After the examination outline was finalized, OPES renumbered the tasks and knowledge statements. The final examination outline for the California RDHAP Laws and Ethics Examination consists of five content areas and is presented in Table 11. Tables 12 and 13 provide a conversion chart indicating the new tasks and knowledge statement numbers in the California RDHAP Laws and Ethics Examination Outline and the original tasks and knowledge statement numbers in the California RDHAP Examination Outline.

TABLE 11 – EXAMINATION OUTLINE FOR THE CALIFORNIA RDHAP LAWS AND ETHICS EXAMINATION

1. Licensing Requirements (30%) - This area assesses the candidate's knowledge of the California laws and regulations governing the RDHAP's license maintenance.

Tasks	*Associated Knowledge Statements*
T1. Maintain RDHAP license according to laws and regulations.	K1. Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California RDHAP license. K2. Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.
T2. Maintain required continuing education units for license renewal.	K3. Knowledge of laws and regulations regarding continuing education requirements to maintain an RDHAP license.

2. Professional Conduct (16%) - This area assesses the candidate's knowledge of the California laws and regulations governing RDHAP professional conduct.

Tasks	*Associated Knowledge Statements*
T3. Adhere to laws and regulations regarding professional conduct.	K4. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting.
T4. Adhere to laws and regulations regarding excessive treatment.	K4. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting. K5. Knowledge of laws and regulations regarding excessive treatment.

3. Patient Confidentiality (10%) - This area assesses the candidate's knowledge of the California laws and regulations governing patient confidentiality.

Tasks	*Associated Knowledge Statements*
T5. Communicate with other dental professionals using telehealth methods and technology.	K6. Knowledge of methods for communicating with health care providers using telehealth. K7. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K8. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T6. Obtain informed consent from patient in accordance with laws and regulations.	K9. Knowledge of laws and regulations related to informed consent.
T7. Maintain confidentiality of patient records in accordance with laws and regulations.	K7. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.
T8. Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.	K7. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K8. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.
T9. Maintain security of patient records in accordance with laws and regulations.	K7. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality. K8. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.

4. Mandated Reporting (4%) - This area assesses the candidate's knowledge of the California laws and regulations governing mandated reporting.

Task	*Associated Knowledge Statement*
T10. Report reasonable suspicion of child, elder, or dependent adult abuse or neglect as legally mandated.	K10. Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse and neglect.

5. Practice Management (40%) - This area assesses the candidate's knowledge of the California laws and regulations governing the management of an RDHAP business.

Tasks	*Associated Knowledge Statements*
T11. Obtain written prescription by dental provider for dental hygiene treatment within 18 months of patient care.	K11. Knowledge of laws and regulations regarding written prescriptions from medical and dental providers.
T12. Submit claims to third party providers for dental hygiene services performed.	K12. Knowledge of documentation required to submit claims to third party providers for dental hygiene services performed.
T13. Employ an RDHAP or DA to assist in practice.	K13. Knowledge of laws and regulations related to managing RDHAP businesses.
T14. Operate a mobile dental hygiene clinic registered as a dental hygiene office or facility.	K13. Knowledge of laws and regulations related to managing RDHAP businesses.
T15. Adhere to regulations regarding billing, billing codes, and documentation.	K14. Knowledge of procedures for receiving insurance reimbursements. K15. Knowledge of laws and regulations regarding discounted fees and services.
T16. Own and manage an RDHAP business in accordance with laws and regulations.	K13. Knowledge of laws and regulations related to managing RDHAP businesses.

TABLE 12 – RENUMBERING OF TASK STATEMENTS

Original Task Number in California RDHAP Examination Outline	New Task Number in California RDHAP Laws and Ethics Examination Outline
47	1
48	2
44	3
45	4
38	5
40	6
41	7
42	8
43	9
46	10
39	11
49	12
50	13
51	14
52	15
53	16

TABLE 13 – RENUMBERING OF KNOWLEDGE STATEMENTS

Original Knowledge Statement Number in California RDHAP Examination Outline	New Knowledge Statement Number in California RDHAP Laws and Ethics Examination Outline
55	1
56	2
57	3
52	4
53	5
48	6
50	7
51	8
49	9
54	10
63	11
59	12
62	13
60	14
61	15

CHAPTER 7 | CONCLUSION

The OA of the RDHAP profession described in this report provides a comprehensive description of current practice in California. The procedures employed to perform the OA were based upon a content validation strategy to ensure that the results accurately represent the RDHAP profession. Results of this OA can be used to ensure that national examinations under consideration for acceptance or already accepted by the Dental Hygiene Board (Board) measure critical RDHAP content.

By adopting the RDHAP Laws and Ethics Examination Outline contained in this report, the Board ensures that the RDHAP Laws and Ethics Examination reflects current practice.

This report provides all documentation necessary to verify that the analysis has been completed in accordance with legal, professional, and technical standards.

APPENDIX A | RESPONDENTS BY REGION

LOS ANGELES COUNTY AND VICINITY

County of Practice	Frequency
Los Angeles	15
Orange	4
TOTAL	19

NORTH COAST

County of Practice	Frequency
Mendocino	2
Sonoma	1
TOTAL	3

RIVERSIDE AND VICINITY

County of Practice	Frequency
Riverside	1
San Bernardino	6
TOTAL	7

SACRAMENTO VALLEY

County of Practice	Frequency
Yolo	1
TOTAL	1

SAN DIEGO COUNTY AND VICINITY

County of Practice	Frequency
Imperial	1
San Diego	5
TOTAL	6

SAN FRANCISCO BAY AREA

County of Practice	Frequency
Alameda	1
Contra Costa	2
Marin	6
San Francisco	1
Santa Clara	5
TOTAL	15

SAN JOAQUIN VALLEY

County of Practice	Frequency
Fresno	2
Kern	2
Merced	2
San Joaquin	1
Stanislaus	2
TOTAL	9

SIERRA MOUNTAIN VALLEY

County of Practice	Frequency
Placer	1
Tuolumne	1
TOTAL	2

SOUTH COAST AND CENTRAL COAST

County of Practice	Frequency
San Luis Obispo	3
Ventura	3
TOTAL	6

APPENDIX B | CRITICALITY INDICES FOR ALL TASKS BY CONTENT AREA

Content Area 1: Treatment Preparation

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
2	Review patient dental records and medical history.	4.57	4.86	22.21
3	Select instruments, equipment, and materials for dental hygiene treatment.	4.26	4.13	18.46
6	Coordinate treatment and referral with dentist and other health care professionals.	4.09	4.27	18.25
1	Prepare operatory for dental hygiene treatment.	3.88	3.86	17.02
7	Take patient vital signs.	2.97	3.46	12.72

Content Area 2: Dental Hygiene Treatment

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
32	Maintain instruments to ensure efficient functioning for dental hygiene treatment.	4.41	4.38	20.76
8	Perform visual oral health screening.	4.48	4.38	20.08
15	Perform oral prophylaxis to remove hard and soft deposits, and stains.	4.29	4.31	19.10
11	Develop dental hygiene care plan that correlates with findings from periodontal assessment.	4.02	3.88	17.32
24	Recognize oral health conditions resulting from personal habits (e.g., tobacco, substance abuse, eating disorders).	3.93	4.04	17.02
19	Apply fluorides and other caries-preventing agents to patients.	3.97	3.94	16.87
18	Evaluate the presence or absence of biofilm and calculus before and after instrumentation.	3.97	3.77	16.08
12	Modify dental hygiene treatment plan based on current information.	3.88	3.71	15.92
9	Complete a comprehensive periodontal assessment.	3.72	3.75	15.62
14	Perform nonsurgical periodontal procedures (e.g., scaling, root planing).	3.47	3.98	15.23
13	Provide dental hygiene services in settings outside of a dental office.	3.58	3.96	15.19
21	Apply topical, therapeutic, and subgingival agents for the control of caries and periodontal disease.	2.86	3.29	11.55
23	Clean and polish removable appliances.	3.02	3.15	10.71
16	Administer topical anesthetic to patients.	2.66	2.77	9.40
10	Expose dental radiographs to assist with diagnosis of caries or periodontal conditions.	1.97	2.66	7.59
22	Place interim therapeutic restoration after diagnosis by dentist.	0.59	1.63	2.14
17	Perform air polishing to remove supragingival and subgingival biofilm and stain.	0.68	0.94	1.57
20	Take impressions for nondiagnostic cast models.	0.25	0.85	0.42

**Note: Shaded tasks deleted by SMEs. (See Chapter 4).*

Content Area 3: Patient Education

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
27	Provide patients with individualized oral hygiene instructions.	4.14	4.12	18.53
26	Communicate assessment findings and dental hygiene care plan to patient.	4.16	4.25	18.16
25	Discuss scheduled dental hygiene treatment with patient.	3.89	4.12	16.59
28	Provide nutritional counseling to improve oral health.	3.66	3.82	15.52

Content Area 4: Infection Control

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
30	Adhere to infection control policies and protocols for performing dental hygiene treatment.	4.61	4.76	22.66
29	Maintain a safe and clean work environment.	4.63	4.72	22.60
5	Wear personal protective equipment (PPE) before providing treatment to help prevent spread of disease.	4.54	4.73	21.89
31	Sterilize instruments in accordance with California infection control guidelines.	4.36	4.48	21.45
4	Provide patient with eyewear and bib to protect patient during dental hygiene treatment.	4.03	4.32	18.72

Content Area 5: Documentation

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
37	Document in patient record the dental services performed.	4.63	4.62	21.72
33	Document patient oral health status.	4.48	4.48	20.12
34	Report abnormalities of the oral cavity to the dentist.	4.25	4.54	19.82
36	Update patient dental records and medical history, including chief complaints and concerns.	4.07	4.22	18.96
35	Document existing and recommended restorative treatment as diagnosed by the dentist.	2.89	3.02	12.10

**Note: Shaded task deleted by SMEs. (See Chapter 4).*

Content Area 6: Laws, Regulations, and Ethics

Task Number	Task Statement	Mean Frequency	Mean Importance	Task Criticality Index
44	Adhere to laws and regulations regarding professional conduct.	4.73	4.82	22.91
48	Maintain required continuing education units for license renewal.	4.71	4.87	22.78
47	Maintain an RDHAP license according to laws and regulations.	4.69	4.87	22.73
42	Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.	4.67	4.76	22.31
41	Maintain confidentiality of patient records in accordance with laws and regulations.	4.59	4.77	22.05
43	Maintain security of patient records in accordance with laws and regulations.	4.59	4.69	21.58
40	Obtain informed consent from patient in accordance with laws and regulations.	4.47	4.62	20.82
45	Adhere to laws and regulations regarding excessive treatment.	4.35	4.36	20.62
52	Adhere to laws and regulations regarding billing, billing codes, and documentation.	3.43	3.75	15.57
53	Own and manage an RDHAP business in accordance with laws and regulations.	3.39	3.49	15.57
39	Obtain written prescription by dental provider for dental hygiene treatment within 18 months of patient care.	3.73	3.67	15.13
46	Report reasonable suspicion of child, elder, or dependent adult abuse, or neglect as legally mandated.	2.27	4.69	10.09
49	Submit claims to third party providers for dental hygiene services performed.	1.94	2.27	6.83
51	Operate a mobile dental hygiene clinic registered as a dental hygiene office or facility.	1.49	1.91	6.22
38	Communicate with other dental professionals using telehealth methods and technology.	1.43	1.73	5.11
50	Employ an RDHAP or DA to assist in practice.	0.59	0.82	2.37

APPENDIX C | KNOWLEDGE IMPORTANCE RATINGS

Content Area 1: Treatment Preparation

Number	Knowledge Statement	Mean Importance
2	Knowledge of conditions related to oral-systemic health (e.g., diabetes, cardiovascular disease).	3.73
4	Knowledge of instruments, equipment, and materials used for dental hygiene treatment.	3.56
21	Knowledge of procedures needed for practicing dental hygiene treatment outside of a dental office.	3.56
3	Knowledge of techniques for assessing vital signs.	3.42
1	Knowledge of procedures and protocols to prepare and break down operatory.	3.31

Content Area 2: Dental Hygiene Treatment

Number	Knowledge Statement	Mean Importance
7	Knowledge of procedures for assessing the oral cavity.	3.73
15	Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using hand instruments.	3.73
19	Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.	3.69
8	Knowledge of methods to assess periodontal conditions using clinical and radiographic findings.	3.65
13	Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using hand instruments.	3.63
20	Knowledge of work conditions necessary to provide dental hygiene treatment outside of a dental office.	3.52
41	Knowledge of sharpening techniques of hand instruments.	3.47
23	Knowledge of techniques for detecting the presence or absence of biofilm and calculus.	3.40
24	Knowledge of application techniques for fluoride and caries-preventing agents.	3.38
14	Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using power instruments.	3.35
25	Knowledge of agents used for the management of periodontal disease.	3.35
11	Knowledge of methods to develop dental hygiene care plans to assess patient needs.	3.33
31	Knowledge of personal habits that affect oral health conditions (e.g., tobacco, substance abuse, eating disorders).	3.31
16	Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using power instruments.	3.23
10	Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment.	3.19
18	Knowledge of conditions that require application of topical anesthesia.	3.13
26	Knowledge of application of agents used for control of caries (e.g., pit and fissure sealants, ITR).	3.13
17	Knowledge of procedures to administer topical anesthetic.	2.91
28	Knowledge of application of agents (e.g., antimicrobials) used for the management of periodontal disease.	2.90
30	Knowledge of procedures for cleaning and polishing removable appliances (e.g., dentures).	2.77
12	Knowledge of procedures to remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.	2.23
9	Knowledge of techniques for exposing and developing dental radiographs.	2.19
29	Knowledge of procedures to place interim therapeutic restorations.	1.92

Content Area 2: Dental Hygiene Treatment, continued

Number	Knowledge Statement	Mean Importance
22	Knowledge of methods to perform air polishing to remove supragingival and subgingival biofilm and stain.	1.53
27	Knowledge of techniques for taking impressions.	1.11

**Note: Shaded knowledge statements were deleted by SMEs. (See Chapter 4)*

Content Area 3: Patient Education

Number	Knowledge Statement	Mean Importance
35	Knowledge of individualized oral hygiene instructions to address specific patient needs.	3.54
32	Knowledge of methods for communicating a dental hygiene care plan with patient.	3.35
33	Knowledge of instructions for postoperative care.	3.27
34	Knowledge of nutritional counseling related to oral health.	3.19

Content Area 4: Infection Control

Number	Knowledge Statement	Mean Importance
36	Knowledge of standards for infection control.	3.88
37	Knowledge of techniques for disinfecting and sterilizing dental hygiene equipment.	3.88
38	Knowledge of techniques for sterilizing dental hygiene instruments.	3.83
5	Knowledge of standard precautions required to protect patients during dental hygiene treatment.	3.79
6	Knowledge of standard precautions required to protect health care workers during dental hygiene treatment.	3.73

Content Area 5: Documentation

Number	Knowledge Statement	Mean Importance
47	Knowledge of protocol for documenting dental hygiene services performed.	3.70
45	Knowledge of methods and protocol for updating patient medical history.	3.68
43	Knowledge of basic characteristics of normal and abnormal oral conditions.	3.65
42	Knowledge of different types of periodontal conditions.	3.63
46	Knowledge of methods and protocol for documenting in patient dental records.	3.53
44	Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist.	3.43

Content Area 6: Laws, Regulations, and Ethics

Number	Knowledge Statement	Mean Importance
50	Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.	3.62
55	Knowledge of laws and regulations regarding maintenance, renewal, and restoration of a California RDHAP license.	3.60
52	Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting.	3.55
49	Knowledge of laws and regulations related to informed consent.	3.51
56	Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.	3.51
57	Knowledge of laws and regulations regarding continuing education requirements to maintain RDHAP license.	3.51
54	Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse and neglect.	3.50
53	Knowledge of laws and regulations regarding excessive treatment.	3.43
51	Knowledge of laws and regulations regarding maintaining physical and electronic patient records.	3.38
62	Knowledge of laws and regulations related to managing an RDHAP business.	3.28
63	Knowledge of laws and regulations regarding written prescriptions from medical and dental providers.	3.23
60	Knowledge of procedures for receiving insurance reimbursements.	2.96
59	Knowledge of documentation required to submit claims to third party providers for dental hygiene services performed.	2.83
61	Knowledge of laws and regulations regarding discounted fees and services.	2.57
50	Knowledge of methods for communicating with health care providers using telehealth.	1.72

APPENDIX D | EMAIL INVITATION TO PRACTITIONERS

2019 Registered Dental Hygienist in Alternative Practice Occupational Analysis Questionnaire

Dear Licensee,

The Dental Hygiene Board of California is requesting your assistance with an important study that will define the entry-level job tasks of the Registered Dental Hygienist in Alternative Practice (RDHAP) in California. The results of the study will serve to inform the content of the RDHAP Licensing Examination in California.

Please complete the questionnaire by July 1, 2019.

Thank you for your participation!

[redacted]
California Department of Consumer Affairs
Office of Professional Examination Services (OPES)
2420 Del Paso Road, Suite 265, Sacramento, CA 95834
[redacted]

Begin Survey

APPENDIX E | QUESTIONNAIRE

Occupational Analysis of the Registered Dental Hygienist in Alternate Practice Profession

Dear Licensed Registered Dental Hygienist in Alternate Practice,

Thank you for participating in this study of the dental hygiene in alternate practice profession in California, a project of the Dental Hygiene Board of California (Board).

The Board is conducting an occupational analysis of the dental hygiene in alternate practice profession. The purpose of the occupational analysis (OA) is to identify the important tasks performed by registered dental hygienists in alternate practice in their current work and the knowledge required to perform those tasks effectively. Results of the OA will be used to ensure that the examinations required for licensure as a registered dental hygienist in alternate practice in California reflect current practice. Your participation in the OA is essential. The Board requires responses from many licensees to achieve representation from different geographic regions of the state and from different work settings.

Please take the time to complete the questionnaire as it relates to your current work. Your responses will be kept confidential and will not be tied to your license or any other personal information. Individual responses will be combined with the responses of other dental hygienists in alternate practice and only group data will be analyzed.

For your convenience, you do not have to complete the questionnaire in a single session. Before you exit, complete the page that you are on. You can resume where you stopped as long as you reopen the questionnaire from the same computer and use the same web browser. The web link is available 24 hours a day, 7 days a week.

To begin the questionnaire, please click Next. Any question marked with an asterisk must be answered before you can progress through the questionnaire. Please submit the completed questionnaire by July 1, 2019.

If you have any questions or need assistance, please contact [redacted] at [redacted]@dca.ca.gov.

The Board welcomes your feedback and appreciates your time!

2019 Registered Dental Hygienist in Alternate Practice Occupational Analysis Questionnaire

Part I - Personal Data

The information you provide here is voluntary and confidential. It will be treated as personal information subject to the Information Practices Act (Civil Code, Section 1798 et seq.), and will be used only for the purpose of analyzing the information from this questionnaire.

* 1. Are you currently practicing as a California-licensed dental hygienist in alternate practice?

- Yes
- No

Part I - Personal Data (Continued)

2. How many years have you been practicing in California as a licensed dental hygienist in alternate practice?

- ◯ 0 to 5 years
- ◯ 6 to 10 years
- ◯ 11 to 15 years
- ◯ 16 or more years

Part I - Personal Data (continued)

3. How many hours per week do you work as a licensed dental hygienist in alternate practice?

- ◯ 0 to 10 hours
- ◯ 11 to 20 hours
- ◯ 21 to 30 hours
- ◯ 31 to 40 hours
- ◯ 41 or more hours

4. What describes the location of your primary work setting?

- ◯ Urban (more than 50,000)
- ◯ Rural (50,000 or fewer)

5. How many different offices employ you as a registered dental hygienist in alternate practice?

- ◯ One
- ◯ Two
- ◯ Three or more

6. How would you describe your primary/current work setting?

- ◯ General
- ◯ Endodontic
- ◯ Orthodontic
- ◯ Periodontic
- ◯ Pedodontic
- ◯ Oral surgery
- ◯ Other (please specify)

7. What other California licenses or certifications do you hold?

- ◯ None
- ◯ RDA
- ◯ RDAEF
- ◯ Periodontal soft tissue curettage
- ◯ Administration of local anesthesia
- ◯ Administration of nitrous oxide and oxygen
- ☐ Other (please specify)

5

Part I - Personal Data (continued)

8. In what California county do you perform the majority of your work?

- Alameda
- Alpine
- Amador
- Butte
- Calaveras
- Colusa
- Contra Costa
- Del Norte
- El Dorado
- Fresno
- Glenn
- Humboldt
- Imperial
- Inyo
- Kern
- Kings
- Lake
- Lassen
- Los Angeles
- Madera
- Marin
- Mariposa
- Mendocino
- Merced
- Modoc
- Mono
- Monterey
- Napa
- Nevada
- Orange
- Placer
- Plumas
- Riverside
- Sacramento
- San Benito
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Santa Cruz
- Shasta
- Sierra
- Siskiyou
- Solano
- Sonoma
- Stanislaus
- Sutter
- Tehama
- Trinity
- Tulare
- Tuolumne
- Ventura
- Yolo
- Yuba

Part II - Task Rating Instructions

In this part of the questionnaire, you will be presented with 53 tasks reflecting the nature of the dental hygiene in alternate practice profession in California.

Please rate each task as it relates to your current practice.

Your frequency and importance ratings should be separate and independent ratings. Therefore, the ratings that you assign on one rating scale should not influence the ratings that you assign on the other rating scale. For example, you may perform a task frequently, but that task may not be important. Or you may perform a task infrequently, but that task may be very important.

If the task is NOT part of your current practice, rate the task "0" (zero) frequency and "0" (zero) importance. Tasks that you perform frequently should be rated high on the frequency scale and tasks that are important to your work as a dental hygienist in alternate practice should be rated high on the importance scale.

Choose the rating that best fits each task.

Please use the scales below to rate the tasks on the following pages.

FREQUENCY SCALE

HOW OFTEN do you perform this task in your current practice? Consider all of the practice tasks you have performed over the past year and make your judgment relative to all other tasks you perform.

0 – DOES NOT APPLY. I do not perform this task in my current practice.
1 – RARELY. I perform this task the least often in my current practice relative to other tasks I perform.
2 – SELDOM. I perform this task less often than most other tasks I perform in my current practice.
3 – REGULARLY. I perform this task as often as other tasks I perform in my current practice.
4 – OFTEN. I perform this task more often than most other tasks I perform in my current practice.
5 – VERY OFTEN. This task is one of the tasks I perform most often in my current practice relative to other tasks I perform.

IMPORTANCE SCALE

HOW IMPORTANT is performance of this task for effective performance in your current practice? Consider all of the job tasks you have performed over the past year and make your judgment relative to all other tasks you perform.

0 – DOES NOT APPLY. I do not perform this task in my current practice.

1 – NOT IMPORTANT. This task is not important for effective performance in my current practice.
2 – FAIRLY IMPORTANT. This task is somewhat important for effective performance in my current practice.
3 – IMPORTANT. This task is important for effective performance in my current practice.
4 – VERY IMPORTANT. This task is very important for effective performance in my current practice.
5 – CRITICALLY IMPORTANT. This task is extremely important for effective performance in my current practice.

8

Part II - Treatment Preparation

9. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
1. Prepare operatory for dental hygiene treatment.		
2. Review patient dental records and medical history.		
3. Select instruments, equipment, and materials for dental hygiene treatment.		
4. Provide patient with eyewear and bib to protect patient during dental hygiene treatment.		
5. Wear personal protective equipment (PPE) before providing treatment to help prevent spread of disease.		
6. Coordinate treatment and referral with dentist and other healthcare professionals.		
7. Take patient vital signs.		

Part II - Dental Hygiene Treatment

10. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
8. Perform oral health screening.		
9. Complete a comprehensive periodontal assessment.		
10. Expose dental radiographs to assist with diagnosis of caries or periodontal conditions.		
11. Develop dental hygiene care plan that correlates with findings from periodontal assessment.		
12. Modify dental hygiene treatment plan based on current information.		
13. Provide dental hygiene services in settings outside of a dental office.		
14. Perform nonsurgical periodontal procedures (e.g., scaling, root planing).		
15. Perform oral prophylaxis to remove hard and soft deposits, and stains.		
16. Administer topical anesthetic to patients.		
17. Perform air polishing to remove supragingival and subgingival biofilm and stain.		
18. Evaluate the presence or absence of biofilm and calculus before and after instrumentation.		
19. Apply fluorides and other caries-preventing agents to patients.		
20. Take impressions for nondiagnostic cast models.		
21. Apply topical, therapeutic, and subgingival agents for the control of caries and periodontal disease.		
22. Place interim therapeutic restoration after diagnosis by dentist.		
23. Clean and polish removable appliances.		
24. Recognize oral health conditions resulting from personal habits (e.g., tobacco, substance abuse, eating disorders).		

Part II - Patient Education

11. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
25. Discuss scheduled dental hygiene treatment with patient.		
26. Communicate assessment findings and dental hygiene care plan to patient.		
27. Provide instructions to patients for oral hygiene and postoperative care.		
28. Provide nutritional counseling to improve oral health.		

Part II - Infection Control

12. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
29. Maintain a safe and clean work environment.		
30. Adhere to infection control policies and protocols for performing dental hygiene treatment.		
31. Sterilize instruments in accordance with California infection control guidelines.		
32. Maintain instruments to ensure efficient functioning for dental hygiene treatment.		

Part II - Documentation and Recordkeeping

13. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
33. Record conditions of the oral cavity.		
34. Report abnormalities of the oral cavity to the dentist.		
35. Record existing and recommended restorative treatment as diagnosed by the dentist.		
36. Update patient dental records and medical history, including chief complaints and concerns.		
37. Document in patient record the dental services performed.		

Part II - Laws and Regulations

14. Please rate the following tasks based on how often you perform the task (Frequency) and how important the task is for effective performance (Importance).

	Frequency	Importance
38. Communicate with other dental professionals using telehealth methods and technology.		
39. Obtain written prescription by dental provider for dental hygiene treatment within 18 months of patient care.		
40. Obtain informed consent from patient in accordance with laws and regulations.		
41. Maintain confidentiality of patient records in accordance with laws and regulations.		
42. Maintain confidentiality of patient treatment and conditions with laws and regulations regarding patient confidentiality.		
43. Maintain security of patient records in accordance with laws and regulations.		
44. Adhere to laws and regulations regarding professional conduct.		
45. Adhere to laws and regulations regarding excessive treatment.		
46. Report reasonable suspicion of child, elder, or dependent adult abuse, or neglect as legally mandated.		
47. Maintain dental hygiene in alternate practice license according to laws and regulations.		
48. Maintain required continuing education units for license renewal.		
49. Submit claims to third party providers for dental hygiene services performed.		
50. Employ an RDHAP or DA to assist in practice.		
51. Operate a mobile dental hygiene clinic registered as a dental hygiene office or facility.		
52. Adhere to regulations regarding billing, billing codes, and documentation.		
53. Own and manage a dental hygiene in alternate practice business in accordance with laws and regulations.		

Part III - Knowledge Rating Instructions

In this part of the questionnaire, you will be presented with 63 knowledge statements. Please rate each knowledge statement based on how important you feel the knowledge is to the effective performance of your tasks.

If a knowledge is NOT a part of your current practice, rate the statement "0" (zero)importance and go on to the next statement.

Use the following scale to rate each knowledge statement's importance.

IMPORTANCE SCALE

HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?
0 – DOES NOT APPLY. This knowledge is not required for effective performance of tasks in my current practice.
1 – NOT IMPORTANT. This knowledge is not important for effective performance of tasks in my current practice.
2 – FAIRLY IMPORTANT. This knowledge is somewhat important for effective performance of tasks in my current practice.
3 – IMPORTANT. This knowledge is important for effective performance of tasks in my current practice.
4 – VERY IMPORTANT. This knowledge is very important for effective performance of tasks in my current practice.
5 – CRITICALLY IMPORTANT. This knowledge is extremely important for effective performance of tasks in my current practice.

Part III - Treatment Preparation

15. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
1. Knowledge of procedures and protocols to prepare and break down operatory.	◯	◯	◯	◯	◯	◯
2. Knowledge of conditions related to oral-systemic health (e.g., diabetes, cardiovascular disease).	◯	◯	◯	◯	◯	◯
3. Knowledge of techniques for assessing vital signs.	◯	◯	◯	◯	◯	◯
4. Knowledge of instruments, equipment, and materials used for dental hygiene treatment.	◯	◯	◯	◯	◯	◯
5. Knowledge of standard precautions required to protect patients during dental hygiene treatment.	◯	◯	◯	◯	◯	◯
6. Knowledge of standard precautions required to protect health care workers during dental hygiene treatment.	◯	◯	◯	◯	◯	◯

Part III - Dental Hygiene Treatment

16. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
7. Knowledge of procedures for assessing the oral cavity.	○	○	○	○	○	○
8. Knowledge of methods to assess periodontal conditions.	○	○	○	○	○	○
9. Knowledge of techniques for exposing and developing dental radiographs.	○	○	○	○	○	○
10. Knowledge of factors that affect the frequency recommended for scheduling dental hygiene treatment.	○	○	○	○	○	○
11. Knowledge of methods to develop dental hygiene care plans to assess patient needs.	○	○	○	○	○	○
12. Knowledge of procedures to remove excess cement from fixed restorations, including crowns, bridges, and orthodontic treatment.	○	○	○	○	○	○
13. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using hand instruments.	○	○	○	○	○	○
14. Knowledge of methods to perform nonsurgical periodontal procedures to remove hard and soft deposits and stain using power instruments.	○	○	○	○	○	○
15. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using hand instruments.	○	○	○	○	○	○
16. Knowledge of methods to perform oral prophylaxis to remove hard and soft deposits and stain using power instruments.	○	○	○	○	○	○
17. Knowledge of procedures to administer topical anesthetic.	○	○	○	○	○	○
18. Knowledge of conditions that require application of topical anesthesia.	○	○	○	○	○	○
19. Knowledge of drug properties, side effects, interactions, and contraindications as they relate to dental hygiene treatment.	○	○	○	○	○	○

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
20. Knowledge of work conditions necessary to provide dental hygiene treatment outside of a dental office.	○	○	○	○	○	○
21. Knowledge of procedures needed for practicing dental hygiene treatment outside of a dental office.	○	○	○	○	○	○
22. Knowledge of methods to perform air polishing to remove supragingival and subgingival biofilm and stain.	○	○	○	○	○	○
23. Knowledge of techniques for detecting the presence or absence of biofilm and calculus.	○	○	○	○	○	○
24. Knowledge of application techniques for fluoride and other caries-preventing agents.	○	○	○	○	○	○
25. Knowledge of agents used for control of caries and periodontal disease.	○	○	○	○	○	○
26. Knowledge of application of agents used for control of caries (e.g., pit and fissure sealants, ITR).	○	○	○	○	○	○
27. Knowledge of techniques for taking impressions.	○	○	○	○	○	○
28. Knowledge of application of agents used for control of periodontal disease (e.g., antimicrobials).	○	○	○	○	○	○
29. Knowledge of procedures to place interim therapeutic restorations.	○	○	○	○	○	○
30. Knowledge of procedures for cleaning and polishing removable appliances (e.g., dentures).	○	○	○	○	○	○
31. Knowledge of personal habits that affect oral health conditions (e.g., tobacco, substance abuse, eating disorders).	○	○	○	○	○	○

Part III - Patient Education

17. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
32. Knowledge of methods for communicating a dental hygiene care plan with patient.	○	○	○	○	○	○
33. Knowledge of instructions for post-operative care.	○	○	○	○	○	○
34. Knowledge of nutritional counseling related to oral health.	○	○	○	○	○	○
35. Knowledge of individualized oral hygiene instructions to address specific patient needs.	○	○	○	○	○	○

Part III - Infection Control

18. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
36. Knowledge of standards for infection control.	○	○	○	○	○	○
37. Knowledge of techniques for disinfecting dental hygiene equipment.	○	○	○	○	○	○
38. Knowledge of techniques for sterilizing dental hygiene instruments.	○	○	○	○	○	○
39. Knowledge of methods to maintain the integrity (sharpening or sterilizing) of hand instruments for dental hygiene treatment.	○	○	○	○	○	○
40. Knowledge of procedures for maintaining (i.e., replacing filter) dental hygiene power instruments.	○	○	○	○	○	○
41. Knowledge of protocols to maintain dental hygiene equipment in working condition.	○	○	○	○	○	○

Part III - Documentation and Recordkeeping

19. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
42. Knowledge of different types of periodontal conditions.	○	○	○	○	○	○
43. Knowledge of basic characteristics of normal and abnormal oral conditions.	○	○	○	○	○	○
44. Knowledge of the characteristics of caries, defective restorations, TMD, and occlusal disorders for referral to dentist.	○	○	○	○	○	○
45. Knowledge of methods and protocol for updating patient medical history.	○	○	○	○	○	○
46. Knowledge of methods and protocol for charting patient dental records.	○	○	○	○	○	○
47. Knowledge of protocol for documenting dental hygiene services performed.	○	○	○	○	○	○

Part III - Laws and Regulations

20. HOW IMPORTANT is this knowledge for effective performance of tasks in your current practice?

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
48. Knowledge of methods for communicating with health care providers using telehealth.	○	○	○	○	○	○
49. Knowledge of laws and regulations related to informed consent.	○	○	○	○	○	○
50. Knowledge of the legal and ethical requirements regarding patient records and patient confidentiality.	○	○	○	○	○	○
51. Knowledge of laws and regulations regarding maintaining physical and electronic patient records.	○	○	○	○	○	○
52. Knowledge of laws and regulations of ethical standards for professional conduct in a dental hygiene setting.	○	○	○	○	○	○
53. Knowledge of laws and regulations regarding excessive treatment.	○	○	○	○	○	○
54. Knowledge of laws governing mandated reporting of child, elder, and dependent adult abuse and neglect.	○	○	○	○	○	○
55. Knowledge of laws and regulations regarding maintenance, renewal, and restoration of California dental hygiene in alternate practice license.	○	○	○	○	○	○
56. Knowledge of laws and regulations regarding citations, fines, and disciplinary actions.	○	○	○	○	○	○
57. Knowledge of laws and regulations regarding continuing education requirements to maintain dental hygiene in alternate practice license.	○	○	○	○	○	○
58. Knowledge of laws and regulations regarding locations that a registered dental hygienist in alternate practice can provide treatment.	○	○	○	○	○	○
59. Knowledge of documentation required to submit claims to third party providers for dental hygiene services performed.	○	○	○	○	○	○

	Not Important/Does Not Apply	Somewhat Important	Fairly Important	Important	Very Important	Critically Important
60. Knowledge of procedures for receiving insurance reimbursements.	○	○	○	○	○	○
61. Knowledge of laws and regulations regarding discounted fees and services.	○	○	○	○	○	○
62. Knowledge of laws and regulations related to managing dental hygiene in alternate practice businesses.	○	○	○	○	○	○
63. Knowledge of laws and regulations regarding written prescriptions from medical and dental providers.	○	○	○	○	○	○

THANK YOU!

You have completed this questionnaire! Thank you for participating!

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Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachment D

Performance Measures for the Last Three Years

DHBC
Dental Hygiene
Board of California

DHBC 2022/23 SUNSET REVIEW REPORT SECTION 13: ATTACHMENTS

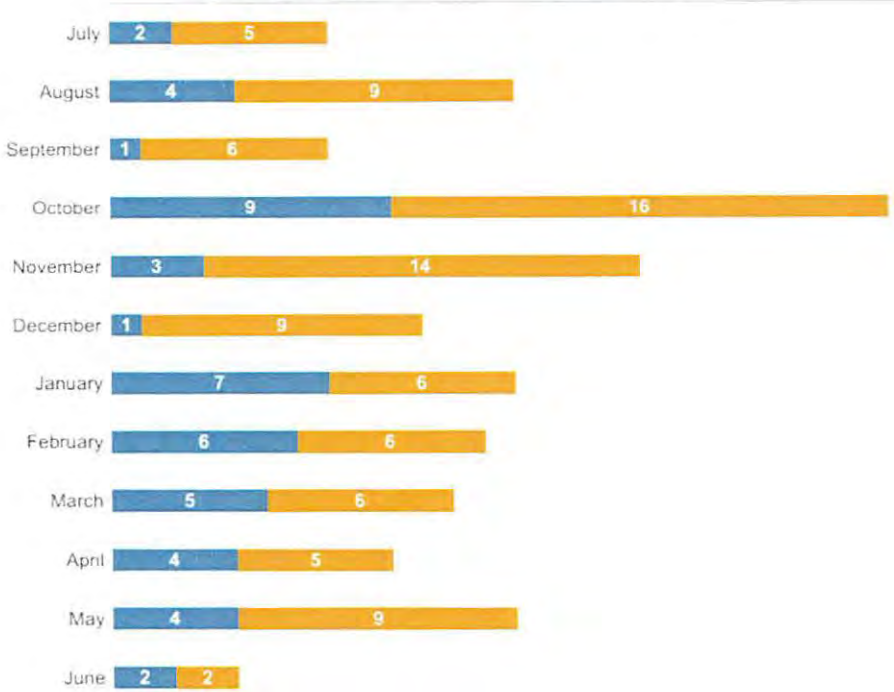
PERFORMANCE MEASURE 1: CASE VOLUME

Board Name
Dental Hygiene Board

State Fiscal Year
SFY 2019

Enforcement Case Type
Complaints Conviction/Arrest

Dental Hygiene Board
SFY 2019: 12-Month | **PM1:** Case Volume by Type



Dental Hygiene Board
SFY 2019: 12-Month | **PM1:** Summary

	Complaints	Conviction/Arrest	Total Volume
Grand Total	**48**	**93**	**141**
July	2	5	7
August	4	9	13
September	1	6	7
October	9	16	25
November	3	14	17
December	1	9	10
January	7	6	13
February	6	6	12
March	5	6	11
April	4	5	9
May	4	9	13
June	2	2	4

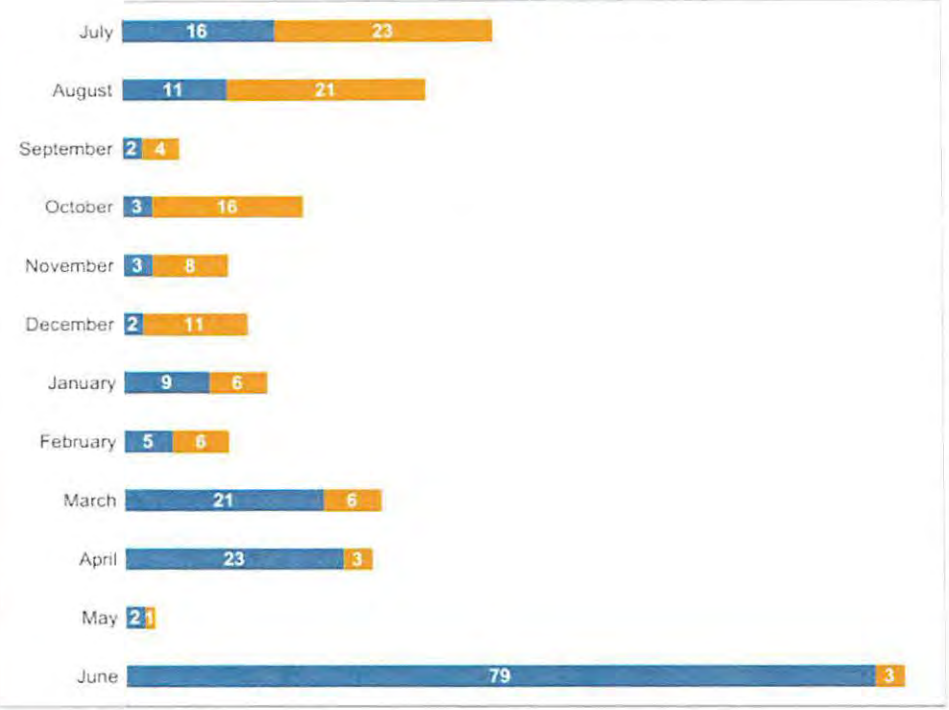
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Board Name
Dental Hygiene Board

State Fiscal Year
SFY 2020

Enforcement Case Type
Complaints | Conviction/Arrest

Dental Hygiene Board
SFY 2020: 12-Month | **PM1:** Case Volume by Type



Dental Hygiene Board
SFY 2020: 12-Month | **PM1:** Summary

	Complaints	Conviction/Arrest	Total Volume
Grand Total	176	108	284
July	16	23	39
August	11	21	32
September	2	4	6
October	3	16	19
November	3	8	11
December	2	11	13
January	9	6	15
February	5	6	11
March	21	6	27
April	23	3	26
May	2	1	3
June	79	3	82

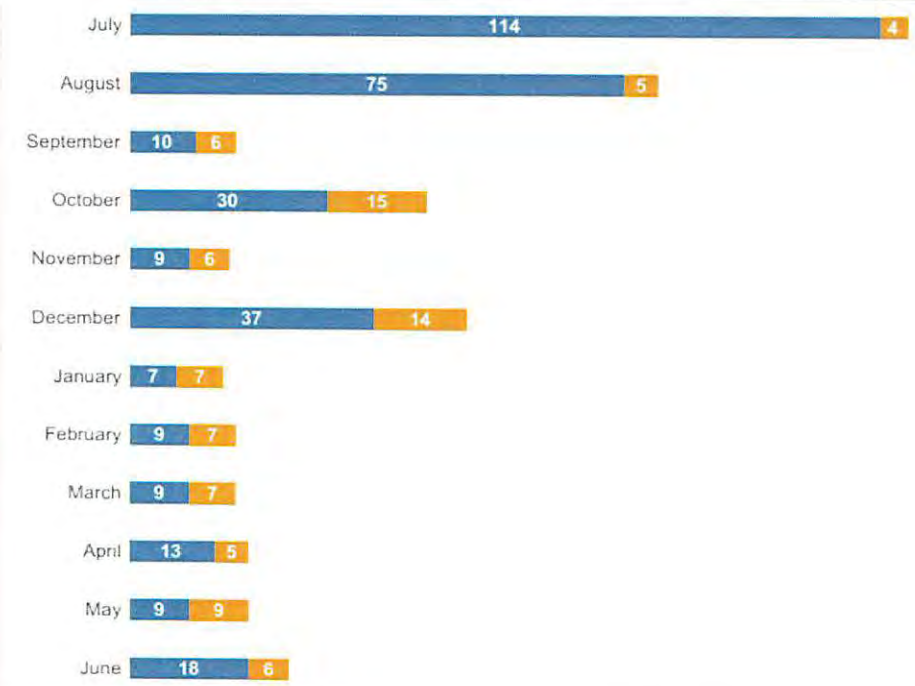
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Board Name
Dental Hygiene Board

State Fiscal Year
SFY 2021

Enforcement Case Type
Complaints | Conviction/Arrest

Dental Hygiene Board
SFY 2021: 12-Month | **PM1:** Case Volume by Type



Dental Hygiene Board
SFY 2021: 12-Month | **PM1:** Summary

	Complaints	Conviction/Arrest	Total Volume
Grand Total	340	91	431
July	114	4	118
August	75	5	80
September	10	6	16
October	30	15	45
November	9	6	15
December	37	14	51
January	7	7	14
February	9	7	16
March	9	7	16
April	13	5	18
May	9	9	18
June	18	6	24

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

DHBC
Dental Hygiene
Board of California

DHBC 2022/23 SUNSET REVIEW REPORT SECTION 13: ATTACHMENTS

PERFORMANCE MEASURE 2: INTAKE

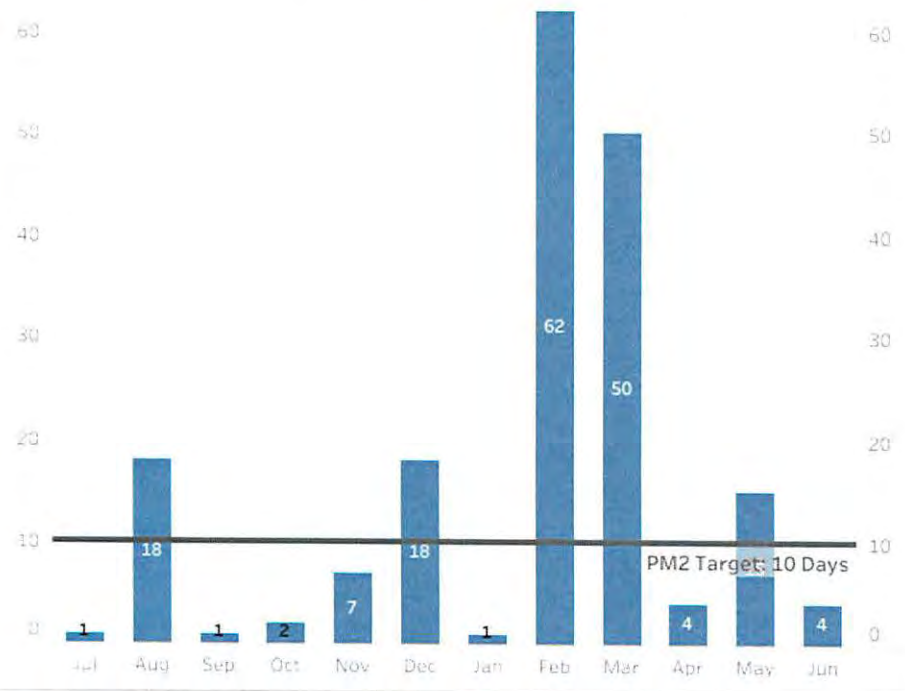
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2019

Cycle Time
Actual Target

Performance v Target
Above Target Below Target

Dental Hygiene Board
SFY 2019: 12-Month | **PM2 -** Intake Cycle Time



Dental Hygiene Board
SFY 2019: 12-Month | **PM2 -** Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	144	10 Days	26 Day(s)	▲ 16 Day(s)
July	5	10 Days	1 Day(s)	▼ -9 Day(s)
August	18	10 Days	18 Day(s)	▲ 8 Day(s)
September	7	10 Days	1 Day(s)	▼ -9 Day(s)
October	18	10 Days	2 Day(s)	▼ -8 Day(s)
November	7	10 Days	7 Day(s)	▼ -3 Day(s)
December	8	10 Days	18 Day(s)	▲ 8 Day(s)
January	1	10 Days	1 Day(s)	▼ -9 Day(s)
February	20	10 Days	62 Day(s)	▲ 52 Day(s)
March	33	10 Days	50 Day(s)	▲ 40 Day(s)
April	9	10 Days	4 Day(s)	▼ -6 Day(s)
May	14	10 Days	15 Day(s)	▲ 5 Day(s)
June	4	10 Days	4 Day(s)	▼ -6 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

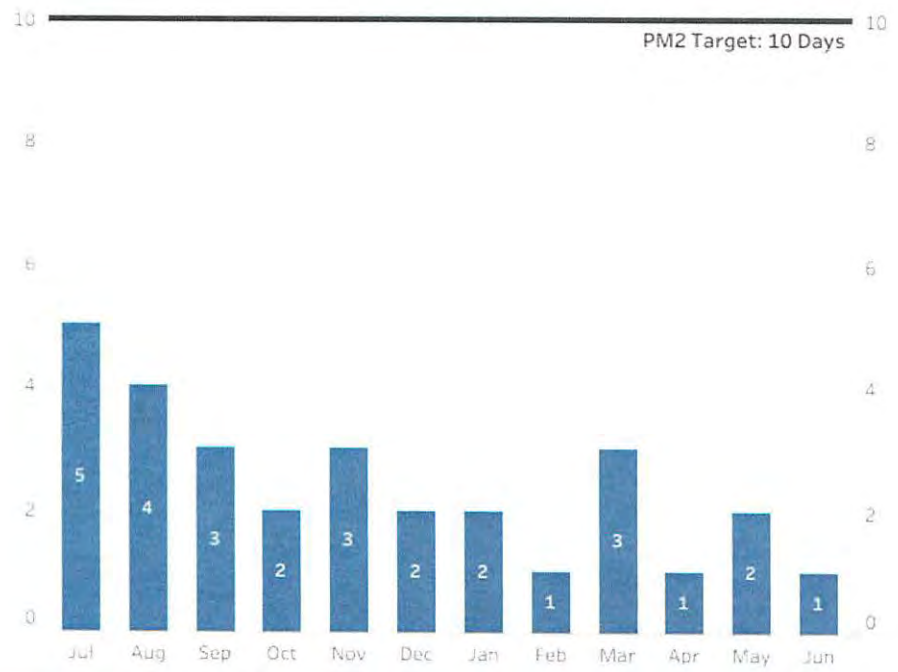
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2020

Cycle Time
Actual Target

Performance v Target
Below Target

Dental Hygiene Board
SFY 2020: 12-Month | **PM2** - Intake Cycle Time



Dental Hygiene Board
SFY 2020: 12-Month | **PM2** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	211	10 Days	3 Day(s)	▼ -7 Day(s)
July	40	10 Days	5 Day(s)	▼ -5 Day(s)
August	32	10 Days	4 Day(s)	▼ -6 Day(s)
September	7	10 Days	3 Day(s)	▼ -7 Day(s)
October	19	10 Days	2 Day(s)	▼ -8 Day(s)
November	10	10 Days	3 Day(s)	▼ -7 Day(s)
December	14	10 Days	2 Day(s)	▼ -8 Day(s)
January	14	10 Days	2 Day(s)	▼ -8 Day(s)
February	11	10 Days	1 Day(s)	▼ -9 Day(s)
March	28	10 Days	3 Day(s)	▼ -7 Day(s)
April	26	10 Days	1 Day(s)	▼ -9 Day(s)
May	2	10 Days	2 Day(s)	▼ -8 Day(s)
June	8	10 Days	1 Day(s)	▼ -9 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

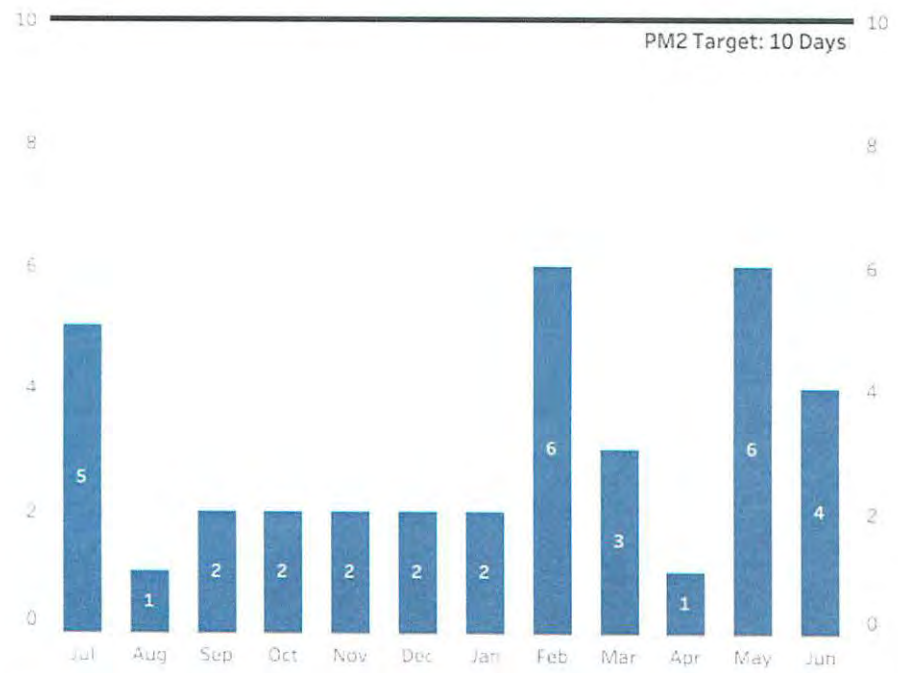
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2021

Cycle Time
Actual Target

Performance v Target
Below Target

Dental Hygiene Board
SFY 2021: 12-Month | **PM2** - Intake Cycle Time



Dental Hygiene Board
SFY 2021: 12-Month | **PM2** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	498	10 Days	3 Day(s)	▼ -7 Day(s)
July	192	10 Days	5 Day(s)	▼ -5 Day(s)
August	79	10 Days	1 Day(s)	▼ -9 Day(s)
September	17	10 Days	2 Day(s)	▼ -8 Day(s)
October	44	10 Days	2 Day(s)	▼ -8 Day(s)
November	14	10 Days	2 Day(s)	▼ -8 Day(s)
December	48	10 Days	2 Day(s)	▼ -8 Day(s)
January	14	10 Days	2 Day(s)	▼ -8 Day(s)
February	16	10 Days	6 Day(s)	▼ -4 Day(s)
March	16	10 Days	3 Day(s)	▼ -7 Day(s)
April	18	10 Days	1 Day(s)	▼ -9 Day(s)
May	14	10 Days	6 Day(s)	▼ -4 Day(s)
June	26	10 Days	4 Day(s)	▼ -6 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

DHBC
Dental Hygiene
Board of California

DHBC 2022/23 SUNSET REVIEW REPORT SECTION 13: ATTACHMENTS

PERFORMANCE MEASURE 3: INVESTIGATION

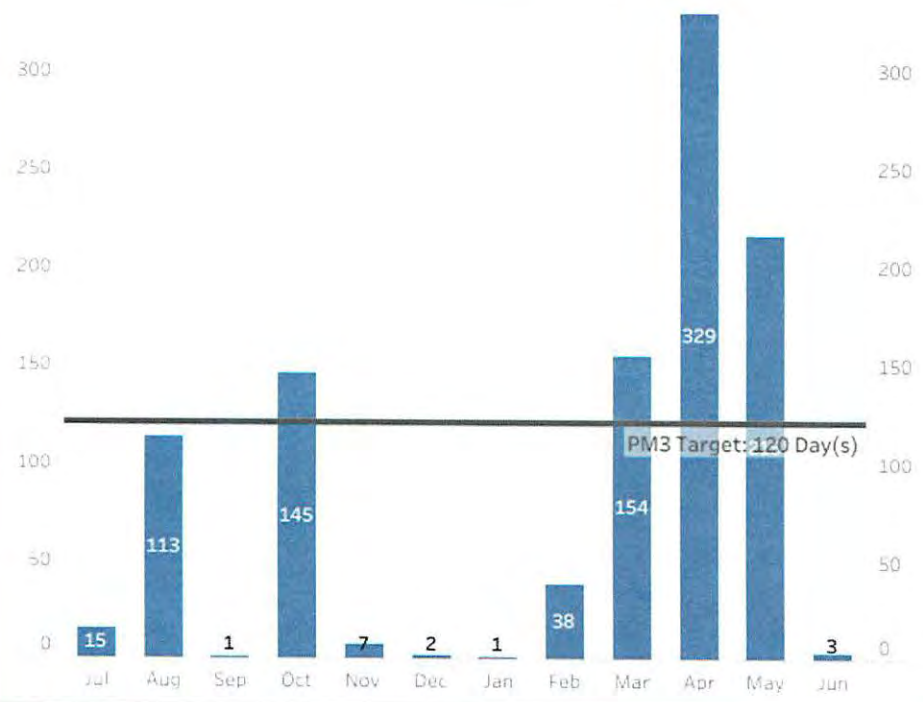
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2019

Cycle Time
Actual Target

Performance versus Target
Above Target Below Target

Dental Hygiene Board
SFY 2019: 12-Month | **PM3** - Investigations Cycle Time



Dental Hygiene Board
SFY 2019: 12-Month | **PM3** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	99	120 Days	116 Day(s)	▼ -4 Day(s)
July	6	120 Days	15 Day(s)	▼ -105 Day(s)
August	9	120 Days	113 Day(s)	▼ -7 Day(s)
September	5	120 Days	1 Day(s)	▼ -119 Day(s)
October	21	120 Days	145 Day(s)	▲ 25 Day(s)
November	6	120 Days	7 Day(s)	▼ -113 Day(s)
December	5	120 Days	2 Day(s)	▼ -118 Day(s)
January	1	120 Days	1 Day(s)	▼ -119 Day(s)
February	3	120 Days	38 Day(s)	▼ -82 Day(s)
March	31	120 Days	154 Day(s)	▲ 34 Day(s)
April	4	120 Days	329 Day(s)	▲ 209 Day(s)
May	5	120 Days	215 Day(s)	▲ 95 Day(s)
June	3	120 Days	3 Day(s)	▼ -117 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

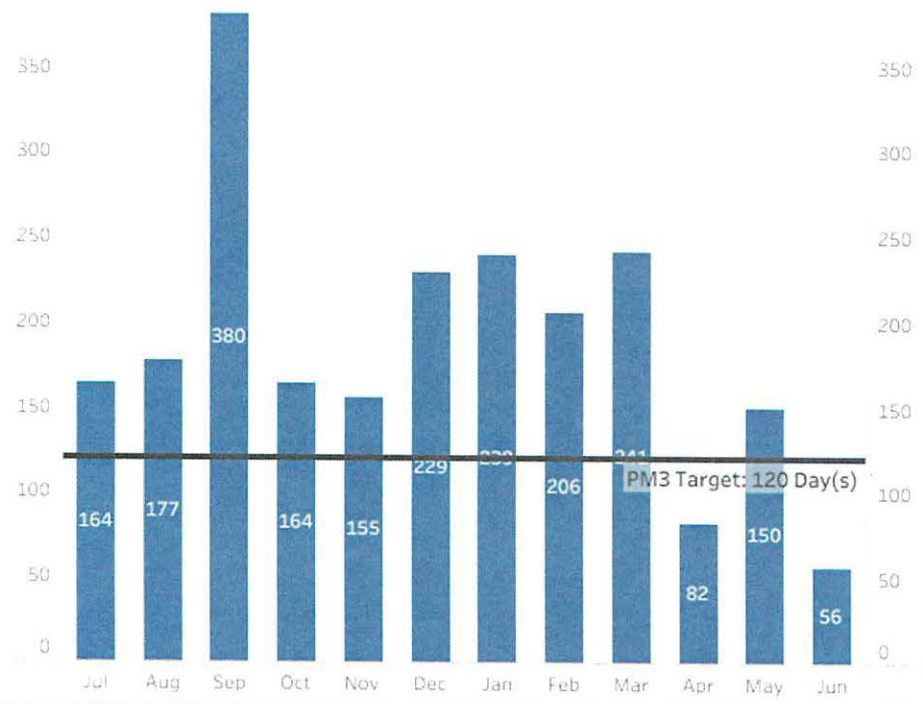
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2020

Cycle Time
Actual | Target

Performance versus Target
Above Target | Below Target

Dental Hygiene Board
SFY 2020: 12-Month | **PM3** - Investigations Cycle Time



Dental Hygiene Board
SFY 2020: 12-Month | **PM3** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	232	120 Days	194 Day(s)	▲ 74 Day(s)
July	33	120 Days	164 Day(s)	▲ 44 Day(s)
August	23	120 Days	177 Day(s)	▲ 57 Day(s)
September	28	120 Days	380 Day(s)	▲ 260 Day(s)
October	20	120 Days	164 Day(s)	▲ 44 Day(s)
November	14	120 Days	155 Day(s)	▲ 35 Day(s)
December	16	120 Days	229 Day(s)	▲ 109 Day(s)
January	23	120 Days	239 Day(s)	▲ 119 Day(s)
February	9	120 Days	206 Day(s)	▲ 86 Day(s)
March	13	120 Days	241 Day(s)	▲ 121 Day(s)
April	35	120 Days	82 Day(s)	▼ -38 Day(s)
May	14	120 Days	150 Day(s)	▲ 30 Day(s)
June	4	120 Days	56 Day(s)	▼ -64 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

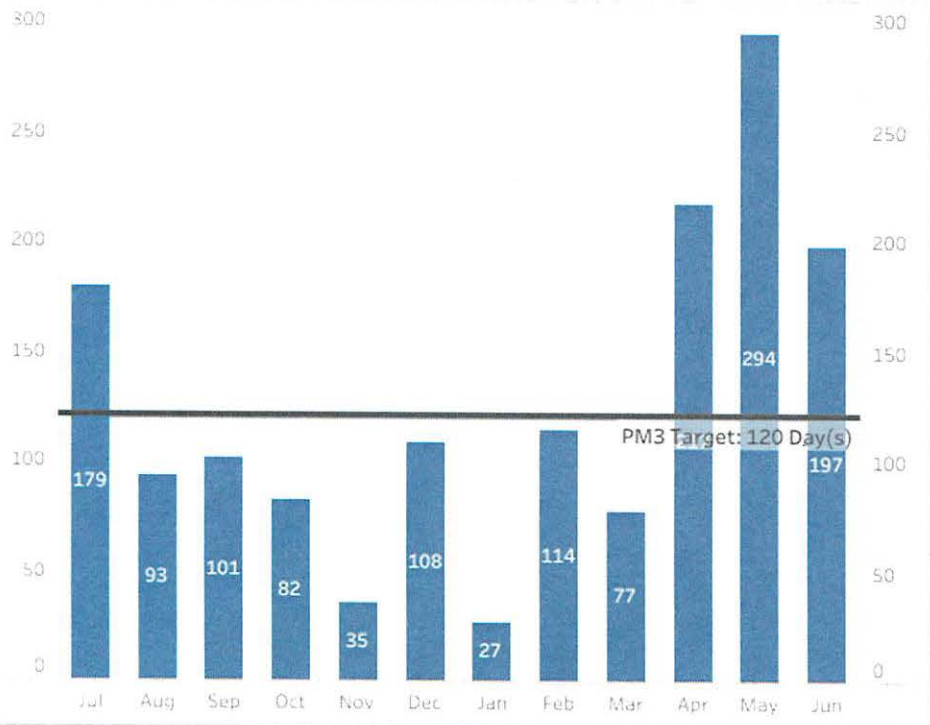
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2021

Cycle Time
Actual Target

Performance versus Target
Above Target Below Target

Dental Hygiene Board
SFY 2021: 12-Month | **PM3** - Investigations Cycle Time



Dental Hygiene Board
SFY 2021: 12-Month | **PM3** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	359	120 Days	183 Day(s)	▲ 63 Day(s)
July	20	120 Days	179 Day(s)	▲ 59 Day(s)
August	20	120 Days	93 Day(s)	▼ -27 Day(s)
September	18	120 Days	101 Day(s)	▼ -19 Day(s)
October	22	120 Days	82 Day(s)	▼ -38 Day(s)
November	10	120 Days	35 Day(s)	▼ -85 Day(s)
December	19	120 Days	108 Day(s)	▼ -12 Day(s)
January	14	120 Days	27 Day(s)	▼ -93 Day(s)
February	21	120 Days	114 Day(s)	▼ -6 Day(s)
March	19	120 Days	77 Day(s)	▼ -43 Day(s)
April	59	120 Days	217 Day(s)	▲ 97 Day(s)
May	105	120 Days	294 Day(s)	▲ 174 Day(s)
June	32	120 Days	197 Day(s)	▲ 77 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

DHBC
Dental Hygiene
Board of California

DHBC 2022/23 SUNSET REVIEW REPORT SECTION 13: ATTACHMENTS

PERFORMANCE MEASURE 4: FORMAL DISCIPLINE

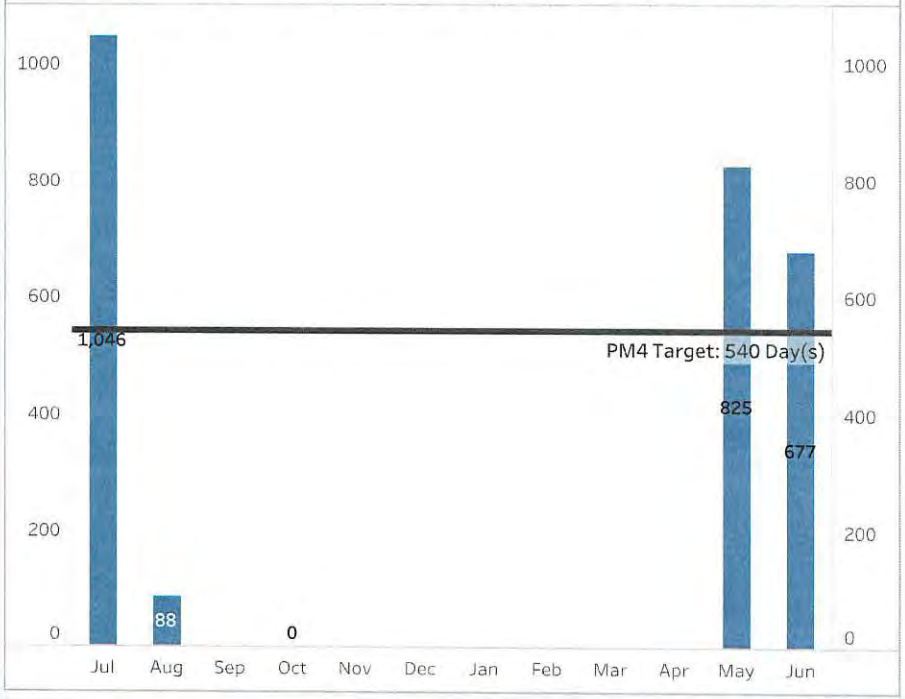
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2019

Cycle Time
Actual | Target

Performance versus Target
Above Target | Below Target

Dental Hygiene Board
SFY 2019: 12-Month | **PM4** - Formal Discipline Cycle Time



Dental Hygiene Board
SFY 2019: 12-Month | **PM4** - Summary

	Case Volume	Target	Actual	Variance
Grand Total	8	540 Days	414 Day(s)	▼ -126 Day(s)
July	1	540 Days	1,046 Day(s)	▲ 506 Day(s)
August	1	540 Days	88 Day(s)	▼ -452 Day(s)
October	3	540 Days	Day(s)	▼ -540 Day(s)
May	1	540 Days	825 Day(s)	▲ 285 Day(s)
June	2	540 Days	677 Day(s)	▲ 137 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

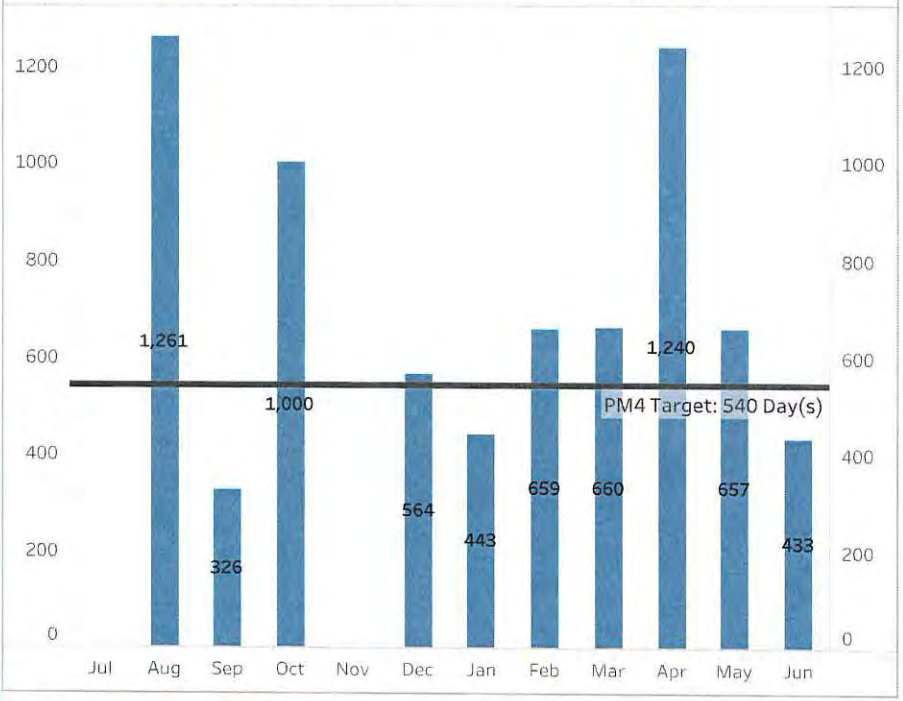
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2020

Cycle Time
Actual Target

Performance versus Target
Above Target Below Target

Dental Hygiene Board
SFY 2020: 12-Month | **PM4** - Formal Discipline Cycle Time



Dental Hygiene Board
SFY 2020: 12-Month | **PM4** - Summary

	Case Volume	Target	Actual	Variance
Grand Total	20	540 Days	686 Day(s)	▲ 146 Day(s)
August	1	540 Days	1,261 Day(s)	▲ 721 Day(s)
September	1	540 Days	326 Day(s)	▼ -214 Day(s)
October	2	540 Days	1,000 Day(s)	▲ 460 Day(s)
December	1	540 Days	564 Day(s)	▲ 24 Day(s)
January	1	540 Days	443 Day(s)	▼ -97 Day(s)
February	3	540 Days	659 Day(s)	▲ 119 Day(s)
March	3	540 Days	660 Day(s)	▲ 120 Day(s)
April	1	540 Days	1,240 Day(s)	▲ 700 Day(s)
May	4	540 Days	657 Day(s)	▲ 117 Day(s)
June	3	540 Days	433 Day(s)	▼ -107 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

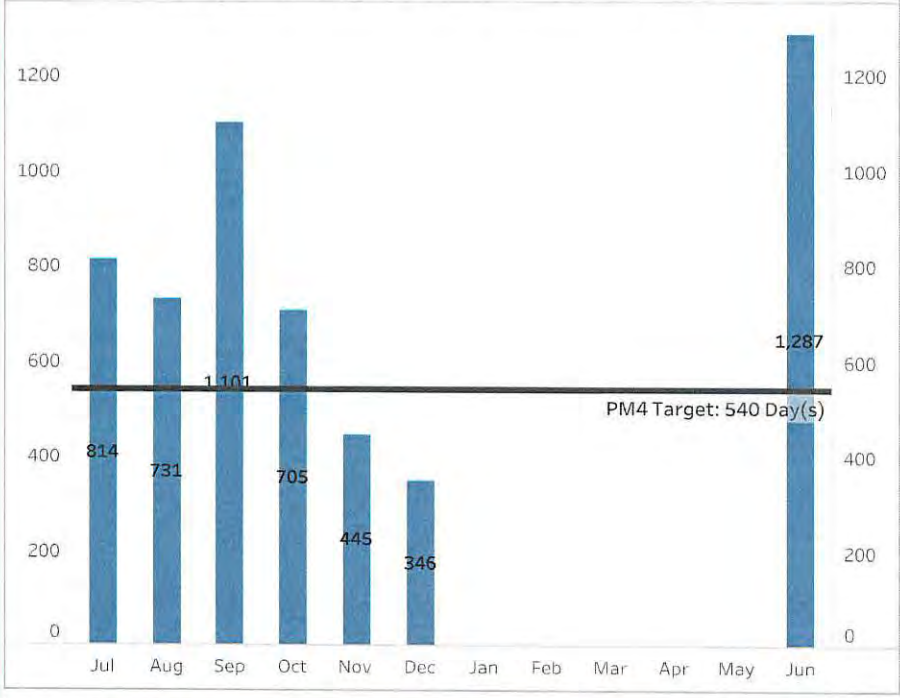
Select a DCA Entity
Dental Hygiene Board

Select a Fiscal Year
SFY 2021

Cycle Time
Actual | Target

Performance versus Target
Above Target | Below Target

Dental Hygiene Board
SFY 2021: 12-Month | **PM4** - Formal Discipline Cycle Time



Dental Hygiene Board
SFY 2021: 12-Month | **PM4** - Summary

	Case Volume	Target	Actual	Variance
Grand Total	8	540 Days	840 Day(s)	▲ 300 Day(s)
July	1	540 Days	814 Day(s)	▲ 274 Day(s)
August	1	540 Days	731 Day(s)	▲ 191 Day(s)
September	1	540 Days	1,101 Day(s)	▲ 561 Day(s)
October	1	540 Days	705 Day(s)	▲ 165 Day(s)
November	1	540 Days	445 Day(s)	▼ -95 Day(s)
December	1	540 Days	346 Day(s)	▼ -194 Day(s)
June	2	540 Days	1,287 Day(s)	▲ 747 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

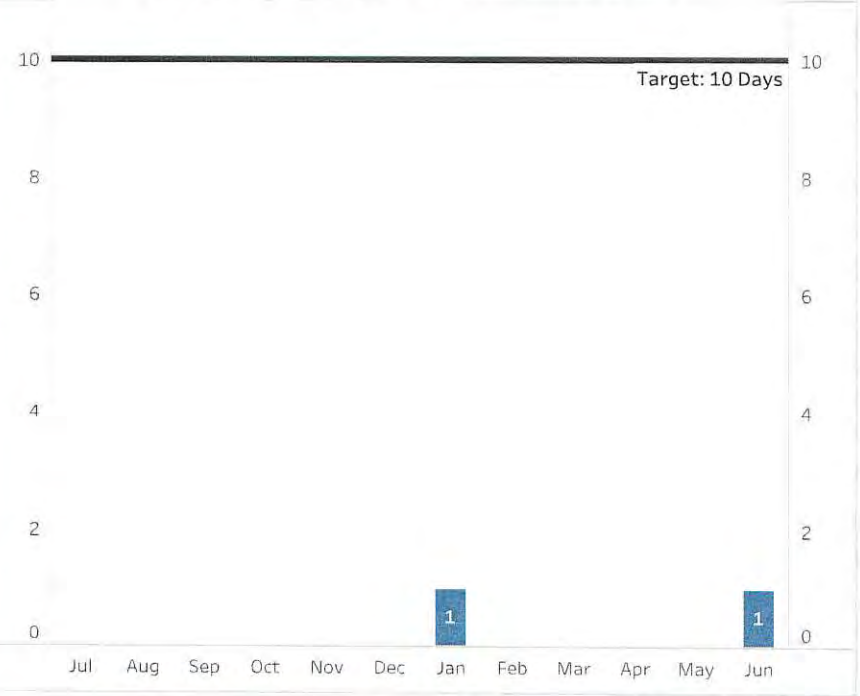
DHBC
Dental Hygiene
Board of California

DHBC 2022/23 SUNSET REVIEW REPORT SECTION 13: ATTACHMENTS

PERFORMANCE MEASURE 7: PROBATION

Select a Board/Bureau	Select a Fiscal Year	Performance Measure	Cycle Time	Performance versus Target
Dental Hygiene Board	SFY 2019	PM7	Actual Target	Below Target

Dental Hygiene Board
SFY 2019: 12-Month | **PM7:** Probation Intake Cycle Time



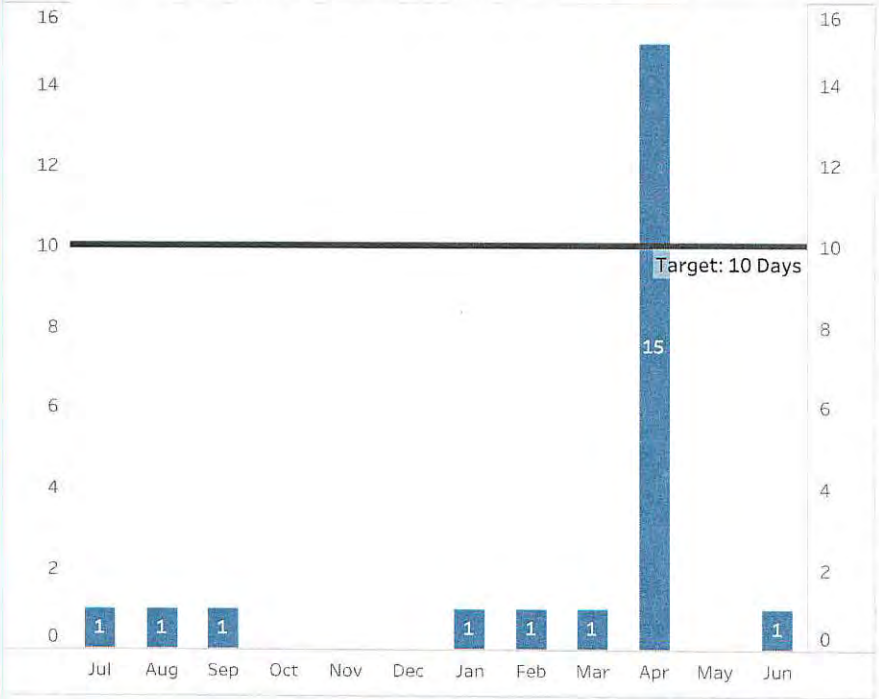
Dental Hygiene Board
SFY 2019: 12-Month | **PM7:** Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	2	10 Days	1 Day(s)	▼ -9 Day(s)
July				
August				
September				
October				
November				
December				
January	1	10 Days	1 Day(s)	▼ -9 Day(s)
February				
March				
April				
May				
June	1	10 Days	1 Day(s)	▼ -9 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Select a Board/Bureau	Select a Fiscal Year	Performance Measure	Cycle Time	Performance versus Target
Dental Hygiene Board	SFY 2020	PM7	Actual Target	Above Target Below Target

Dental Hygiene Board
SFY 2020: 12-Month | **PM7:** Probation Intake Cycle Time



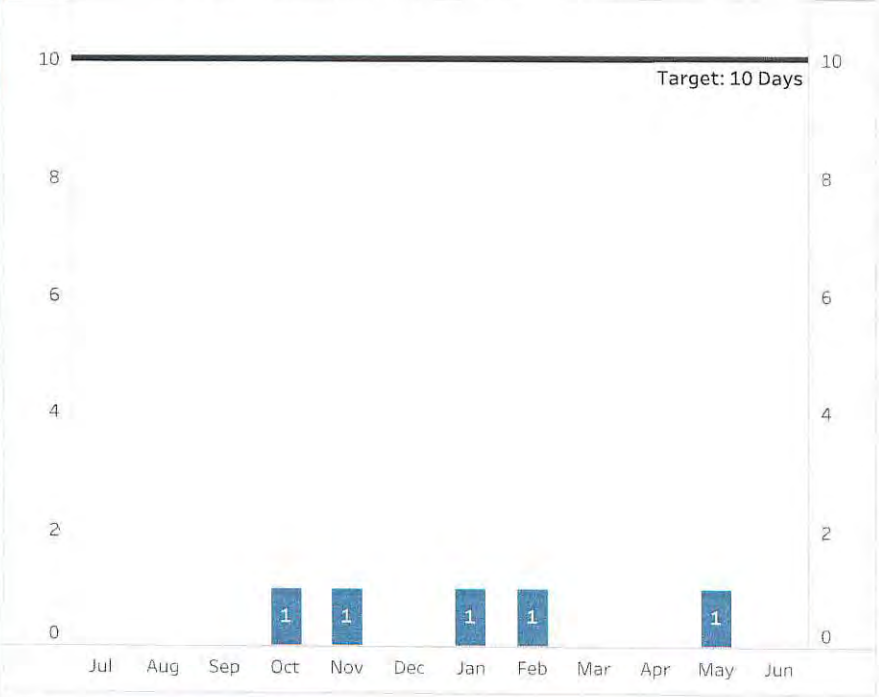
Dental Hygiene Board
SFY 2020: 12-Month | **PM7:** Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	12	10 Days	2 Day(s)	▼ -8 Day(s)
July	1	10 Days	1 Day(s)	▼ -9 Day(s)
August	2	10 Days	1 Day(s)	▼ -9 Day(s)
September	1	10 Days	1 Day(s)	▼ -9 Day(s)
October				
November				
December				
January	2	10 Days	1 Day(s)	▼ -9 Day(s)
February	2	10 Days	1 Day(s)	▼ -9 Day(s)
March	2	10 Days	1 Day(s)	▼ -9 Day(s)
April	1	10 Days	15 Day(s)	▲ 5 Day(s)
May				
June	1	10 Days	1 Day(s)	▼ -9 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Select a Board/Bureau	Select a Fiscal Year	Performance Measure	Cycle Time		Performance versus Target
Dental Hygiene Board	SFY 2021	PM7	Actual	Target	Below Target

Dental Hygiene Board
SFY 2021: 12-Month | **PM7:** Probation Intake Cycle Time



Dental Hygiene Board
SFY 2021: 12-Month | **PM7:** Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	5	10 Days	1 Day(s)	▼ -9 Day(s)
July				
August				
September				
October	1	10 Days	1 Day(s)	▼ -9 Day(s)
November	1	10 Days	1 Day(s)	▼ -9 Day(s)
December				
January	1	10 Days	1 Day(s)	▼ -9 Day(s)
February	1	10 Days	1 Day(s)	▼ -9 Day(s)
March				
April				
May	1	10 Days	1 Day(s)	▼ -9 Day(s)
June				

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Dental Hygiene Board of California
2022/23 Sunset Review Report

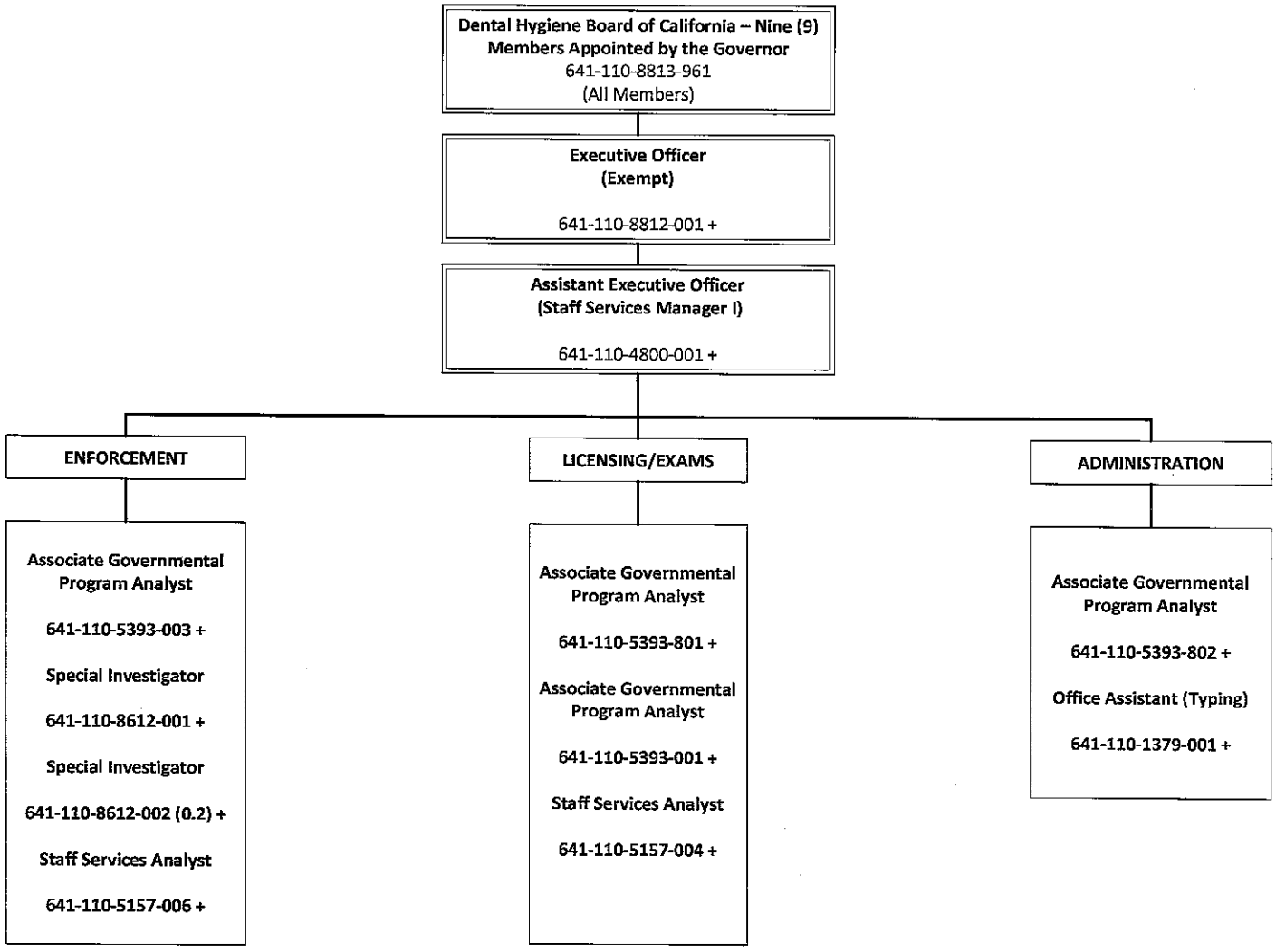
Section 13: Attachment E

Year-end Organizational Charts for the Last Four Fiscal Years

June 1, 2019

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE BOARD OF CALIFORNIA

CURRENT ORG CHART
FY 2018-19
Authorized Positions: 10.2



Anthony Lum, Executive Officer

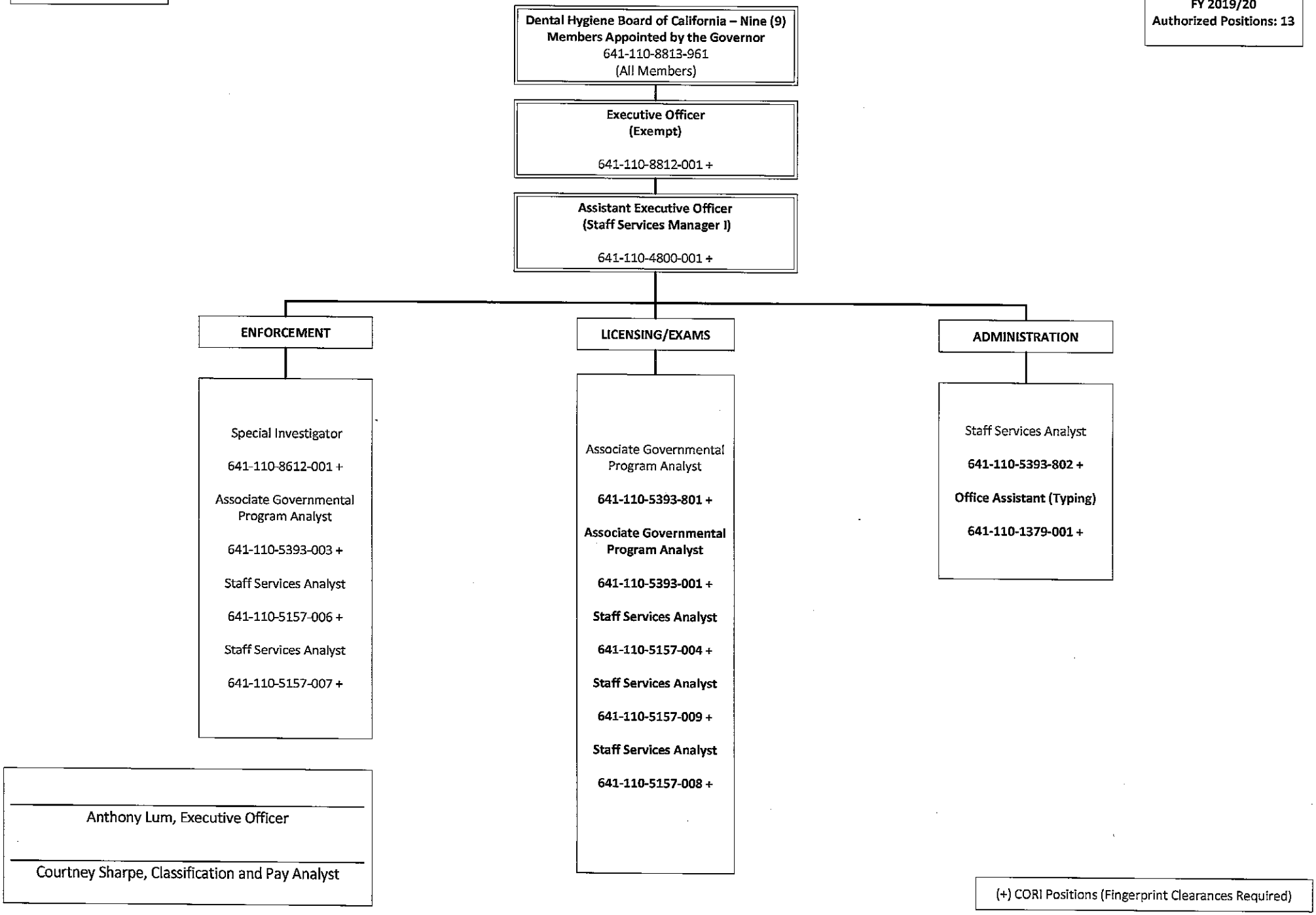
Casey Gates, Classification and Pay Analyst

(+) CORI Positions (Fingerprint Clearances Required)

June 2020
CURRENT

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE BOARD OF CALIFORNIA

CURRENT ORG CHART
FY 2019/20
Authorized Positions: 13



Anthony Lum, Executive Officer

Courtney Sharpe, Classification and Pay Analyst

(+) CORI Positions (Fingerprint Clearances Required)

June 2021

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE BOARD OF CALIFORNIA

CURRENT ORG CHART
FY 20/21
Authorized Positions: 13

Dental Hygiene Board of California
Nine (9) Members Appointed
2 Public Members, 1 Dentist, 4 Dental Hygienists Appointed by the Governor
1 Public Member Appointed by the Senate on Committee Rules
1 Public Member Appointed by the Speaker of the Assembly
641-110-8813-961
(All Members)

ENFORCEMENT

Special Investigator

641-110-8612-001 +

Executive Officer
(Exempt)

641-110-8812-001 +

LICENSING/EDUCATION & EXAMINATIONS PROGRAM

Staff Services Manager I

641-110-4800-002+

Assistant Executive Officer
(Staff Services Manager I)

641-110-4800-001 +

ENFORCEMENT

Associate Governmental Program Analyst

641-110-5393-003 +

Staff Services Analyst

641-110-5157-006 +

Staff Services Analyst

641-110-5157-007 +

LICENSING/EXAMS

Associate Governmental Program Analyst

641-110-5393-801 +

Associate Governmental Program Analyst
VACANT
641-110-5393-001 +

Staff Services Analyst

641-110-5157-004 +

Staff Services Analyst

641-110-5157-009 +

Staff Services Analyst

641-110-5157-802 +

ADMINISTRATION

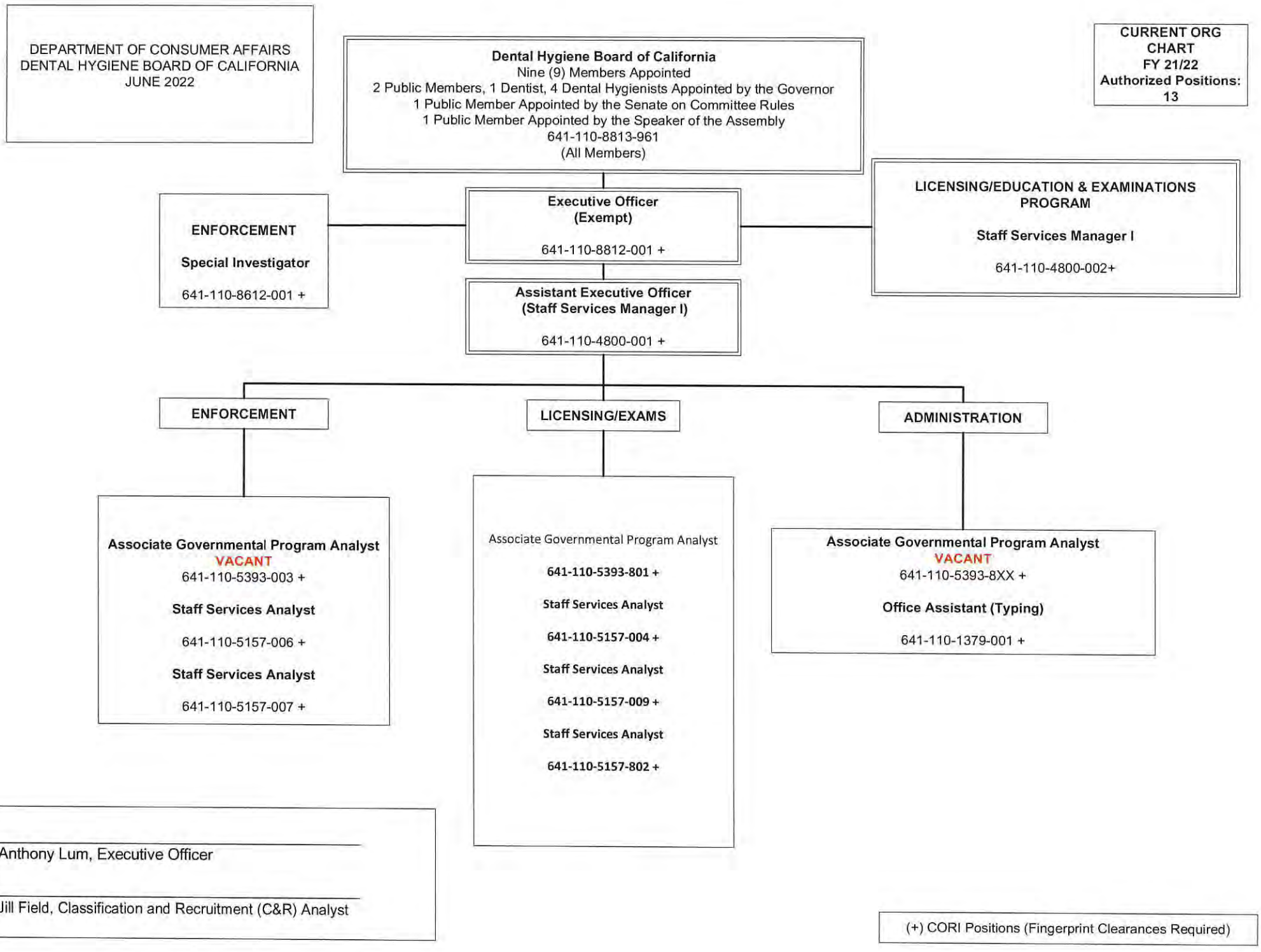
Office Assistant (Typing)

641-110-1379-001 +

Anthony Lum, Executive Officer

Jill Field, Classification and Recruitment Analyst

(+) CORI Positions (Fingerprint Clearances Required)


DEPARTMENT OF CONSUMER AFFAIRS
DENTAL HYGIENE BOARD OF CALIFORNIA
JUNE 2022
CURRENT ORG CHART
FY 21/22
Authorized Positions: 13
Dental Hygiene Board of California
Nine (9) Members Appointed
2 Public Members, 1 Dentist, 4 Dental Hygienists Appointed by the Governor
1 Public Member Appointed by the Senate on Committee Rules
1 Public Member Appointed by the Speaker of the Assembly
641-110-8813-961
(All Members)
ENFORCEMENT
Special Investigator
641-110-8612-001 +
Executive Officer
(Exempt)
641-110-8812-001 +
LICENSING/EDUCATION & EXAMINATIONS PROGRAM
Staff Services Manager I
641-110-4800-002+
Assistant Executive Officer
(Staff Services Manager I)
641-110-4800-001 +
ENFORCEMENT
LICENSING/EXAMS
ADMINISTRATION
Associate Governmental Program Analyst
VACANT
641-110-5393-003 +
Staff Services Analyst
641-110-5157-006 +
Staff Services Analyst
641-110-5157-007 +
Associate Governmental Program Analyst
641-110-5393-801 +
Staff Services Analyst
641-110-5157-004 +
Staff Services Analyst
641-110-5157-009 +
Staff Services Analyst
641-110-5157-802 +
Associate Governmental Program Analyst
VACANT
641-110-5393-8XX +
Office Assistant (Typing)
641-110-1379-001 +
Anthony Lum, Executive Officer
Jill Field, Classification and Recruitment (C&R) Analyst
(+) CORI Positions (Fingerprint Clearances Required)

Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachment F

California Dental Hygienists' Association's Letter of Support
for the Dental Hygiene Board of California

California Dental Hygienists' Association
The Voice of Dental Hygiene

September 23, 2022

Anthony Lum, Executive Officer
Dental Hygiene Board of CA
2005 Evergreen Street, Suite 1350
Sacramento, CA 95815

RE: Sunset Review Packet

Dear Mr. Lum and Board Members,

The CA Dental Hygienists' Association (CDHA) fully supports the extension of the Dental Hygiene Board of CA (DHBC).The DHBC provides vital consumer protection and management of the dental hygiene licensure categories that is critical to maintaining profession standards and integrity.

CDHA supports sunset review language that would allow APs currently practicing in Dental Health Professional Shortage Areas (DHPSAs) to keep their practices if the DHPSA designation is removed. It makes no sense to take away an AP's practice, when it is their practice that has helped to address the shortage. The recent survey conducted by CDHA (attached) indicated that APs would be more likely to begin practices in these shortage areas if they would not lose their business should the DHPSA designation change. As you are aware, one reason the AP licensure category was created was to reach patients in underserved areas. Removing this barrier to APs practicing in DHPSAs is required to help patients in those areas get connected to the dental team and address the lack of access.

CDHA supports sunset review language that would change RDH supervision for extended functions (Nitrous Oxide, Local Anesthesia, or Soft Tissue Curettage) from direct supervision to general *or* direct supervision at the discretion of the dentist. This allows RDHs confident in these functions to provide the care under standing orders or with more oversight depending on the how the specific dental office chooses to operate. This change in supervision would allow more flexibility for the dental team to meet the needs of patients more efficiently.

CDHA supports a moderate increase in the Executive Officer's higher exempt level and associated salary to accommodate for the Board's future growth, staff retention, and succession planning efforts. The Board is experiencing a compaction in its managerial positions and the state's supervision requirements prohibit any future growth for proper oversight of rank and file staff. As the Board continues to grow to meet its mandated oversight responsibilities, the higher EO exempt level will provide the managerial room in its structure for appropriate supervision that's needed to run the Board's program operations effectively.

Thank you for considering CDHA's positions on the items above. I'm available to discuss this further at your convenience. We look forward to working with the DHBC through the 2023 sunset review.

Sincerely,

Kathy Kane

KATHY KANE
President, CA Dental Hygienists' Association
Cc: DHBC Board Member

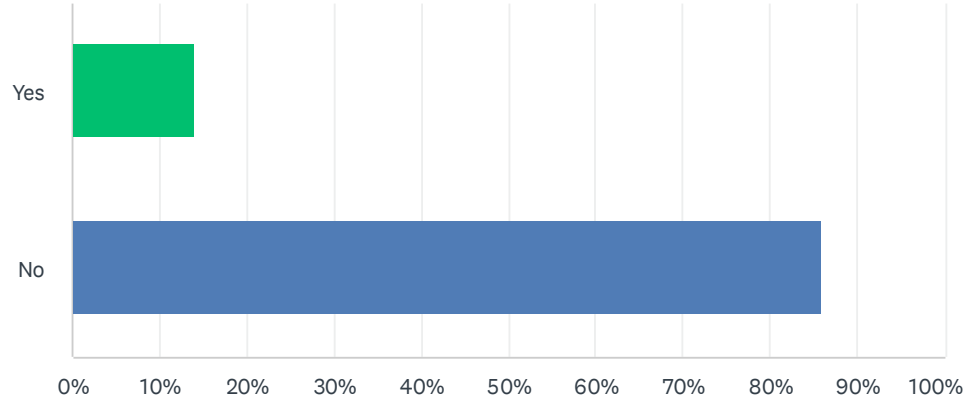
Dental Hygiene Board of California
2022/23 Sunset Review Report

Section 13: Attachment G

California Dental Hygienists' Association's RDHAP Survey of Licensees (of Opening a Stand-alone Clinic in Designated Dental Health Professional Shortage Area - DHPSA)

Q4 Do you have a RDHAP practice that occupies a brick and mortar building that is located in a designated Dental Health Professional Shortage Area (DPSA)?

Answered: 64 Skipped: 0



Yes	14.06%	9
No	85.94%	55
Total Respondents: 64		

Q5 Where is your practice building located?

Answered: 64 Skipped: 0

ANSWER CHOICES	RESPONSES	
City	100.00%	64
County	100.00%	64

#	CITY	DATE
1	Temecula	8/25/2022 9:59 PM
2	None	8/24/2022 10:11 PM
3	none	8/19/2022 11:37 AM
4	Na	8/18/2022 9:32 PM
5	No building	8/18/2022 9:00 PM
6	Sonora	8/17/2022 8:50 AM
7	Downey	8/17/2022 6:59 AM
8	Ventura	8/16/2022 9:53 PM
9	NA	8/16/2022 8:45 PM
10	porter ranch	8/16/2022 8:37 PM
11	Novato	8/16/2022 5:37 PM
12	Rocklin	8/16/2022 4:16 PM
13	No practice building.	8/16/2022 2:52 PM
14	325 11th street, Richmond Ca. 94801	8/16/2022 1:27 PM
15	Camarillo	8/14/2022 1:20 PM
16	N/A	8/14/2022 11:42 AM
17	Pico Rivera	8/14/2022 10:28 AM
18	N/a	8/13/2022 10:29 PM
19	Don’t have one	8/13/2022 6:13 PM

20	Costa Mesa	8/13/2022 5:56 PM
21	NA	8/13/2022 4:44 PM
22	Mobile only	8/13/2022 2:12 PM
23	Los angeles	8/13/2022 1:19 PM
24	Los Angeles	8/13/2022 1:01 PM
25	Red Bluff	8/13/2022 12:47 PM
26	Corona	8/13/2022 11:44 AM
27	Rancho Cucamonga and upland	8/13/2022 11:43 AM
28	N/a	8/13/2022 11:38 AM
29	Paso Robles	8/12/2022 7:06 PM
30	Visalia	8/12/2022 5:42 PM
31	Santa Rosa	8/12/2022 4:08 PM
32	Planning for Redlands Ca soon	8/11/2022 7:03 AM
33	N/a	8/11/2022 6:12 AM
34	San Francisco	8/10/2022 11:43 PM
35	Hayward	8/10/2022 10:15 PM
36	Hayward	8/10/2022 9:33 PM
37	NA	8/10/2022 9:12 PM
38	Sherman Oaks	8/10/2022 7:36 PM
39	Richmond	8/10/2022 5:58 PM
40	McKinleyville	8/10/2022 9:26 AM
41	Fresno	8/10/2022 4:08 AM
42	Novato	8/9/2022 7:55 PM
43	Redwood Valley	8/9/2022 7:40 PM
44	La Jolla	8/9/2022 7:07 PM
45	Big Bear City	8/9/2022 6:42 PM
46	Santa Rosa	8/9/2022 6:27 PM
47	Rancho cucamonga	8/9/2022 3:05 PM

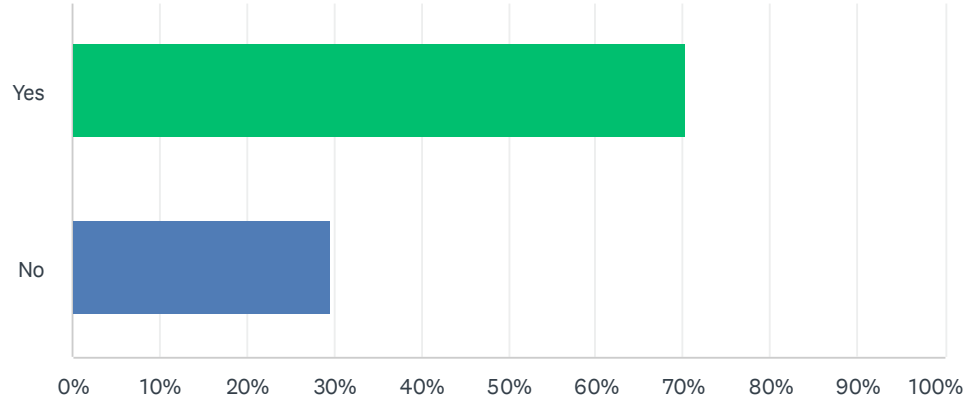
48	encino	8/9/2022 2:53 PM
49	San fernando	8/9/2022 2:17 PM
50	I don’t have one	8/9/2022 1:25 PM
51	Bakersfield	8/9/2022 12:51 PM
52	N/A	8/9/2022 12:28 PM
53	na	8/9/2022 12:11 PM
54	Durham	8/9/2022 12:03 PM
55	Na	8/9/2022 11:44 AM
56	Murrieta	8/9/2022 11:10 AM
57	Redding	8/9/2022 10:51 AM
58	Ukiah	8/9/2022 10:37 AM
59	N/a	8/9/2022 10:31 AM
60	Chino Hills	8/9/2022 10:01 AM
61	NA	8/9/2022 9:58 AM
62	retired	8/9/2022 8:17 AM
63	San Francisco	8/8/2022 6:02 PM
64	Eureka	8/8/2022 5:23 PM
#	**COUNTY**	**DATE**
1	Riverside	8/25/2022 9:59 PM
2	None	8/24/2022 10:11 PM
3	none	8/19/2022 11:37 AM
4	Na	8/18/2022 9:32 PM
5	N/A	8/18/2022 9:00 PM
6	tuolumne	8/17/2022 8:50 AM
7	LA	8/17/2022 6:59 AM
8	CA	8/16/2022 9:53 PM
9	Na	8/16/2022 8:45 PM
10	Los Angeles	8/16/2022 8:37 PM

11	Marin	8/16/2022 5:37 PM
12	Placer	8/16/2022 4:16 PM
13	Not applicable.	8/16/2022 2:52 PM
14	Contra Costa	8/16/2022 1:27 PM
15	California	8/14/2022 1:20 PM
16	N/A	8/14/2022 11:42 AM
17	Los Angeles	8/14/2022 10:28 AM
18	N/a	8/13/2022 10:29 PM
19	Don’t have one	8/13/2022 6:13 PM
20	Orange	8/13/2022 5:56 PM
21	N/A	8/13/2022 4:44 PM
22	N/A	8/13/2022 2:12 PM
23	La	8/13/2022 1:19 PM
24	Los Angeles	8/13/2022 1:01 PM
25	Tehama	8/13/2022 12:47 PM
26	Riverside	8/13/2022 11:44 AM
27	San Bernardino	8/13/2022 11:43 AM
28	N/a	8/13/2022 11:38 AM
29	San Luis Obispo	8/12/2022 7:06 PM
30	Tulare	8/12/2022 5:42 PM
31	Sonoma	8/12/2022 4:08 PM
32	San Bernardino	8/11/2022 7:03 AM
33	N/a	8/11/2022 6:12 AM
34	San Francisco	8/10/2022 11:43 PM
35	Alameda	8/10/2022 10:15 PM
36	Alameda	8/10/2022 9:33 PM
37	NA	8/10/2022 9:12 PM
38	Los Angeles	8/10/2022 7:36 PM

39	Contra costa	8/10/2022 5:58 PM
40	Humboldt	8/10/2022 9:26 AM
41	San Joaquin	8/10/2022 4:08 AM
42	Marin County	8/9/2022 7:55 PM
43	Mendocino	8/9/2022 7:40 PM
44	CA	8/9/2022 7:07 PM
45	California	8/9/2022 6:42 PM
46	Sonoma	8/9/2022 6:27 PM
47	San Bernardino	8/9/2022 3:05 PM
48	CA	8/9/2022 2:53 PM
49	Los Angeles	8/9/2022 2:17 PM
50	I don’t have one	8/9/2022 1:25 PM
51	Kern	8/9/2022 12:51 PM
52	N/A	8/9/2022 12:28 PM
53	na	8/9/2022 12:11 PM
54	Butte	8/9/2022 12:03 PM
55	Na	8/9/2022 11:44 AM
56	Riverside	8/9/2022 11:10 AM
57	Shasta	8/9/2022 10:51 AM
58	Mendocino	8/9/2022 10:37 AM
59	N/a	8/9/2022 10:31 AM
60	California	8/9/2022 10:01 AM
61	NA	8/9/2022 9:58 AM
62	retired was in Tulare and Kings Counties	8/9/2022 8:17 AM
63	San francisco	8/8/2022 6:02 PM
64	Humboldt	8/8/2022 5:23 PM

Q6 If there were not a limit on RDHAP practices in a DHPSA area, would you be interested in opening up a brick and mortar dental hygiene practice?

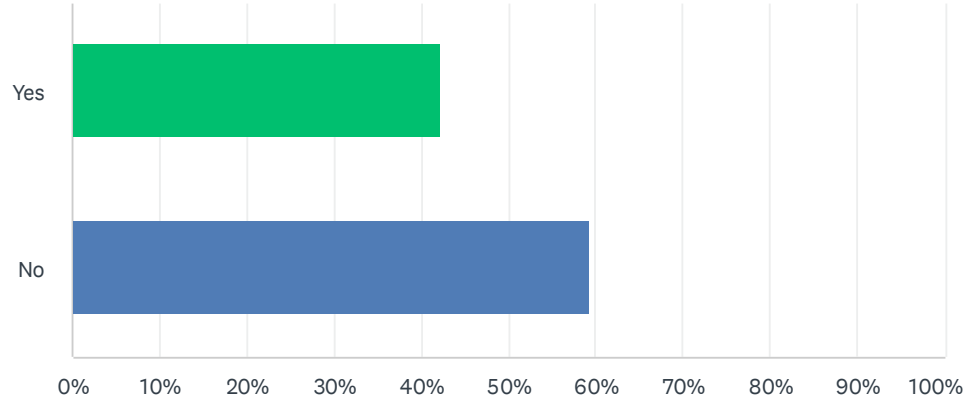
Answered: 64 Skipped: 0



Yes	70.31%	45
No	29.69%	19
Total Respondents: 64		

Q7 If you currently live in or near a DHPSA, are you considering establishing a brick and mortar practice?

Answered: 64 Skipped: 0



Yes	42.19%	27
No	59.38%	38
Total Respondents: 64		

Q8 Are there any other issues that CDHA should know about and be addressing for the RDHAP profession?

Answered: 42 Skipped: 22

#	RESPONSES	DATE
1	I currently work full time at a dental school. I do work occasional at a local assisted living. It would be nice to work more but I don't live close to underserved areas	8/24/2022 10:11 PM
2	Need for improved data collection. Thank you.	8/18/2022 9:00 PM
3	SDF and ITR training courses	8/16/2022 9:53 PM
4	I closed my practice August 2020. I had a brick and mortar practice and was not in a DHPSA area, because I was in the original #139 and #155 research projects that created data that was presented to the legislature to get the law passed establishing the RDHAP license.	8/16/2022 4:16 PM
5	Remove the exam after 18 mos and the X-ray requirement.	8/16/2022 2:52 PM
6	Having dental insurance companies acknowledge us and allow RDHAP's do X-rays and SCRP	8/16/2022 1:27 PM
7	Communication	8/14/2022 1:20 PM
8	The required medical orders are difficult to obtain. I have several patient's that don't have dentists because lack of mobile Medical-cal dentists in my area that make house calls. The MDs give push back on this. Both dentists and MDs feel this order form gives them liability over my work. It's a big barrier. I know we tried to remove this requirement and didn't have success. Is there any hope that this could ever be brought back to the table for change in the future?	8/14/2022 11:42 AM
9	RDHAP's are one of the main groups that treat patients with special needs especially patients with developmental disabilities. DentiCal has made it very difficult for RDHAP's to get a fair reimbursement for services provided for these patients for a long time. I think CDHA should fight for us and help us get a fair reimbursement for our services treating this population that not many dental providers are willing to treat. I know some RDHAP's have retired early, or are thinking about a different profession because it is very difficult working with this population and then we still have to fight with the insurance companies especially DentiCal to get reimbursement.	8/14/2022 10:28 AM
10	Help with locating DHPSA locations. A little better or clearer communication on updates and changes.	8/13/2022 6:13 PM
11	More atomy, work in hospitals, oncology, cardiology, all assisted living facility (needs to be the standard of care) etc … stop having to check in with DDS - stop having DDS place restrictions on ITR.	8/13/2022 5:56 PM
12	This issue is the reason I do not open a practice. It's a ridiculous limitation. Either you want to help all underserved communities or you do not. In this case I feel the CDA is limiting trade and CA has been allowing it. I was hopeful with the recent legislation that this limitation would be erased. Alas it isn't :(	8/13/2022 4:44 PM
13	Opening a practice wherever we want. Clarify Teeth whitening, because it doesn't belong to dentistry- it's cosmetic per the	8/13/2022 1:19 PM

	Supreme Court. Make it easier to compete in the market for patients to have great hygienist. Help the RDH and RDHAP be entrepreneurs.	
14	Providing business classes and Information and networking opportunities that don't cost hundreds to be a part of or join. Making ITR certificates accessible and affordable Making it more main steam to incorporate our practices in hospital settings like in Oregon Allowing us to open brick and mortar anywhere like in Colorado	8/13/2022 1:01 PM
15	Administering Botox to head and neck	8/13/2022 11:43 AM
16	We need to be able to perform our duties without red tape oversight from DDS. This includes relationship form. This form means nothing. We also need our duties to be WS (without supervision) for ALL RDH duties allowed in California.	8/13/2022 11:38 AM
17	Getting Denti-cal to be reasonable in their fees especially with periodontally involved patients.	8/12/2022 5:42 PM
18	Would like to remove the supervising dentist and medical order request. These 2 items are restrictive for no reason.	8/12/2022 4:08 PM
19	Help with recognition by dental insurance providers, for billing support, would be amazing. The 2 year "prescription" could possibly use some deeper thought. Just an idea, but it could maybe be revised to something more along the lines of RDHAP's assuring that patients are making a conscious effort to be sure their patients are seen by a dentist and not neglected, using a reasonable time frame. Some patients only dental care comes from and RDHAP and the 2-year prescription can limit/discourage that access. Thank you so much!!!	8/11/2022 7:03 AM
20	Find a way to work with CDA. Help us establish new DHPSAs. I talked to the people who make such designations and they said the city I wanted to classify didn't meet the criteria. Change the criteria so it can exist, and with the changes it sounds like you want, too, the criteria can be changed so it will persist.	8/10/2022 11:43 PM
21	As RDHAP's we loose some skill sets that we've been practicing as RDH's. Such as taking impressions and whitening services. We are beyond skilled and trained for these services. The community would be in safer hands with sterile equipment to seek a whitening service with an RDHAP vrs a pop up shop in the mall with a completion certificate. Also, impressions can be helpful for any community for sports guards and night guards for many preventative reasons yes as RDHAP's we are no longer able to provide these services unless under a dentist supervision.	8/10/2022 10:15 PM
22	Where do I start? The inability to hire an RDA I order to complete coronal polishing and OHI to the patients. Having to fill out a new DDS relationship form every two years. Having to pay for two licenses. Whitening services.	8/10/2022 9:33 PM
23	Workshops on how to fill out provider forms for Medical and private insurances. As well as how to bill.	8/10/2022 9:12 PM
24	What happens if your location changes status? Is there an easier path for insurance to recognize the license?	8/10/2022 7:36 PM
25	I think RDHAP should be allowed to open a practice anywhere. We should also be allowed to learn fillings and extractions.	8/10/2022 5:58 PM
26	I am a RDHAP that does live in a DHPSA. I do not own a brick and mortar practice yet. I certainly would not want to be limited on opening a practice in my area if our DHPSA status ever changed.	8/10/2022 9:26 AM
27	The prescription for oxygen in order to administer local is a barrier as well as prescriptions for CHX. Having to take xrays for pre auth on SRPs is also a huge barrier for anyone working with bed bound developmentally disabled, Parkinson's, or Alzheimer's	8/9/2022 7:07 PM
28	I'm an educator, I am not currently practicing as a RDHAP, but I want to support the RDHAP practice. Thank-you!	8/9/2022 6:27 PM
29	Introduce the RDHAP profession to medical personnel. Integrate dental and medical profession to provide comprehensive care to the community.	8/9/2022 2:17 PM

30	In regards to DPSA, would cdha consider advocating for RDHAP brick and mortar practices for Dentical shortage areas? For example there are areas in the city of San Francisco they are Medical Dental shortage areas	8/9/2022 1:25 PM
31	Allow more independence like Ontario,Canada dental hygiene practice to serve the population in need. Practicing in underserved area for 18+ years has taught me the dental hygiene need is unmet and we should be allowed to continue hygiene treatment without the prescription every 2year. We as hygienist are not taking the dentist s patients, but are assisting them with periodontal care so they have teeth to restore.Lol	8/9/2022 12:51 PM
32	Patients have reduced access to care because of the MD or DDS prescription requirement for dental hygiene treatments. Sometimes there is a long wait to obtain these prescriptions	8/9/2022 12:28 PM
33	I am not a practicing RDHAP currently	8/9/2022 12:11 PM
34	Dentist refusing to sign standing orders on mutual patients so patients can continue to see RDHAP at their brick and mortar office for cleanings. Also, insurances refusing to reimburse dental cleanings by RDHAPs.	8/9/2022 12:03 PM
35	Allow us to purchase restricted products and allow us to cancel the relationship with a dentist renewal requirement.	8/9/2022 11:44 AM
36	There are a lot of restrictions that are on us that are against the Fair Trade Act. The Supreme Court ruled that a Dental Board that's majority members being DDS making rules for what non-DDS in a anti competitive way (meaning blocking us from doing things that are already proven to be safe in our capacity) is is illegal. Ie: selling and placing whitening products, having us jump threw a lot of hoops to try and see patients, to make it difficult on us so that we can't see patients or just give up IE: having to have a prescription every 24 months from a dentist on an actual prescription pad, while we already also have to have a form filled out stating that we have a dentist that we have a relationship with. We can do 1910 a, and b but not c or d. we can only have an office in a certain zone because it competes with new DDS to have it anywhere. All of these things are illegal. I think we need to file a complaint with the FTC honestly. I could go on and on. I have a lot to say. I feel like it falls on deaf ear a lot of the time because everyone is so afraid of the board. Honestly we need to hold the government responsible for letting the board do this to us. We need a letter written campaign to the governor as well.	8/9/2022 11:10 AM
37	I would like to discuss CDT Vs. Procedure codes and what it would mean for an RDHAP if that changes the way we will insurance. Many RDHAP would like to take impressions and perform in office whitening with an Rx from the DDS	8/9/2022 10:51 AM
38	We should be allowed to submit more than one DDS we work with. We work together in the community with different DDS for different reasons. The requirement should be "One active DDS on file" but you should be able to list more than one. Your last two questions are N/A for those that already have a practice, but that is not an option so I put yes because it requires me to answer it but I am not interested in opening another practice.	8/9/2022 10:37 AM
39	There are so many restrictions. Please alleviate them so we can help the poor and underserved in the area	8/9/2022 10:31 AM
40	Medi-cal employees need to be aware of the rdhap. I frequently get conflicting answers regarding who and what is covered for rdhal care	8/9/2022 10:01 AM
41	I have not been able to establish my business yet because lack guidance on the business side. Dilemmas like this one mentioned is very discouraging. We definitely need to organize and protect established RdhAPs livelihood!	8/9/2022 9:58 AM
42	CDHA needs to seriously work to ensure best practices and reimbursements from Medi-Cal Dental.	8/9/2022 8:17 AM