DHCC
Dental Hygiene
Committee
of California

DHCC 2013/14
SUNSET REVIEW REPORT

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
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2013/14 DHCC SUNSET REVIEW REPORT

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DHCC 2013/14 SUNSET REPORT TABLE OF ACRONYMS

AG	Attorney General's Office
ALJ	Administrative Law Judge
BCP	Budget Change Proposal
BPC	Business and Professions Code
BPED	Business, Professions and Economic Development Committee
BPPE	Bureau for Private Postsecondary Education
CalHR	California Department of Human Resources
CCR	California Code of Regulations
CDHA	California Dental Hygienists' Association
CDHEA	California Dental Hygiene Educator's Association
CE	Continuing Education
CODA	Commission on Dental Accreditation
COMDA	Committee on Dental Auxiliaries
DBC	Dental Board of California
DCA	Department of Consumer Affairs
DEC	Diversion Evaluation Committee
DHBC	Dental Hygiene Board of California
DHCC	Dental Hygiene Committee of California
DOJ	Department of Justice
DPA	Dental Practice Act
EDC	Education Code
EO	Executive Officer
FNP	Fictitious Name Permit
FTB	Franchise Tax Board
FY	Fiscal Year
IOM	Institute of Medicine
ITR	Interim Therapeutic Restorations
JCNDE	Joint Commission on National Dental Examiners
JLSRC	Joint Legislative Sunset Review Committee
LBC	Licensure By Credential
MOU	Memorandum of Understanding
N/A	Not Applicable
NDHBE	National Dental Hygiene Board Examination
OE&E	Operating Expenses and Equipment
OHR	Office of Human Resources
OIS	Office of Information Services
OSHPD	Office of Statewide Health Planning and Development
PC	Penal Code
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienist in Alternative Practice
RDHEF	Registered Dental Hygienist in Extended Functions
SB	Senate Bill
WREB	Western Regional Examination Board

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
[DHCC Sunset Review Report for 2013/14]

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.

As an independent committee, the DHCC represents the only self-regulating dental hygiene agency of its kind in the United States. The DHCC has the authority regarding all aspects of the licensing of dental hygienists, all enforcement and investigation authority regarding all dental hygienists, and the approval of educational programs that provide the prerequisite education to become a licensed dental hygienist. According to the Business and Professions Code (BPC), Section 1900, the purpose for the DHCC 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 DHCC 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 DHCC develops and administers written and clinical licensing examinations, conducts occupational analyses of the various professional categories, evaluates educational courses, pursues legislation, establishes regulations, approves educational programs, and has licensing and enforcement responsibilities. The DHCC 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 DHCC regulates the dental hygiene profession by the guidance of its statutes contained in the BPC, Sections 1900 – 1966.6 (cf., Section 12, Attachment A1).

1. Describe the make-up and functions of each of the board's committees (cf., Section 12, Attachment B).

   The make-up of the DHCC consists of nine members (four dental hygienists, four public members, and one practicing dentist) appointed by the Governor. The function of the DHCC is to discuss, deliberate, address, hear public comment, and possibly act upon any programmatic, legislative, or

[1] The term "board" in this document refers to a board, bureau, commission, committee, department, division, program, or agency, as applicable. Please change the term "board" throughout this document to appropriately refer to the entity being reviewed.

other issue(s) that may affect its professional population, interested stakeholders, but most of all, the consumers of California.

The make-up and function of each of the DHCC's Subcommittees are:

Make-up: each subcommittee consists of three to four members as appointed by the DHCC President to review, discuss, deliberate, hear public comment, and vote on any issue(s) that pertain to the specific subcommittee's jurisdiction and bring forth recommendation(s) to the full Committee consisting of all DHCC members to discuss and take possible action.

a) Education and Outreach Subcommittee – The purpose of the Education and Outreach Subcommittee is to provide recommendations to the DHCC on the development of informational brochures and other publications, planning of outreach events for consumers and licensees, preparing articles for submission in trade magazines, and attending trade shows.

b) Enforcement Subcommittee – The purpose of the Enforcement Subcommittee is to advise the DHCC on policy matters that relate to protecting the health and safety of consumers. This includes maintenance of disciplinary guidelines, and other recommendations on the enforcement of the DHCC's statutes and regulations.

c) Legislative and Regulatory Subcommittee – The purpose of the Legislative and Regulatory Subcommittee is to review and track legislation which affects the DHCC's licensees and consumers, and recommends positions on legislation. It also provides information and recommendations to the DHCC on regulatory additions or changes.

d) Licensing and Examination Subcommittee – The purpose of the Licensing and Examination Subcommittee is to advise the DHCC on policy matters relating to the examining and licensing of individuals who want to practice dental hygiene in California. The subcommittee may also provide information and recommendations on issues relating to curriculum and school approval, exam appeals, and laws and regulations.

Table 1a. Attendance			
Member: Susan Good, Public Member			
Date Appointed: April 5, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes
Member: Sherrie-Ann Gordon, Public Member			
Date Appointed: April 5, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	No
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes

Table 1a. Attendance (continued)

Member: Michelle Hurlbutt, RDH Educator			
Date Appointed: October 21, 2009; Re-appointed: 8/23/2012			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
October 23, 2013 Sunset Review Ad-Hoc Meeting	10/23/2013	Sacramento	Yes
October 16, 2013 Sunset Review Ad-Hoc Meeting	10/16/2013	Sacramento	Yes
October 9, 2013 Education Regulations Ad-Hoc Meeting	10/8/2013	Sacramento	Yes
September 16 – 17, 2013 Regulatory and Sunset Review Report Ad-Hoc Meetings	9/16-17/2013	Sacramento	Yes
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes
February 2013 Teleconference Meeting	2/27/2013	Loma Linda, CA	Yes
December 2012 DHCC Meeting	12/4/2012	Sacramento, CA	Yes
December 2012 Legislative and Regulatory Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
December 2012 Licensing and Regulatory Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
July 2012 Teleconference Meeting	7/9/2012	Multiple Locations	No
April 2012 DHCC Meeting	4/17/2012	San Diego, CA	Yes
April 2012 Licensing and Examination Subcommittee Meeting	4/16/2012	San Diego, CA	Yes
April 2012 Legislative and Regulatory Subcommittee Meeting	4/16/2012	San Diego, CA	Yes
April 2012 Enforcement Subcommittee Meeting	4/16/2012	San Diego, CA	Yes
December 2011 DHCC Meeting	12/13/2011	Sacramento, CA	Yes
December 2011 Licensing and Examination Subcommittee Meeting	12/12/2011	Sacramento, CA	Yes
December 2011 Legislative and Regulatory Subcommittee Meeting	12/12/2011	Sacramento, CA	Yes
April 2011 DHCC Meeting	4/29/2011	El Segundo, CA	Yes
December 2010 DHCC Meeting	12/6/2010	Sacramento, CA	Yes
December 2010 Legislative and Regulatory Subcommittee Meeting	12/5/2010	Sacramento, CA	Yes
December 2010 Education and Outreach Subcommittee Meeting	12/5/2010	Sacramento, CA	Yes
December 2010 Licensing and Examination Subcommittee Meeting	12/4/2010	Sacramento, CA	Yes

Table 1a. Attendance (continued)

September 2010 DHCC Meeting	9/28/2010	Sacramento, CA	Yes
September 2010 Legislative and Regulatory Subcommittee Meeting	9/27/2010	Sacramento, CA	Yes
September 2010 Licensing and Examination Subcommittee Meeting	9/27/2010	Sacramento, CA	Yes
September 2010 Education and Outreach Subcommittee Meeting	9/27/2010	Sacramento, CA	Yes
September 2010 DHCC Strategic Plan Meeting	9/26/2010	Sacramento, CA	Yes
July 2010 DHCC Strategic Plan Meeting	7/28/2010	Sacramento, CA	Yes
June 2010 Teleconference Meeting	6/8/2010	Upland, CA	Yes
March 2010 DHCC Meeting	3/22/2010	Ontario, CA	Yes
January 2010 Licensing and Examination Subcommittee Meeting	1/10/2010	Sacramento, CA	Yes
December 2009 DHCC Meeting	12/10/2009	Sacramento, CA	Yes
Member: Noel Kelsch, RDHAP			
Date Appointed: August 23, 2012			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes
February 2013 Teleconference Meeting	2/27/2013	Plattsburg, NY	Yes
December 2012 DHCC Meeting	12/4/2012	Sacramento, CA	Yes
December 2012 Enforcement Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
December 2012 Legislative and Regulatory Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
December 2012 Licensing and Examination Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
Member: Timothy Martinez, DMD			
Date Appointed: August 23, 2012			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes
February 2013 Teleconference Meeting	2/27/2013	Pomona, CA	Yes
December 2012 DHCC Meeting	12/4/2012	Sacramento, CA	Yes
December 2012 Legislative and Regulatory Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes

Table 1a. Attendance (continued)

December 2012 Licensing and Examination Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
December 2012 Education and Outreach Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
Member: Nicolette Moultrie, RDH			
Date Appointed: August 23, 2012			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
October 23, 2013 Sunset Review Ad-Hoc Meeting	10/23/2013	Sacramento	Yes
October 16, 2013 Sunset Review Ad-Hoc Meeting	10/16/2013	Sacramento	Yes
October 9, 2013 Education Regulations Ad-Hoc Meeting	10/8/2013	Sacramento	Yes
September 16 – 17, 2013 Regulatory and Sunset Review Ad-Hoc Meetings	9/16-17/2013	Sacramento	Yes
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes
February 2013 Teleconference Meeting	2/27/2013	Martinez, CA	Yes
December 2012 DHCC Meeting	12/4/2012	Sacramento, CA	Yes
December 2012 Enforcement Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
December 2012 Education and Outreach Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
Member: Garry Shay, Public Member			
Date Appointed: April 5, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes
Member: Evangeline Ward, RDH			
Date Appointed: February 12, 2012			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
September 7, 2013 DHCC Sunset Review Meeting	9/7/2013	South San Francisco, CA	Yes
September 6, 2013 DHCC Meeting	9/6/2013	South San Francisco, CA	Yes
May 2013 DHCC Meeting	5/3/2013	Glendale, CA	Yes

Table 1a. Attendance (continued)

February 2013 Teleconference Meeting	2/27/2013	Vacaville, CA	Yes
December 2012 DHCC Meeting	12/4/2012	Sacramento, CA	Yes
December 2012 Legislative and Regulatory Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
December 2012 Licensing and Examination Subcommittee Meeting	12/3/2012	Sacramento, CA	Yes
July 2012 Teleconference Meeting	7/9/2012	Vacaville, CA	Yes
April 2012 DHCC Meeting	4/17/2012	San Diego, CA	Yes
April 2012 Legislative and Regulatory Subcommittee Meeting	4/16/2012	San Diego, CA	Yes
April 2012 Licensing and Examination Subcommittee Meeting	4/16/2012	San Diego, CA	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)
Susan Good	4/05/13	N/A	1/1/14	Governor	Public
Sherrie-Ann Gordon	4/05/13	N/A	1/1/16	Governor	Public
Michelle Hurlbutt, RDH Educator	10/21/09	8/23/12	1/1/16	Governor	Professional, RDH Educator
Noel Kelsch, RDHAP	8/22/12	N/A	1/1/16	Governor	Professional, RDH, RDHAP
Timothy Martinez, DMD	8/23/12	N/A	1/1/14	Governor	Professional, Public Health Dentist
Nicolette Moultrie, RDH	8/23/12	N/A	1/1/14	Governor	Professional, RDH, RDHAP
Garry Shay	4/05/13	N/A	1/1/14	Governor	Public
Evangeline Ward, RDH	2/12/12	N/A	1/1/14	Governor	Professional, RDH
Vacant Member	N/A	N/A	N/A	Governor	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?

   The DHCC has been privileged to have dedicated and engaged members (both currently and in the past) that participate in the DHCC 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. As such, the DHCC has never had an inability to conduct its meetings due to a quorum issue over the past four years.

3. Describe any major changes to the board (Committee) since the last Sunset Review, including:

   - Internal Changes (i.e., reorganization, relocation, change in leadership, strategic planning)

     Over the past two fiscal years, the DHCC has experienced a major reorganization and change in leadership as seven out of eight DHCC members were replaced with new Governor appointees and only a single member remained as the veteran member to maintain and continue the institutional memory and program knowledge. This member, President Michelle Hurlbutt, is an original founding member of the DHCC and had an instrumental role in the creation of the current DHCC strategic plan and program functions.

     - As the DHCC works to fulfill its mission to protect the consumer and to be accountable to its stakeholders, the workload for the existing staff has increased. The Executive Officer (EO) has had to fulfill the job responsibilities of EO as well as being a manager. With budget constraints playing a major role in staffing, the workload that needs to be completed to efficiently and effectively run the daily operations of the DHCC is being done without adequate managerial staff. The need for the managerial position has become increasingly apparent as programmatic workloads such as regulations, citation and fine, continuing education (CE), educational program review and audits continue to increase. The DHCC, in comparison to boards of similar size and programs who have managerial positions, has been struggling to perform all of the functions that are required by statute.

     The DHCC is planning to relocate its office location in the near-future, as the current office suite cannot accommodate additional authorized staff. The Department of Consumer Affairs (DCA) is working with the DHCC to accommodate additional office space in anticipation for new staff to address current and additional programmatic workloads. The relocation is pending until two other DCA programs relocate and the DHCC will then backfill one of those program's office suites. Until the office relocation occurs, there is a programmatic issue to address any new workload due to a lack of office space for new staff, equipment, and supplies.

     The DHCC originally met in July 2010 to determine the important issues that should be contained in its strategic plan. In September 2010, the DHCC voted to approve its first strategic plan that detailed the mission, goals, and objectives to be completed over the next three years. In May 2013, the DHCC extended its strategic plan from a 3-year to a 5-year plan with an expiration date in 2015. Although many of the Strategic Plan goals have been completed, there are still more complex and time-consuming objectives from its original plan that could not be completed within the original three year time frame.

- All legislation sponsored by the board and affecting the board since the last sunset review.

  The DHCC worked in collaboration with the California Dental Hygienists' Association (CDHA), the sponsors of SB 1202 (Leno – Ch. 331, Statutes of 2012), to pass new legislative mandates that went into effect January 1, 2013. The legislative changes enacted by this bill are:

  - Registered dental hygienists licensed in another state can teach in a California dental hygiene college without being licensed in California if they are issued a special permit by the DHCC.

  - New educational programs must provide a feasibility study to the DHCC demonstrating the need for a new program and financial sustainability before seeking approval for initial accreditation from the Commission on Dental Accreditation (CODA).

  - Any examinee for a registered dental hygienist license who fails the DHCC Clinical Licensure Examination or Western Regional Examining Board (WREB) clinical exam in three attempts or who fails the DHCC Clinical Licensure Examination as a result of imposing gross trauma on a patient, is not eligible for further examination until he or she has successfully completed a remedial education course approved by the DHCC.

  - Clarifies the requirement that all applicants must complete the DHCC-approved course in soft tissue curettage, administration of local anesthesia, and administration of nitrous oxide and oxygen analgesia for licensure.

  - Provides that extramural dental hygiene facilities associated with a dental hygiene program must register with the DHCC.

  - RDHAPs may operate a mobile dental hygiene unit after applying to the DHCC for a permit.

  - RDHAPs must register with the DHCC where they practice.

  - RDHAPs who own more than one office location must obtain additional office permits from the DHCC.

  - New license renewal fee ceilings were established. Any changes to the fees must be voted on and approved by the DHCC.

  The DHCC had an active role in SB 1575, Senate Business, Professions and Economic Development (BPED) (Chapter 799, Statutes of 2012). This bill gave the DHCC the authority to do the following:

  - Collect survey data from licensees as part of the initial licensure and any subsequent application for renewal of a license.

  - Require licensees who change their physical address of record or e-mail address to notify the DHCC within 30 days of the change.

  - Deny a license to anyone who is required to register as a sex offender.

  The DHCC also included legislative language within SB 821 (BPED – 2013/14) amending the Welfare and Institutions Code to cover the necessary dental hygiene services rendered by an

RDH, RDHAP, or RDHEF as long as the services are within the scope of Denti-Cal benefits and other minor technical corrections.

- All regulation changes approved by the board since the last sunset review. Include the status of each regulatory change approved by the board.

  BPC, Section 1906(a) gives the DHCC the authority to adopt, amend, and revoke regulations. The DHCC is in the process of writing the regulations required to implement the provisions of Article 9 of the BPC. To do this, the DHCC has developed a three phase process to implement all of the current regulations pertaining to dental hygiene practice, education, examination, licensure, and enforcement. The three phases consist of:

  1. Phase I contains regulatory sections relative to definitions, delegations to the Executive Officer (EO), examinations, and minimum standards for infection control, as these sections are of the first priority for the DHCC to address. The rulemaking file for Phase I was recently adopted by the DHCC and will be noticed for the 45-day public comment.

  2. Phase II regulatory sections involve the approval of educational programs, remedial education, and CE.

  3. Phase III regulatory sections are those that will require the DHCC to obtain statutory authority prior to requesting the changes through the rulemaking process, such as continued competency and rules for dental hygiene corporations.

  The following table displays each regulatory phase and the regulatory sections to be completed in each phase.

DHCC REGULATORY PHASES	
Phase I	California Code of Regulations (CCR) Regulatory Sections
Article 1: Definitions	1100 Definitions
Article 2: Administration	1101 Delegation to the DHCC's Executive Officer (EO)
Article 6: Examinations	1121 Dental Hygiene Written Examinations 1122 General Procedures for the DHCC Written Examination 1124 General Procedures for the DHCC Clinical Licensure Examination 1126 Conduct of the DHCC Clinical Licensure Examination 1127 DHCC Clinical Licensure Examination Review: Procedures and Appeals 1133 Minimum Standards for Infection Control
Phase II	
Article 3: Educational Programs	1103 Definitions 1104 Approval of RDH Educational Programs 1105 Requirements for RDH Educational Programs 1106 Radiation Safety 1109 Approval of RDHAP Educational Programs 1110 Requirements of RDHAP Educational Programs 1111 Approval of RDHEF Educational Programs 1114 List of Approved Schools 1128 Remedial Education
Article 9: Continuing Education	1134 Purpose 1135 CE Providers and Courses 1136 CE Units Required for Renewal of License 1137 Inactive Licenses 1146 Additional Offices
Phase III	
Article 4: Procedures	1116 RDH Procedures
Article 12: Dental Hygiene Corporation	1145 Professional Relationships, Responsibilities, and Conduct Not Affected 1147 Security for Claims Against a Dental Corporation 1148 Shares: Ownership and Transfer

The following regulatory packets have been approved by the DHCC:

- Disciplinary Guidelines: This regulatory packet was forwarded to the Business, Consumer Services, and Housing Agency for review on September 30, 2013 and is still under review.
- Educational Programs, Licensing, and Exam Requirements: Language approved to be set for notice.
- Soft Tissue Curettage, Local Anesthetic, and Nitrous Oxide Courses: Language approved and a public hearing was conducted on August 21, 2013.
- Remedial Education: Language drafted to be approved by the DHCC.
- The Sponsored Free Healthcare Clinics regulation has been completed.
- Retroactive Fingerprint regulation has been completed.

4. Describe any major studies conducted by the board (cf. Section 12, Attachment C).

   The DHCC initiated a regional exam survey to obtain examination information from all five regional examination boards from around the U.S. to explore the possibility of accepting their regional dental hygiene examinations. To date, the DHCC is continuing to gather the information in support of the survey and the results are still to be determined. A sample of the letter sent to the regional examination boards is attached (cf. Section 12, Attachment C).

   The DHCC has also conducted an ongoing workforce survey where all licensees are required to disclose on their renewal applications their practice and employment status. Information is also collected regarding their cultural background and foreign language proficiency. This information is shared with the Healthcare Workforce Clearing House so that an occupational fact sheet can be produced.

   The DHCC's intention is to pursue further study in other areas such as alternative pathways to licensure. This may allow graduates from approved programs to graduate license ready.

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 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 DHCC does not belong to any national, regional, or local associations or regional testing agencies. The DHCC does require licensee candidates to pass the dental hygiene national examination prior to applying for the DHCC clinical licensure examination.

   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 is required prior to taking the DHCC Clinical Licensure Examination.

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 as published on the DCA website

   The DHCC quarterly and annual Performance Measures for the last three years are attached (cf., Section 12, Attachment E).

7. Provide results for each question in the customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys. (Note: the data is presented by calendar year, as that is the methodology used to collect the data by the contracted vendor).

SURVEY QUESTION	2009*	2010	2011	2012	2013**
1. During the past 12 months, how often have you contacted the Dental Hygiene Committee of California?					
• 1-5 Times	0	10	23	15	16
• 6-10 Times	0	7	3	1	2
• More than 10 times	0	4	2	5	3
• Skipped Question	0	0	1	0	2
2. Which of the following best describes you?					
• Current Licensee	0	9	17	14	13
• Applicant for Licensure	0	4	9	5	8
• Consumer of Dental Hygiene Services	0	2	1	1	1
• Educator	0	4	3	1	2
• Employer	0	1	0	0	0
• Other (please specify)	0	4	2	3	4
• Skipped Question	0	1	1	0	0
3. Did you receive the service/assistance you requested?					
• Yes	0	16	16	4	16
• No	0	5	12***	17***	7
• Skipped Question	0	13	4	17	7

SURVEY QUESTIONS (continued)

4. Please rate the Dental Hygiene Committee of California's staff in the following					
• Accessibility					
Excellent	0	9	6	3	10
Good	0	6	4	1	4
Fair	0	1	4	2	5
Poor	0	1	4	2	1
Unsatisfied	0	4	6	11	0
• Courtesy/Helpfulness					
Excellent	0	12	9	3	12
Good	0	3	3	1	2
Fair	0	2	1	2	5
Poor	0	2	3	2	0
Unsatisfied	0	2	9	8	2
• Knowledge/Expertise					
Excellent	0	11	9	2	12
Good	0	4	3	2	1
Fair	0	3	3	2	5
Poor	0	0	2	1	1
Unsatisfied	0	3	8	9	2
• Successful Resolution					
Excellent	0	11	9	2	12
Good	0	3	2	1	2
Fair	0	2	0	1	3
Poor	0	1	2	2	1
Unsatisfied	0	4	12***	11***	3
• Overall Satisfaction					
Excellent	0	10	9	2	12
Good	0	4	2	1	2
Fair	0	1	0	0	4
Poor	0	1	2	2	0
Unsatisfied	0	5	12***	13***	3
• Skipped Question	0	4	4	2	2
5. Do you find the Dental Hygiene Committee of California's Website useful?					
• Yes	0	19	19	7	19
• No	0	1	10***	13***	5
• Skipped Question	0	2	10	14	4

SURVEY QUESTIONS (continued)

6. How do you rate the Dental Hygiene Committee of California's Website?					
• Easy to Navigate					
Excellent	0	8	8	3	11
Good	0	8	13	6	6
Fair	0	4	3	3	2
Poor	0	0	3	3	2
Unsatisfied	0	1	1	3	0
• Information Easy to Find					
Excellent	0	7	8	2	10
Good	0	7	9	6	9
Fair	0	5	3	3	2
Poor	0	0	3	3	0
Unsatisfied	0	1	3	3	1
• I regularly visit the Committee's Website					
Excellent	0	7	7	2	9
Good	0	6	7	5	4
Fair	0	7	5	5	5
Poor	0	0	3	1	1
Unsatisfied	0	1	0	1	0
• Skipped Question	0	0	1	2	0
7. Have you interacted with any other state licensing/regulatory agency?					
• Yes	0	8	15	10	10
• No	0	12	14	9	12
• Skipped Question	0	1	12	2	1
8. Would you be willing to provide an email address to receive a newsletter?					
• Yes	0	12	14	7	13
• No	0	9	13	11	7
• Skipped Question	0	0	2	3	3
9. Please provide additional comments or suggestions.	0	10	11	14	13
• Skipped Question	0	11	18	7	10

*No data because DHCC was created in 2009

**For 2013, data through 8/23/2013

***See bulleted note below

The survey data above indicates that compared to the number of individuals who utilize the DHCC's website on a daily basis, only a fraction of the users participate in the satisfaction survey. Many of the individuals who participated in the survey were licensees who were satisfied with the website's ease of use and found it useful with all of the information it contains. Individuals who completed the survey and were unsatisfied provided reasons such as non-qualification for an exam, inadequate information to renew a license, and additional information required to issue a license for their dissatisfaction.

The DHCC staff continually directs applicants, individuals, licensees, and the public to the DHCC website in order to obtain answers to their inquiries. Then, if any questions remain, the DHCC staff is readily available to provide further information for clarity. The information on the DHCC website is continually updated to provide licensees, interested stakeholders, and the public the most current information possible.

The DHCC receives many comments through its online survey; however, there are no discernable trends on the specific issues identified. Some examples of the topics received in the survey comments range from great to poor DHCC customer service, suggestions to change the DHCC procedures or forms, and requests to provide an online license renewal service which is currently in progress with the implementation of the BreEZe computer system. A majority of the survey users elected to leave the comment section of the survey blank with no response.

- In the data from 2011 and 2012, the survey reflected a greater dissatisfaction with the DHCC's responsiveness to their inquiries. The retroactive fingerprint requirement for all licentiates went into effect that year, which could be a major reason for the decrease in satisfaction for individuals completing the survey.

  With no increases in staff, the DHCC had a difficult time responding to the high volume of calls, inquiries, and communications received that arose as a result of the implementation of the fingerprinting requirement. The DHCC staff spent an exorbitant amount of time away from their primary program functions to respond to licentiate's concerns about the fingerprint requirement. This caused temporary workload backlogs and additional paid overtime to complete program functions.

  As the DHCC begins to monitor educational programs as a result of the passage of SB 1202 (Ch. 331, Statutes of 2012), additional staff will be needed to perform all of the workload associated with approval of new programs and the monitoring of existing educational programs. Without the support staff needed for the educational programs, stakeholder satisfaction will most likely exhibit a downward trend with the stakeholder being dissatisfied with the DHCC's performance.

Section 3
Fiscal and Staff

Fiscal Issues

8. Describe the board's current reserve level, spending, and if a statutory reserve level exists.

   The DHCC's current fund reserve is projected to be very low by the end of FY 2013/14 to approximately 1.1 months which is equivalent to about $141,000. The DHCC currently spends about $100,000 to $120,000 per month on expenditures, depending upon the month. This includes personnel services and operating expenses and equipment (OE&E). The funding is used to run its programs of licensing, enforcement, examinations, outreach/education, and administration, including legislation and regulation. The projected 1.1 months reserve ($141,000) is not adequate for today's programmatic operations and by FY 2014/15, the DHCC fund is threatened with insolvency without additional revenue. One expensive lawsuit, an extensively involved enforcement case, or new mandate could cause the fund to be insolvent even sooner than projected. The decrease in the fund reserve is considered a normal occurrence resulting from the increased cost of doing business with no additional revenue being added to the fund.

The DHCC's statutory fund reserve limit is 24 months as per BPC, Section 128.5, and with the projected 1.1 months reserve by the end of FY 2013/14, is well within the reserve limit.

9. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

   The DHCC is projected to experience a fund reserve deficiency in FY 2014/15; however, it is anticipated that there will be a very low fund reserve (1.1 months) by the end of FY 2013/14. Without a means to increase revenue and replenish the fund reserve, the DHCC's fund is threatened with insolvency. The reasons for the decrease in the fund reserve are:

   a) The cost of doing business continually increases as contracted services, equipment and supplies, travel, and salary and wages, progressively increase each year.
   b) The DHCC was restricted from raising its primary revenue generating fee (RDH license renewal fee), as it was already at its statutory maximum of $80. Once the maximum fee ceiling was increased by SB 1202 (Ch. 331, Statutes of 2012), staff was able to present fee increase scenarios to the DHCC for additional revenue generation options. The scenarios presented would increase revenue to sustain its fund for an extended period (projected 3-5 years), barring any additional expenses or mandates, to avoid insolvency.
   c) A decrease in the number of examination candidates electing to take the DHCC Clinical Licensing Examination in preference of the WREB regional examination has lowered the amount of examination revenue available to the DHCC to pay for the examination and examiner contracts.
   d) The amount of overall revenue that the DHCC collected from its fees has decreased since its inception in FY 2009/10, with a substantial drop in FY 2012/13 due to a decrease in the number of applicants taking the DHCC Clinical Licensing Examination. As such, the existing fund reserve was used to pay for the increased cost of doing business and thus, gradually depleted the reserve. Without any additional revenue, the current revenue generation is projected to remain flat for the foreseeable future and will not maintain the fund's solvency.

   To avoid insolvency of its fund, an overdue fee increase to collect additional revenue is anticipated by January 1, 2014. The primary revenue generating fees that will have a substantial effect on the fund balance to avoid insolvency are the biennial license renewal and delinquent renewal fees for each of the licensure categories of RDH, RDHAP, and RDHEF.

   At its September 2013 meeting, the DHCC approved an increase of the license renewal fees for all licensure categories including Fictitious Name Permits (FNP) by $80.00 (to $160 biennially) effective January 1, 2014. This fee increase is comparable or lower than the same license renewal fees in other regions of the United States (i.e., Nevada = $300 biennially; Arizona = $300 triennially; Oregon = $155 biennially). To avoid insolvency of its fund, it was necessary for the DHCC to make this decision to increase its revenue. The DHCC waited until it was absolutely necessary to raise its fees for additional revenue knowing the increases may cause a financial burden on its licensees. The increase in revenue is projected to sustain the fund's solvency for three to five years, barring any new additional mandates or programmatic expenses.

Table 2 displays the DHCC's fund condition for the FYs indicated.

Table 2. Fund Condition

(Dollars in Thousands)	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
Beginning Balance*	$85	$423	$714	$888	$565	$141
Revenues and Transfers**	$1,350	$1,305	$1,119	$1,089	$1,106	$1,105
Total Revenue	$1,435	$1,728	$1,833	$1,977	$1,671	$1,246
Budget Authority	$1,521	$1,193	$1,354	$1,409	TBD	TBD
Expenditures	$1,009	$1,032	$945	$1,412	$1,530	$1,553
Loans to General Fund	N/A	N/A	N/A	N/A	N/A	N/A
Accrued Interest, Loans to General Fund	N/A	N/A	N/A	N/A	0	0
Loans Repaid From General Fund	N/A	N/A	N/A	N/A	0	0
Fund Balance	$426	$696	$888	$565	$141	**-$307**
Months in Reserve	5.0	8.8	7.5	4.4	1.1	**-2.3**

*Beginning Balance is the amount of reserve from the prior FY remaining in the fund.

**Reflects the revenue that is received by the DHCC per FY.

10. Describe the history of general fund loans. When were the loans made? When were payments made? What is the remaining balance?

Since the DHCC's genesis in FY 2009/10, there have not been any loans to the State's General Fund and, as such, no outstanding payments or remaining balances exist to be repaid to the DHCC fund.

11. Describe the amounts and percentages of expenditures by program component. U se *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.

The DHCC's expenditures by program component are broken down by each FY in Table 3. The expenditures for each program are calculated at the following percentages:

Enforcement = 25%, Examination = 32%, Licensing = 28%, and Administration = 15%

Table 3. Expenditures by Program Component

	FY 2009/10		FY 2010/11		FY 2011/12		FY 2012/13	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	81,482	124,016	107,881	103,962	105,360	106,880	146,229	135,896
Examination	105,138	209,070	138,087	170,370	134,860	249,796	187,730	155,347
Licensing	91,259	100,675	120,826	85,357	118,003	98,292	163,776	102,799
Administration *	48,889	53,933	64,728	45,492	63,216	52,666	87,737	55,071
DCA Pro Rata	N/A	233,261	N/A	132,912	N/A	227,716	N/A	259,471
Diversion (if applicable)	N/A	1,482	N/A	0	N/A	0	N/A	6,469
TOTALS	$326,768	$722,437	$431,522	$538,093	$421,439	$735,350	585,472	715,053

*Administration includes cost for executive staff, board, administrative support, and fiscal services.

The DHCC expenditures have fluctuated over the past four years primarily due to staffing issues. With a variable number of staff during this time (mostly understaffed due to departures or the state's hiring freeze) from a low of three positions to a high of six out of seven authorized positions, personnel services expenditures fluctuated and thus affected the amount of OE&E cost the DHCC incurred over the past two fiscal years.

The DHCC experienced difficulty with filling its vacant positions over the past four years due to the state's hiring freeze and economic climate. Consequently, many programmatic functions were difficult to complete and strategic plan objectives and goals were delayed in being addressed. However, in FY 2011/12 when the state hiring freeze was eliminated, the DHCC was able to hire three new analysts to fill vacant positions in the administration, enforcement, and examination/licensing programs. These hires resulted in increases in programmatic efficiencies and the elimination of some workload backlogs; however, there are still many DHCC issues to be addressed such as CE review and audit, educational program audits, regulations, legislation, and citation and fine.

12. Describe license renewal cycles and history of fee changes in the last 10 years. G ive the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

The DHCC is a special fund agency that generates its revenue from its fees. The DHCC's main source of revenue is from its applicants and licensees through the collection of examination, licensing, and renewal fees. These fees support the licensing, examination, enforcement, and administration programs, which includes processing and issuing licenses, maintaining DHCC records, administration of the DHCC Clinical Licensure Examination, the law and ethics examination, mediating consumer complaints, enforcing statutes, disciplinary actions, personnel expenditures, general operating expenses.

The DHCC's authority to charge the fees in its schedule is provided by BPC, Section 1944.

Because the DHCC was created in FY 2009/10, the history of fee changes can only be provided for the past four (4) years. When the DHCC began operations in FY 2009/10, the primary means of revenue, the RDH biennial license renewal fee, was at its maximum ceiling of $80 and has remained at this level until January 1, 2014, when new fee increases are implemented (detailed in question #9).

In FY 2011/12, SB 1202 (Ch. 331, Statutes of 2012), increased the RDH biennial renewal fee ceiling to $160, in addition to creating new permit categories for additional office spaces for RDHAPs, extramural clinical facilities for educational institutions, teaching permits for out-of-state licensees, mobile dental hygiene clinics, and their associated renewal fees. Although these new fee categories were created in FY 2012/13, they will not generate enough continuous and reliable revenue to sustain the fund to avoid insolvency.

With the DHCC's fund threatened with insolvency by FY 2014/15, staff prepared scenarios to increase revenue to avoid insolvency. The only continuous and reliable source of revenue to maintain the fund's solvency is to increase all license renewal and delinquency fees. The DHCC's license renewals for all license types are based on biennial renewal cycles. Table 4 displays the fee schedule and revenue over the FYs indicated. Some of the fees in the table are no longer valid due to a change in the rate or did not exist in the particular FY, but are listed because some licensees are required to pay prior fees from earlier charges in order to validate their license.

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2009/10 Revenue [a]	FY 2010/11 Revenue [a]	FY 2011/12 Revenue [a]	FY 2012/13 Revenue [a]	% of Total Revenue
APPLICATION FEES							
RDH Application Fee ($50)	$50	$250	8,900	49,350	46,350	30,800	Various %
RDH Application Fee ($20)	$20	$250	3,520	N/A	N/A	N/A	Various %
RDHAP Application Fee ($50)	$50	$250	1,200	3,650	3,000	2,700	Various %
RDHEF Application Fee ($50)	$50	$250	0	0	0	0	0%
CE Provider Application Fee ($250)	$250	$500	0	0	0	0	0%
EXAMINATION FEES							
RDH Clinical Exam Fee ($525)	$525	Actual Cost of Exam	184,790	481,374	309,225	100,800	Various %
RDHEF Clinical Exam Fee ($250)	$250	Actual Cost of Exam	0	0	0	0	0%
Dental Student Exam Fee ($525)	$525	Actual Cost of Exam	0	0	0	0	0%
LICENSURE FEES							
RDH Original License Application Fee* ($100)	$100	$250	N/A	N/A	N/A	26,400	Various %
RDHAP Initial License Fee ($100)	$100	$250	N/A	N/A	N/A	2,700	Various %
RDHAP License Fee ($250)	$250	$250	10,250	18,250	15,000	13,500	Various %
RDHAP FNP Initial License Fee ($80)	$80	$250	400	1,920	3,040	1,840	Various %
RDHAP FNP ½ Initial License Fee ($40)	$40	$125	120	320	560	240	Various %
RENEWAL FEES							
RDH Biennial Renewal Fee ($80)	$80	$160	620,920	706,290	701,030	736,640	Various %
RDH Biennial Renewal Fee ($70)	$70	$80	7,060	3,430	770	N/A	Various %
RDH Biennial Renewal Fee ($55)	$55	$80	1,100	990	275	N/A	Various %
RDH Biennial Renewal Fee ($35)	$35	$80	210	660	315	N/A	Various %
RDHAP Biennial Renewal Fee ($80)	$80	$160	9,440	11,680	15,520	16,160	Various %
RDHAP FNP Biennial Renewal Fee ($80)	$80	$80	0	800	2,240	2,960	Various %
RDHAP FNP ½ Biennial Renewal Fee ($40)	$40	$80	0	0	0	0	Various %
RDHAP FNP ½ Biennial Renewal Fee ($35)	$35	$70	0	0	35	N/A	0%
RDHEF Biennial Renewal Fee ($80)	$80	$160	1,440	640	1,760	720	Various %
RDH Delinquent Renewal Fee ($40)	$40	½ License Renewal Fee	10,020	11,230	12,680	13,040	Various %

Table 4. Fee Schedule and Revenue (continued)

RDH Delinquent Renewal Fee ($35)	$35	½ License Renewal Fee	2,870	1,530	70	N/A	Various %
RDH Delinquent Renewal Fee ($25)	$25	½ License Renewal Fee	625	825	150	N/A	Various %
RDHAP Delinquent Renewal Fee ($40)	$40	½ License Renewal Fee	190	120	160	80	Various %
RDHAP FNP Delinquent Renewal Fee ($40)	$40	½ License Renewal Fee	0	40	120	0	Various %
RDHEF Delinquent Renewal Fee ($40)	$40	½ License Renewal Fee	0	0	0	0	0%
OTHER DHCC PROGRAM FEES							
Duplicate License Fee ($25)	$25	$25	7,025	6,100	6,750	8,625	Various %
Certification of Licensure Fee ($25)	$25	½ License Renewal Fee	2,275	1,875	2,150	1,950	Various %
CE Course Review Fee* ($300)	$300	$300	N/A	N/A	N/A	300	0%
CE Provider Annual Renewal Fee ($250)	$250	$250	0	0	0	0	0%
Curriculum Review & Site Evaluation Fee* ($2,100)	$2,100	$2,100	N/A	N/A	N/A	0	Various %
RDHAP Additional Office Permit Fee* ($100)	$100	$250	N/A	N/A	N/A	0	Various %
RDHAP Additional Office Permit Renewal Fee* ($100)	$100	$250	N/A	N/A	N/A	0	Various %
Extramural Dental Facility Fee* ($200)	$200	$250	N/A	N/A	N/A	200	Various %
Mobile Dental Hygiene Unit Permit Fee* ($100)	$100	$250	N/A	N/A	N/A	0	Various %
Mobile Dental Hygiene Unit Permit Renewal Fee* ($100)	$100	$250	N/A	N/A	N/A	0	Various %
Special Permit (Teaching)* ($80)	$80	$160	N/A	N/A	N/A	0	Various %
Special Permit (Teaching) Renewal Fee* ($80)	$80	$160	N/A	N/A	N/A	0	Various %

Note: Revenue data is listed as per CALSTARS FM13 reports; N/A = not applicable due to fee change or not implemented

*Fees effective as of January 1, 2013

a) Total Revenue: FY 2009/10 = $1,349,526; FY 2010/11 = $1,307,531; FY 2011/12 = $1,121,228; FY 2012/13 = $972,256

13. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Despite the poor economic climate in the state that has existed since the creation of the DHCC in 2009, the DHCC has worked diligently to maximize its resources while staying within budget parameters set by the Governor's Office, Department of Finance, and the DCA. However, the inability to successfully fill requested positions has meant that the DHCC has not been able to meet all of the targeted Strategic Plan goals. Table 5 displays the BCPs presented to address programmatic issues and their results.

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
N/A	2011/12	Staff for Continuing Education Program	1.0, Staff Services Analyst	0	$63,000	0	$13,000	0
1110-01L	2012/13	Special Permits (created by SB 1202 – Ch. 331, Statutes of 2012)	1.0 (Office Technician – typing)	1.0 (Office Technician – typing)	$53,000	$53,000	$13,000	$13,000

Staffing Issues

14. Describe any staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

The DHCC's vacancy rate is roughly 13% which equals to about one vacant position per year out of the eight positions the DHCC is currently authorized. In FY 2010/11, and part of FY 2011/12, the DHCC had difficulty in filling vacated positions due to the state's hiring freeze that was in place at the time. For one of these two years, the DHCC operated with only three staff where only vital program operations could be addressed. Once the hiring freeze was lifted, additional staff was hired and the DHCC has not had any issue with recruiting qualified individuals to fill its vacant positions. The challenge for the DHCC has been to acquire new positions to address current staff workloads that need to be addressed such as CE review and audits, educational institution reviews, regulations, and citation and fine.

The DHCC previously requested additional staff through a BCP to address the CE review and audit programmatic workloads. However, due to the economic climate within the state at that time, the request was denied. The DHCC needs an additional staff person to address the CE Review and Audit Program workload to ensure that the licensees who have had their licenses renewed remain compliant with the license renewal law (BPC, Section 1936.1). The CE audit provides the DHCC a method to ensure compliance with the license renewal requirements, otherwise, licensees may be subject to consequences such as citation and fine. These licensees may also be a detriment to the public by not being current in their practice techniques or CE requirements such as infection control and basic life support, etc. This can cause a direct threat to consumer protection if a licensee is not aware of or does not apply current infection control procedures as cross-contamination can occur, or is unfamiliar with basic life support skills should an incident happen with a patient.

In 2013, the DHCC also attempted to re-classify one of its vacant positions to create a managerial position to assist the EO with programmatic oversight and management. This would free the EO to address other pressing issues such as enforcement, outreach, education, and communication with associations, dental hygiene schools, licentiates, the Legislature, the DCA Executive Office, and other interested stakeholders. Unfortunately, the request was denied by the DCA Office of Human Resources (OHR) as they indicated that it did not conform to the current CalHR standards due to an insufficient number of analytical staff that the manager would supervise.

After a review of the CalHR standards for managerial positions as posted on their website, the DHCC disagrees with the DCA OHR's decision that the request does not conform to the manager standards. As per CalHR standards, a Staff Services Manager I is the first working supervisor level that supervise a small group of analysts performing journeyperson level work and personally performs the most difficult or sensitive work and may direct functions such as budgeting, management analysis, and/or personnel. There is no "small group of analysts" definition on the website and, as such, the DHCC's re-classification request fulfilled the CalHR standard's programmatic function and supervisory description by having four analytical positions on staff. The reclassification and/or position request will be sought through the Sunset Review process as the DHCC's view is that the request should not have been denied.

The EO has the ultimate responsibility to oversee all of the DHCC's programs; however, a supervising managerial position is needed for specific oversight of support staff and the day-to-day office operations and decisions to allow the EO to focus her efforts on the issues outside of program operations. In order for the DHCC to properly educate and inform the public, educational institutions, associations, and other interested stakeholders of the DHCC's existence, governing mandates, and oversight, the EO must have the time and resources to contact and communicate with these parties to convey the DHCC's primary mandate of consumer protection and how it conducts business. With most of her attention focused on the daily programmatic operations of the DHCC office, she is prohibited from completing these functions and can only address them periodically. As a result, the DHCC has not been able to promote itself to the extent of the DHCC's goals which inhibits the growth of the only existing stand-alone dental hygiene program in the country.

The DHCC was recently informed by the DCA Facilities Unit that an anticipated move date into a larger office will be in early 2014. The DHCC has no additional workspace to accommodate any new positions in its current office location. New office space is not only needed for additional staff, but to adequately house the DHCC's equipment, supplies, licensing and enforcement records, reference and historical materials, and anticipated additional programmatic growth. The DCA is working to provide the DHCC with additional office space in the current building, but needs to move two other boards before new space becomes available.

The DHCC has been involved with the DCA's master succession plan and will continue to participate in its development. Because the DHCC is a small program, there is ample opportunity for staff cross-training and professional growth and knowledge.

15. Describe the board's staff development efforts and how much is spent annually on staff development.

The DHCC is fortunate to be a part of the DCA, who provide a plethora of educational and training courses for all staff to participate in at minimal or no cost to the program. The DCA training program is called SOLID Training Solutions. They provide the majority of education and training courses in topics such as contracts, project management, purchasing, sexual harassment, business writing, and many other topics that apply to the state's work environment. As such, the DHCC has projected to spend approximately $500 - $1,000 each year for training staff utilizing external vendors. The EO 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

The California Dental Practice Act (DPA), with related statutes and regulations, establishes the requirements for an RDH license. There are three pathways to obtain licensure in California. The three pathways are:

- DHCC Clinical Licensure Exam;
- WREB exam; and
- Licensure by Credential (LBC).

16. What are the board's performance targets/expectations for its licensing[2] program?

The DHCC's performance targets/expectations for its licensing program meets the guidelines as presented in California Code of Regulations (CCR), Section 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 state agency to engage in a particular activity or act. The DHCC 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 period of time allotted to notify an applicant that their application is complete or deficient is 90 days. The DHCC is currently processing applications within 30 days, which is well within the specified timeframe of 120 days.

Is the board meeting those expectations?

The DHCC is not only meeting, but exceeding its expectations and takes an average of 30 days to process a completed application. If an application is incomplete or deficient, the processing time increases to an average of 58 days to complete an application, which is still within the allotted timeline of 120 days.

If not, what is the board doing to improve performance?

The DHCC continues to improve its efficiencies in processing applications and intends to remain well within the allotted timelines to process all applications and permits. The DHCC is part of a department-wide effort to replace its two antiquated computer systems with a single system called BreEZe. The BreEZe system, when implemented, is a computer program that will increase all existing program efficiencies. Some examples of the BreEZe system capabilities are to allow licensees to renew their license online with a credit card in real time, improve the tracking of applicant and licensee data in a single source, make address and name changes in real time by the licensee rather than having to rely on program staff, and other programmatic efficiency changes associated with a new modern computer system.

[2] The term "license" in this document includes a license certificate or registration.

17. Describe any increase or decrease in average time to process applications, administer exams, and/or issue licenses.

Since the addition of an examination analyst position in 2012, the DHCC has improved the processing time for examination results. The average time between the examination and the issuance of a license has decreased from 4 to 6 weeks in 2012 to approximately 2 weeks in 2013.

The electronic fingerprint requirements have delayed licensure renewal in some cases, as the licensee must complete this task through the livescan process at a local law enforcement agency. We expect this to be relieved with the implementation of the BreEZe computer system which will allow license renewals to be completed online.

The DHCC is anticipating an increase in the average time for processing applications and license renewals with the initial implementation of the BreEZe computer system. With the new system being implemented, the DHCC will need to dedicate staff time to monitor how efficient the system is functioning during the transition. Having a manager to oversee staff during this time is essential to help alleviate any issues as they arise. The transition to the new system could also cause workload backlogs and delays with staff redirecting their efforts to ensure a smooth transition to the BreEZe system. Once the BreEZe system is functioning as planned, the DHCC expects the average processing times to be reduced significantly.

Have pending applications grown at a rate that exceeds completed applications?

The DHCC has not experienced a growth rate in pending applications that exceeds the completed applications.

If so, what has been done to address them?

N/A.

What are the performance barriers and what improvement plans are in place?

As was discussed previously, the most significant performance barrier for the DHCC is the lack of a managerial position to directly oversee programmatic functions, including the transition to the new BreEZe computer system, support staff, and have the ability to make executive-level and supervisory decisions in the absence of the EO. Without adequate managerial staff, the EO has had to perform the functions of both EO and working manager which leads to a decrease in programmatic performance and efficiency for the DHCC.

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?

If any performance issues arise for the DHCC to properly process its applications or license renewals, it will review office and departmental policy and procedures, promulgate regulations, submit BCP(s), or pursue legislation to address and alleviate those issues.

18. How many licenses or registrations does the board issue each year? H ow many renewals does the board issue each year?

The DHCC issues approximately 800 licenses and approximately 9,000 renewals per year.

The DHCC is responsible for the license renewal and oversight of over 18,000 active licentiates and over 30,000 licenses total inclusive of those licenses on an inactive status. Table 6 displays

the breakdown of each license category and the number of active licenses. With 30 dental hygiene programs now operating in the state, the number of new graduates is over 800 per year.

Table 7b displays the total number of license renewals that the DHCC issued for the past three fiscal years. On average, the number of renewals for active licentiates per year is 8,484 for RDH, RDHEF, and RDHAP licenses.

Table 6. Licensee Population

		FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Registered Dental Hygienist (RDH)	Active	17,472	17,964	18,139	18,548
	Out-of-State	N/A	N/A	N/A	N/A
	Out-of-Country	N/A	N/A	N/A	N/A
	Delinquent	1,823	1,876	2,168	2,205
Registered Dental Hygienist Alternative Practice (RDHAP)	Active	288	339	403	445
	Out-of-State	N/A	N/A	N/A	N/A
	Out-of-Country	N/A	N/A	N/A	N/A
	Delinquent	15	17	13	16
Registered Dental Hygienist Extended Function (RDHEF)	Active	31	30	31	31
	Out-of-State	N/A	N/A	N/A	N/A
	Out-of-Country	N/A	N/A	N/A	N/A
	Delinquent	1	2	1	1
Fictitious Name Permit (FNP)	Active	6	36	85	106
	Out-of-State	N/A	N/A	N/A	N/A
	Out-of-Country	N/A	N/A	N/A	N/A
	Delinquent	2	1	3	8

Table 7a. Licensing Data by Type

	Application Type	Received	Approved[a]	Closed	Issued[a]	Pending Applications[c]			Cycle Times (avg. # of days)[d]		
						Total[b] (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps[d]	combined, IF unable to separate out
FY 2010/11	(Exam)	682	549	N/A	N/A	133	N/A	0	30	60	N/A
	(License)	774	837[a]	N/A	837[a]	0	N/A	0	45	60	N/A
	(Renewal)	N/A	6,199	N/A	6,199	N/A	N/A	0	10	18	N/A
FY 2011/12	(Exam)	656	611	N/A	N/A	45	N/A	0	21	50	N/A
	(License)	919	841	N/A	841	78	N/A	0	40	60	N/A
	(Renewal)	N/A	10,106	N/A	10,106	N/A	N/A	0	0	12	N/A
FY 2012/13	(Exam)	533	401	N/A	N/A	132	N/A	0	14	45	N/A
	(License)	1,364	897	N/A	897	467[c]	N/A	0	30	58	N/A
	(Renewal)	N/A	9,149	N/A	9,149	N/A	N/A	0	0	10	N/A

* Optional. List if tracked by the board.
[a] - Approved and Issued for Exam and License may include pending applications from the prior year.
[b] – Exam administered just before close of FY.
[c] – Pending applications for licensure have increased due to an increase in WREB applicants.
[d] – Average # of days depend upon how quickly the applicant or licensee responds to DHCC's request(s) for information.

Table 7b. Total Licensing Data			
	FY 2010/11	FY 2011/12	FY 2012/13
Initial Licensing Data:			
Initial License/Initial Exam Applications Received (California)	619	546	375
Initial License/Initial Exam Applications Received {includes Registered Dental Hygienist (RDH) California Clinical, Licensure By Credential (LBC) & Western Regional Examination Board (WREB)}	702	858	721
Initial License/Initial Exam Applications Approved (RDH)	384	210	15
Initial License/Initial Exam Applications Approved (WREB)	193	282	311
Initial License/Initial Exam Applications Approved (LBC)	42	54	49
Initial License/Initial Exam Applications Received {Registered Dental Hygienist in Alternative Practice (RDHAP)}	72	61	44
Initial License/Initial Exam Applications Approved (RDHAP)	53	62	52
Initial License/Initial Exam Applications Received {Fictitious Name Permits (FNP)}	28	52	28
Initial License/Initial Exam Applications Approved (FNP)	6	51	28
Initial License/Initial Exam Applications Closed	N/A	N/A	N/A
License Issued RDH[a]	764	779	739
License Issued RDHAP[a]	53	62	52
License Issued FNP[a]	6	51	28
Initial License/Initial Exam Pending Application Data[b]:			
Pending Applications (total at close of FY)	15	13	18
Pending Applications (outside of board control)*	N/A	N/A	N/A
Pending Applications (within the board control)*	0	0	0
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE)[c]:			
Average Days to Application Approval (All - Complete/Incomplete)	40	35	30
Average Days to Application Approval (incomplete applications)*	30	28	25
Average Days to Application Approval (complete applications)*	6	5	3
License Renewal Data:			
License Renewed	6,199	10,106	9,149

* Optional. List if tracked by the board.

Note:

a) The number of licenses issued does not reflect the number of applications received in any given FY.

b) The pending applications outside of the DHCC's control include applicants awaiting fingerprint clearances from the DOJ and/or FBI.

c) The average # of days for the Cycle Time Data to process an incomplete application depends upon how quickly the applicant or licensee responds to the DHCC's request(s) for information.

19. How does the board verify information provided by the applicant?

a. What process is used to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?

The DHCC requires all applicants to provide electronic fingerprints (livescan), any pertinent court documents, and a letter of explanation about the unlawful act from the applicant.

b. Does the board fingerprint all applicants?

The DHCC requires fingerprinting of all its applicants using the livescan process.

c. Have all current licensees been fingerprinted? If not, explain.

The DHCC promulgated regulations requiring all active licensees to be electronically fingerprinted. The DHCC has completed the fingerprinting of approximately 90% of the dental hygiene licensing population. The remaining 10% are either in an inactive license status, making them exempt from the fingerprinting requirement, or reside outside of California. Many licensees reside outside of California or elect to place their license on an inactive status, exempting them from the fingerprint requirement because they are not practicing in the state.

d. Is there a national databank relating to disciplinary actions?

Yes, the National Practitioner Databank is the repository for reporting DHCC licensee disciplinary actions.

Does the board check the national databank prior to issuing a license?

The DHCC checks this databank prior to issuing a license.

Renewing a license?

No, the DHCC does not check the national databank for license renewals because it receives subsequent arrest reports from the Department of Justice (DOJ) and FBI, which are reviewed by the DHCC enforcement program.

e. Does the board require primary source documentation?

The DHCC requires primary source documentation as per BPC, section 1917, to obtain a California dental hygiene license. The documentation consists of:

- Proof of satisfactory completion directly from the NDHBE;
- Proof of graduation directly from a dental hygiene educational program approved by the DHCC and accredited by CODA;
- Proof of satisfactory completion of the DHCC Clinical Licensure Examination or from WREB; and
- Proof of satisfactory completion of the DHCC Law and Ethics Examination.

20. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

The DHCC 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, Sections 1917 and 1917.1. The only exception is the implementation of BPC, Section 115.5 whereby these individuals are granted priority during the application process due to their spouse or domestic partner's military status.

21. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis?

Yes, the DHCC sends a notice to the DOJ whenever a license is revoked. An individual who had a license revoked and petitions the DHCC for reinstatement, must start the licensure process as a new applicant including electronic fingerprints.

Is this done electronically?

The DHCC sends No Longer Interested notifications to the DOJ by either fax or regular mail.

Is there a backlog? If so, describe the extent and efforts to address the backlog.

The DHCC does not have a workload backlog for No Longer Interested notifications to the DOJ.

Examinations

Table 8 summarizes the examination data over the past four (4) years for each of the licensure categories indicated.

Table 8. Examination Data

The DHCC Clinical Licensure and Law and Ethics Examinations

	License Type	RDH	RDH	RDHAP
	Exam Title	DHCC Clinical	Law and Ethics	Law and Ethics
FY 2009*	# of 1st Time Candidates	783	486	14
	Pass %	83	98	100
FY 2010*	# of 1st Time Candidates	682	674	38
	Pass %	81	80	84
FY 2011*	# of 1st Time Candidates	656	700	73
	Pass %	86	78	70
FY 2012*	# of 1st time Candidates	533	739	65
	Pass %	88	75	72
	Date of Last Occupational Analysis (OA)	1998	2010	2010
	Name of OA Developer	DCA/OPES**	DCA/OPES**	DCA/OPES**
	Target OA Date	TBD	TBD	TBD

National (NDHBE) Examination *(PLEASE SEE NDHBE NOTE BELOW***)*				
	License Type	RDH	RDH	RDH
	Exam Title	NDHBE	NDHBE	NDHBE
FY 2009/10	# of 1st Time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
FY 2010/11	# of 1st Time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
FY 2011/12	# of 1st Time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
FY 2012/13	# of 1st time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
	Date of Last OA	N/A	N/A	N/A
	OA Developer	N/A	N/A	N/A
	Target OA Date	N/A	N/A	N/A

Note:

a) *The exam data for 2009, 2010, 2011, and 2012 are calendar years, not fiscal years, as calendar years capture complete exam cycles.

b) **DCA/OPES = the Department of Consumer Affairs Office of Professional Examination Services.

c) ***The National Dental Hygiene Board Examination (NDHBE) maintains its own records and does not readily share the examination data with outside agencies. As such, the DHCC could not obtain the information requested about the national examination.

22. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?

There are three examinations that are required for licensure: The NDHBE and the DHCC Clinical Licensure Examination, or the WREB (a regional examination), and the DHCC Law and Ethics Examination that all candidates must pass.

The purpose of the NDHBE 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 NDHBE 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 NDHBE is available in their 2013 Guide on their website at: www.ada.org.

The purpose of the WREB is to evaluate an applicant's ability to utilize professional judgment and clinical competency in providing oral health care to a patient.

The WREB exam consists of two examinations: a Local Anesthesia Exam and a Dental Hygiene Examination. The Local Anesthesia Exam and the Dental Hygiene Exam are two-part exams with written and clinical components with patient treatment required. Overall successful completion of the WREB Local Anesthesia Examination and the Dental Hygiene Examination requires a passing score in both the written exam and the clinical exam components.

The Local Anesthesia Written examination includes a 55 question, multiple-choice, computer administered exam. The Local Anesthesia Clinical examination requires two nerve block injections to be performed during the test. The Dental Hygiene Clinical examination covers patient qualifications, calculus detection and removal, and periodontal probing and recession measurements. The written exam is an interactive computer exam that simulates the process of dental hygiene care in a clinical setting. Information about the WREB dental hygiene exam is available in their 2013 Guide on their website at: www.wreb.org.

RDH's are licensed in California by the DHCC. Applicants must pass both clinical and written examinations in ethics and California dental law and undergo a criminal history investigation, prior to receiving a license. Protection of the public shall be the highest priority for the DHCC in exercising its licensing, regulatory, and disciplinary functions as per BPC, Section 1902.1 which states:

> "Protection of the public shall be the highest priority for the committee in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount."

The DHCC Clinical Licensure Examination is designed to ensure that all candidates for licensure are clinically competent. Each candidate must pass a clinical examination which includes an examination of a patient and complete scaling and root planing of one or two quadrants. Each applicant for licensure as a RDH who attains a grade of 75% in the practical examination designated by the DBC shall be considered as having passed the examination as per CCR, Section 1083(a).

Prior to issuance of a license, an applicant for licensure as a RDH shall successfully complete a supplemental written examination in the DHCC Law and Ethics. The DHCC Law and Ethics Examination, as stated in CCR, Section 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.

23. What are pass rates for first time vs. retakes in the past four fiscal years? *(Refer to Table 8: Examination Data)*

In 2009, the pass rate for first time DHCC Clinical Examination takers was 83% and the exam retake pass rate was 50%. In 2010, the pass rate for first timers was 81%, while the retake pass rate was 59%. In 2011, the first time pass rate was 87% and the retake pass rate was 65%. In

2012, the first timer pass rate was 88% and the retake pass rate was 69%. The table below summarizes the exam pass rates for first time exam takers and the percentage of pass rates for individuals retaking the exam in their respective years. The data is presented in calendar year rather than fiscal year to coincide with the examination schedule.

Calendar Year	DHCC Clinical Exam Pass Rate – *1st Time*	DHCC Clinical Exam Pass Rate - *Retake*
2009	83%	50%
2010	81%	59%
2011	87%	65%
2012	88%	69%

24. 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 DHCC RDH and RDHAP Law and Ethics Examinations are computer-based tests. The law and ethics exams are available at multiple testing centers statewide and are administered on a continuous basis. Applicants schedule their own examination appointments at their convenience. The DHCC uses a secured vendor, Psychological Services, Incorporated (PSI Services, Inc.), as part of the department-wide contract to administer the law and ethics examinations.

25. 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 efficiency of processing the DHCC license applications. However, with new regulations proposed requiring the review and processing of other types of applications (e.g., soft tissue curettage, local anesthesia, nitrous oxide and oxygen analgesia administration, feasibility study applications, educational programs), there will be an additional workload to address and the current DHCC staff cannot absorb it. The DHCC will need additional staff to process these new applications. If the DHCC cannot add additional staff, it could potentially have a negative impact on the processing of applications for licensure and examinations due to the added workload created by the new regulations.

School approvals

26. Describe legal requirements regarding school approval.

The legal requirements for school approvals are set forth in BPC, Section 1941 and CCR, Sections 1072 – 1073.3. The DHCC also has the authority to evaluate currently approved educational programs for RDH, RDHAP, and RDHEF.

The DHCC shall grant or renew approval of only those educational programs that meet the statutory and regulatory requirements set by the DHCC which includes adherence to CODA standards. The DHCC may withdraw or revoke a dental hygiene school approval if CODA has indicated intent to withdraw approval or has withdrawn approval.

New educational programs must submit a feasibility study demonstrating the need for a new educational program and apply for approval prior to seeking initial accreditation from the national

accrediting body, CODA. The program must also be provided by a college or institution of higher education accredited by a regional agency recognized by the United States Department of Education. The DHCC has the authority to approve, provisionally approve, or deny approval of a new dental hygiene educational program.

Current regulations stipulate dental hygiene educational programs shall be two academic years and not less than 1,600 clock hours that leads to an associate or higher degree.

Who approves your schools?

By law, dental hygiene educational programs approved by the DBC on or before June 30, 2009, are deemed approved. Effective January 1, 2013, the DHCC has the authority to approve, provisionally approve, deny, or renew approval of the dental hygiene educational programs in California.

The DHCC is in the process of promulgating regulations to clarify and strengthen requirements for dental hygiene educational programs in California. This includes specific requirements for admission, curriculum, faculty and faculty resources, facilities, and equipment that will be required for all California dental hygiene programs by 2016.

What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?

The highest priority of the DHCC and the DCA Bureau for Private Postsecondary Education (BPPE) is the protection of the public. The DHCC has met with BPPE and have conferred on issues of mutual concern regarding approval of educational programs. The DHCC and BPPE are currently working to form a Memorandum of Understanding (MOU) to collaborate between agencies in the private postsecondary school approval process. This MOU is projected to be completed sometime in 2014.

Both agencies have agreed that a person shall not open, conduct, or do business as a private postsecondary educational institution in this state without obtaining an approval to operate [Education Code (EDC), Section 94886]. An approval to operate shall be granted only after an applicant has presented sufficient evidence to the DHCC, and the DHCC has independently verified the information provided by the applicant through site visits or other methods deemed appropriate by the DHCC, that the applicant has the capacity to satisfy the minimum operating standards. The DHCC shall deny an application for an approval to operate if the application does not satisfy these standards of law (EDC, Section 94887 and BPC, Section 1941).

If the DHCC provides an approval to offer an educational program and the institution already has a valid approval to operate issued by the BPPE, the DHCC's educational program approval may satisfy the requirements without further review by the BPPE. The BPPE may incorporate the educational program into the institution's approval to operate when the BPPE receives documentation signifying the conferral of the educational program approval by the DHCC (EDC, Section 94892).

The DHCC and BPPE maintain constant communication and share information with regard to the dental hygiene educational programs throughout the state. The BPPE concentrates its efforts on private, non-exempt schools, while the DHCC oversees all dental hygiene educational programs. The DHCC will also promulgate new regulations to require new dental hygiene schools to obtain approval from the BPPE prior to implementing their program.

27. How many schools are approved by the board? How often are schools reviewed?

The DHCC has current oversight of 30 CODA accredited dental hygiene educational programs in the state. These programs are reviewed by CODA every seven years and must continue to meet strict requirements in order to continue their accreditation. The DHCC relied on CODA's review of the educational programs to remain in compliance in the past; however, starting in January 2013, the DHCC began to review all new and existing dental hygiene programs to ensure that they meet the minimum standards as set by CODA and contained in the DHCC statutes and regulations.

The DHCC has requested the accreditation approval information from all of the California educational programs to be placed on file. The DHCC intends to utilize its resources to review all of the educational programs in the state to ensure they are in compliance with all applicable laws and regulations. Since the DHCC has just begun to review the dental hygiene educational programs, the frequency at which the schools are reviewed is still to be determined. If an issue arises to where a review of a school is warranted that is not scheduled for a review, the DHCC will act immediately to initiate a review of the school.

28. What are the board's legal requirements regarding approval of international schools?

The DHCC does not have statutory authority to review or approve any international schools.

Continuing Education/Competency Requirements

29. Describe the board's continuing education/competency requirements, if any. D escribe any changes made by the board since the last review.

a. How does the board verify CE or other competency requirements?

The DHCC requires, as a condition of biennial license renewal, that licensees complete 25 hours (RDH & RDHEF licensees) or 35 hours (RDHAP licensees) of CE, of which two (2) hours of CE is in infection control standards and two (2) hours of CE is in the California Dental Practice Act. In addition, the completion of a four unit maximum certification training course in basic life support is required (CCR, Section 1017). Licensees sign an affidavit that the number of CE units (hours) have been met as well as the mandatory courses have been completed.

In addition, the DHCC voted to amend BPC, Section 1936.1 to include continued competency requirements in SB 1202 (Ch. 331, Statutes of 2012). Continued competence assures the public that practitioners continue to be competent and safe to practice years after completing education and first becoming licensed. During the legislative process for SB 1202, due to the political climate, it was recommended that the language for continued competence be removed from the bill.

b. Does the board conduct CE audits on its licensees? Describe the board's policy on CE audits.

The DHCC has the authority to conduct CE audits pursuant to CCR, Section 1017(a)(n)(o); however, due to limited staff resources, they cannot be completed on an ongoing basis. Currently, the DHCC only conducts CE audits for licensees under investigation for enforcement issues. The goal for CE audits is to add more staff to address the CE audit workload. Once the DHCC has adequate staff for CE compliance audits, they will be conducted on approximately 3% of all hygiene licensees per month, which is about 45 licensees (18,000 licensees/12 months x 3% = 45 audits/month) to ensure compliance for their license renewal. As explained in Question 13, a BCP was submitted in FY 2011/12 for a staff

position to address the ongoing CE workload. Unfortunately, the request was denied at that time due to the State's economic climate and hiring freeze. Additional staff is needed to address the CE Review and Audits workload and the DHCC plans to pursue an additional position to address it through the Sunset process.

c. What are consequences for failing a CE audit?

All licensees who fail a CE audit are provided notice that their license has been placed on an inactive status, and they must cease the practice of dental hygiene until the non-compliance status is cleared and their license is re-activated by the DHCC. The licensee will also be subject to fines by the DHCC citation and fine program.

d. How many CE audits were conducted in the past four fiscal years? How many fails?

The DHCC conducted 98 CE compliance audits in the last four years. The limited numbers of audits were due to a lack of staff during the state's economic downturn and hiring freeze. A BCP was submitted for an additional position starting in FY 2011/12 to address the CE review and audit workload; however, the request was denied. Of the 98 CE audits conducted, none failed as a result of the follow-up compliance action by the licensees.

e. What is the board's course approval policy?

The DHCC is in the process of promulgating regulations to clarify and strengthen the CE approval policy.

f. Who approves CE providers?

The DHCC is permitted to approve CE providers and accept the DBC approved providers by BPC, Section 1936.1(c). The DHCC currently utilizes CCR, Section 1016 for its CE provider approvals.

Who approves CE courses? If the board approves them, what is the board application review process?

The DHCC has the responsibility to approve CE courses and is in the process of promulgating regulations to clarify and strengthen the CE course approval and review process.

g. How many applications for CE providers and CE courses were received?

Due to the DHCC being in the process of promulgating regulations to approve CE providers and courses, there have been no applications received to date. Once regulations are promulgated, the DHCC will have to process all of the CE provider and CE course applications received.

How many were approved?

See above response.

h. Does the board audit CE providers?

The DHCC will audit CE providers once the new regulations are approved and additional staff is hired to address the new workload.

If so, describe the board's policy and process.

Once implemented, the DHCC plans to conduct a random audit on a certain percentage of CE providers on a biennial basis. The exact process in which the DHCC will audit CE providers will be determined after the new regulations are approved.

i. Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensees' continuing competence.

The DHCC submitted statutory language in SB 1202 (Ch. 331, Statutes of 2012); however, it was stricken during the legislative process. The DHCC will continue its efforts to implement statutory language for continued competency.

Section 5
Enforcement Program

30. What are the board's performance targets/expectations for its enforcement program?

The DCA's system of quarterly performance measurements (cf., Section 12, Attachment E – Performance Measurements) has the following objectives for investigations:

1. Intake of Investigations within 30 days.
2. Intake and Investigation within 120 days.

The DCA performance measurement objectives are the guidelines the DHCC follows for its targets/expectations for its enforcement program. The DHCC's highest priority is the protection of the public and is committed to investigate all complaints as quickly as possible. The DHCC is currently meeting and exceeding the above stated targets/expectations.

Is the board meeting those expectations? If not, what is the board doing to improve performance?

The DHCC's statistics show that the DCA Performance Measurement expectations are being met. For example in Quarter 2 of 2012, our average for the intake of investigations was two (2) days and for intake and investigations, it was 97 days. The DHCC Enforcement program is exceeding its expectations in processing its enforcement cases and, as such, will monitor its current efficiencies and modify them as needed to improve performance.

31. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending, or other challenges.

In the last few years, the DHCC has seen an increase in the number of complaints received. For example, in FY 2011/12, 10 complaints were received and in FY 2012/13, a total of 23 complaints were received, which is a 130% increase in the number of complaints received. The number of Attorney General (AG) Office cases initiated in FY 2011/12 was four cases, while in FY 2012/13, a total of 13 cases were initiated, which is a 225% increase in the number of cases initiated. The number of accusations filed against a licensee has also increased. In FY 2011/12, one accusation was filed but in 2012/13 a total of eight accusations were filed which is a 700% increase in the number of accusations filed against a licensee.

What are the performance barriers?

One main performance barrier that affects the DHCC is the six to twelve month long process when referring cases to the AG's Office for administrative discipline. Due to the AG Office's heavy workload and shortage of staff, there are always delays when they prepare accusations and statement of issues for the DHCC cases.

What improvement plans are in place?

The DHCC enforcement staff regularly communicates with the AG's Office regarding the status of its cases; however, because the AG's Office has such a heavy workload and is understaffed, the DHCC can only request a quicker processing of its cases to reduce the time to complete accusations or statement of issues. Whether the DHCC's request is fulfilled is dependent upon the current caseload at the AG's Office.

What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

Recently, the DHCC has exercised its statutory authority to issue initial probationary licenses to applicants who are not qualified for a non-restrictive license due to a criminal background (BPC, Section 1932). The DHCC's ability to issue a probationary license without referring to the AG's Office has dramatically decreased the time required for enforcement action in this instance.

In the future as the amount of enforcement actions increase, the DHCC may need to request the following in order to address enforcement workload issues:

1) Review the DHCC enforcement policies and procedures to improve efficiencies;
2) Increase the number of enforcement staff through the BCP process to address the additional workload;
3) Submit regulatory requests depending upon new mandates or needs; and
4) Request new legislation to expand the DHCC's enforcement mandates.

The DHCC's Enforcement Statistics are shown in Tables 9(a)(b)(c) and Table 10.

Table 9a. Enforcement Statistics

	FY 2010/11	FY 2011/12	FY 2012/13
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	18	10	23
Closed	0	0	0
Referred to INV	19	10	22
Average Time to Close	16 days	3 days	4 days
Pending (close of FY)	0	0	1
Source of Complaint (Use CAS Report 091)			
Public	8	5	11
Licensee/Professional Groups	0	1	1
Governmental Agencies	105	205	164
Other	8	2	5

Table 9a. Enforcement Statistics (continued)

Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	103	203	162
CONV Closed	107	210	161
Average Time to Close	28 days	4 days	1 day
CONV Pending (close of FY)	7	0	1
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied	0	0	0
SOIs Filed	1	0	2
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0	0	0
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	3	1	8
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	112 days	35 days	216 days
Pending (close of FY)	7	8	14

Table 9b. Enforcement Statistics			
	FY 2010/11	FY 2011/12	FY 2012/13
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	1	1	3
Stipulations	1	1	2
Average Days to Complete	1,545 days	785 days	581 days
AG Cases Initiated	4	4	13
AG Cases Pending (close of FY)	7	8	14
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	1	1	2
Voluntary Surrender	0	0	1
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	2	1	2
Probationary License Issued	0	0	0
Other	1	0	0
PROBATION			
New Probationers	1	1	2
Probations Successfully Completed	0	0	1
Probationers (close of FY)	7	8	8
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	0	0	0
Probations Extended	0	0	0
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	1

Table 9b. Enforcement Statistics (continued)

DIVERSION			
New Participants	0	1	0
Successful Completions	0	0	0
Participants (close of FY)	1	2	2
Terminations	0	0	0
Terminations for Public Threat	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0

Table 9c. Enforcement Statistics			
	FY 2010/11	FY 2011/12	FY 2012/13
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	126	220	183
Closed	123	222	195
Average days to close	111 days	45 days	63 days
Pending (close of FY)	26	24	12
Desk Investigations (Use CAS Report EM 10)			
Closed	28	2	1
Average days to close	52 days	42 days	40 days
Pending (close of FY)	0	0	0
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	95	218	194
Average days to close	128 days	45 days	63 days
Pending (close of FY)	26	24	12
Sworn Investigation			
Closed (Use CAS Report EM 10)	0	0	0
Average days to close	0	0	0
Pending (close of FY)			
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	0	0	0
PC 23 Orders Requested	0	0	1
Other Suspension Orders	0	0	0
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	0	0	0
Referred for Diversion	0	0	0
Compel Examination	0	0	1
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued	0	0	24
Average Days to Complete	0	0	35
Amount of Fines Assessed	0	0	$1,650
Reduced, Withdrawn, Dismissed	0	0	0
Amount Collected	0	0	$1,400
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	0

Table 10. Enforcement Aging						
	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	0	2	2	20%
2 Years	0	0	1	2	3	30%
3 Years	0	1	1	1	3	30%
4 Years	0	0	0	1	1	10%
Over 4 Years	0	1	0	0	1	10%
Total Cases Closed	0	2	2	6	10	100%
Investigations (Average %)						
Closed Within:						
90 Days	56	76	185	156	473	75%
180 Days	15	27	16	21	79	13%
1 Year	1	13	15	17	46	7%
2 Years	8	6	5	1	20	3%
3 Years	1	1	0	2	4	1%
Over 3 Years	1	0	0	1	0	1%
Total Cases Closed	82	123	221	198	622	100%

Note: For all Enforcement statistics, the number of cases, the number of days to close cases, and the number of days to investigate cases may fluctuate due to the length of the investigations, complexity of the cases, and/or amount of time to obtain official documents pertinent to cases.

32. What do overall statistics show as to increases or decreases in disciplinary action since the last review.

The overall statistics show that the DHCC has a steady increase in the number of disciplinary cases referred to the AG's Office. The increase of cases is the result of having full time, dedicated enforcement staff, the implementation of new disciplinary guidelines, and the notifications of subsequent arrests from the Department of Justice (DOJ) and Federal Bureau of Investigations that notify the DHCC of new arrests and convictions of licensees. In FY 2010/11, four cases were initiated and referred to the AG's Office compared to thirteen cases in FY 2012/13; a 225% increase in the number of cases referred to the AG's Office.

33. How are cases prioritized?

When complaints are received, they are reviewed and prioritized based upon the type of alleged violation(s) involved (e.g., quality of care, criminal conviction, drug and/or alcohol abuse, sexual misconduct, etc.). The DHCC has a zero tolerance policy for drugs or abuse of alcohol. An example of a Priority 1 complaint would be if a hygienist is requested to call in prescriptions by the dentist to a pharmacy for patients, but the hygienist is accused of ordering unauthorized prescriptions for herself.

What is the board's complaint prioritization policy?

The urgent priority violations are considered the most serious and may pose a risk to the public. High and routine priority violations are less serious but may still be referred to the AG's Office for formal disciplinary action. The DHCC prioritizes its complaints using:

1. Urgent Priority - (requires immediate attention and has the highest priority) A case involving sexual misconduct, quality of care issues, arrest(s) or conviction(s), drug or alcohol abuse, or other serious offenses.

2. High Priority - (second highest priority type) A case involving unlicensed activity, negligence, or incompetence without serious bodily injury.
3. Routine Priority - (handled in the normal course of business) A case involving false or misleading advertising, fraud, or record keeping violations.

Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)?

The DHCC Complaint Prioritization Policy is the same as the DCA Complaint Prioritization Guidelines for Health Care Agencies (August 31, 2009).

If so, explain why.

The complaint prioritization policies are the same between the DHCC and the DCA as listed above.

34. Are there mandatory reporting requirements? F or example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report actions taken against a licensee.

- Penal Code (PC), Section 11105.2 – This section requires the DOJ to report to the DHCC whenever a licensee is arrested and convicted of crime(s).
- BPC, Section 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 DHCC within 10 days after the judgment is entered.
- BPC, Section 1950.5(x) – This section requires the licensee to report to the DHCC 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, Section 1950.5(y) – This section requires the licensee to report to the DHCC all deaths occurring in his or her practice with a copy sent to the dental office.
- PC, Section 11164 et seq. – This section requires the licensee to report any child abuse and neglect.
- Welfare and Institutions Code, Section 15600 et seq. – This section requires the licensee to report elder abuse.

Are there problems with receiving the required reports?

In cases that involve criminal convictions, the DHCC must request documentation from law enforcement agencies and from the various state and federal courts. Some of these agencies take months to respond to our requests which can cause severe delays in the processing of the case. Also, several arresting agencies and courts are now requiring a fee for certified arrest and court records which can cause a longer delay to receive the needed documentation due to the payment process.

If so, what could be done to correct the problems?

Correcting the problems in obtaining required reports is difficult because the DHCC has to rely on outside agencies to take the time to retrieve the record(s) requested and copy and mail it to the

DHCC. If there is a payment involved for the record(s), the process could be delayed even longer, as requests for payments take time to process in addition to the delay in processing the record request by the outside agency.

The only option available to the DHCC to correct the problem is to consistently and frequently follow-up with the outside agency from where the record(s) are being requested. The DHCC has no jurisdiction over the outside agencies where the information or report is requested and must rely on professional courtesy and cooperation to obtain the needed information.

As for the payment for records issue, the DHCC is researching with the DCA as to whether the Cal-card can be used to pay for requested records in lieu of another payment method since the DHCC does not maintain a "petty cash" account for minor purchases.

35. Does the board operate with a statute of limitations?

BPC, Section 1670.2 requires the DHCC to operate within a statute of limitations on initiating proceedings for violations of the Act. For example, depending on the alleged action, an accusation must be filed within three (3) years after the DHCC discovers the act or omission alleged or within seven (7) years after the act or omission occurs, whichever occurs first. In an alleged action committed on a minor, the seven-year or ten year period would be tolled until the minor reaches the age of majority.

If so, please describe and provide citation.

Depending on the alleged act, an accusation must be filed within three (3) years after the act or omission alleged is discovered or within seven (7) or 10 years after the act or omission, whichever occurs first. In an alleged action committed on a minor, the seven-year or ten year period would be tolled until the minor reaches the age of majority. An accusation alleging fraud or willful misrepresentation is not subject to the limitation (BPC, Section 1670.2).

If so, how many cases were lost due to statute of limitations?

To date, no cases have been lost due to the DHCC's statute of limitations.

If not, what is the board's policy on statute of limitations?

The public's protection is the highest priority for the DHCC and the current statute of limitations policy allows a case to be filed in a timely manner.

36. Describe the board's efforts to address unlicensed activity and the underground economy.

To prevent unlicensed activity, information is presented to educate the public and all licensees on the DHCC's website, newsletter articles, and several outreach programs. In addition, a supplemental law and ethics examination is required for all applicants with an emphasis on personal ethics and morals. When renewing a license, mandatory CE courses are required for the licensees that pertain to the laws, dental billing practices, professional misconduct, and ethical issues.

To date, there have been no reported instances to the DHCC of dental hygienists operating in the underground economy.

Cite and Fine

37. Discuss the extent to which the board has used its cite and fine authority.

Since the DHCC's regulation to issue citations and fines was initiated in December 2012, 24 citations for violations of the law have been issued. Due to statutory and regulatory changes (e.g., retroactive fingerprinting requirements and physical address and email address change requirements), the DHCC expects the number of citation and fines to increase as more violations are reported.

Discuss any changes from last review and last time regulations were updated.

This is the first Sunset Review for the DHCC, so there are no changes that have occurred since the last review. Also, the DHCC is in the process of implementing its own regulatory framework and as part of that process, updating all regulatory sections pertaining to dental hygiene.

Has the board increased its maximum fines to the $5,000 statutory limit?

The DHCC has not increased its maximum fines to the $5,000 statutory limit because to date, there has not been any citable action to warrant a $5,000 fine.

38. How is cite and fine used?

Citation and fines are used by the DHCC as a means to notify the licensee that a violation has occurred and that they are not in compliance with the law. In situations where the DHCC does not seek to suspend or revoke a license, a citation and fine may be issued to impose a monetary fine and/or order of abatement as an administrative action against a licensee.

What types of violations are the basis for citation and fine?

If a licensee commits a violation that is not serious enough to warrant referral to the AG's Office for formal discipline, the DHCC may issue a citation and fine to take administrative action against a licensee. Examples of citation and fine violations issued to licensees are:

- Failure to notify the DHCC of an address change or email change within 30 days;
- Failure to properly notate the services performed in the patient's treatment record; and
- Failure of the CE audit process.

39. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals in the last 4 fiscal years?

The DHCC has not received any requests for an informal conference pertaining to a citation and no requests for administrative hearings in the last four years. When a citation is issued, the licensee may request an informal conference within 10 days after issuance of the citation. The informal conference would allow the licensee to present additional information to the EO. The EO may affirm, modify, or dismiss the original citation after the informal conference. In addition to requesting an informal conference, the licensee may request an administrative hearing within 30 days after issuance of the citation. The administrative law judge (ALJ) will render a decision which will be presented to the DHCC for adoption or rejection.

40. What are the 5 most common violations for which citations are issued?

The five most common violations are listed in the chart below.

BPC Section	Citation
1934	Change of address or Name: Failure to notify the Committee of an address change within 30 days and for a name change, it is within 10 days.
1950(a)	Consequences of conviction of crime substantially related to the licensee's qualifications, functions, or duties: DUI
1950.5(e)	The use of any false or fictitious name in advertising: False advertising on website and brochure.
1950.5(v)	Any action or conduct that would have warranted the denial of the license: False entry on a license renewal application.
1953(a)	Failure to identify in patient record services performed and treatment entries.

41. What is average fine pre and post appeal?

The allowable fines range from $50 to $5,000 per violation, depending on prior violations, the gravity of the violation, the harm committed, if any, to the complainant, client, or public, and other mitigating evidence.

The average fine issued by the DHCC is $250. At this time, the DHCC has not received any requests for an appeal.

42. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

The DHCC has not used the Franchise Tax Board (FTB) intercept to collect any outstanding fines; however, if the DHCC chooses to use this method, the procedure would be as follows:

California residents/licensees who owe delinquent debts to government agencies and are scheduled to receive state income tax refunds, unclaimed property, or state lottery winnings, could have those funds garnished and transferred to pay their debt to agencies such as the DHCC. The FTB would collect the funds for the DHCC that would otherwise be unobtainable unless exorbitant resources were used. The advantage of using the FTB to collect any outstanding fines is that the cost is lower than other collection methods.

Cost Recovery and Restitution

43. Describe the board's efforts to obtain cost recovery.

BPC, Section 125.3 authorizes the recovery of investigation costs that are associated with the formal discipline of a licensee. The DHCC's policy is to seek cost recovery in all cases where it is authorized. As a result, the DHCC's Disciplinary Guidelines lists the reimbursement of costs as a standard term of probation and is included when settling cases with a stipulated settlement, and most, but not all, administrative hearing decisions. When initially meeting with a probationer, the reimbursement of costs is discussed and an installment plan may be made at that time.

Discuss any changes from the last review.

Since this is the first Sunset Review for the DHCC, there have not been any changes since the last review.

44. How many and how much is ordered for revocations, surrenders and probationers?

Typically, costs are included in all stipulated surrenders and revocations. The amount is determined by the investigation time and by costs incurred by the AG's Office. In the past four years, the DHCC revoked four licenses and two licenses were surrendered. The amount ordered for cost recovery in these instances was $18,624, an average of $3,104 per case.

During that same time period, five licenses were placed on probation. The amount ordered for cost recovery in those cases was $29,091, an average of $5,812 per case. In probation cases, the amount ordered is paid in installments during the probationary period and must be paid in full by the end of the probationary term.

How much do you believe is uncollectable? Explain.

Costs awarded with a penalty of license revocation or license surrender are considered uncollectible until the licensee either petitions the DHCC for reinstatement or reapplies for licensure. Based on current revoked or surrendered licenses, $18,624 could be considered uncollectable.

45. Are there cases for which the board does not seek cost recovery?

After a hearing, the ALJ may find that it would be an extreme hardship on the licensee to reimburse the DHCC the cost of their case and will not seek cost recovery. Another scenario where the DHCC would not seek cost recovery is in a statement of issues matter.

Why?

The DHCC does not have the statutory authority to seek cost recovery in a statement of issues case.

46. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

The process in which the DHCC would use the FTB intercepts to collect cost recovery is:

1) The DHCC will complete an FTB Cost Recovery Form and submit it to the DCA for processing and notification to the FTB.
2) The DCA will then notify the DHCC of the collections by sending a copy of the Notice of Collections letter to them that was sent to the licensee.
3) The FTB will use its intercepts methods to collect cost recovery for the DHCC.

47. 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.

Obtaining restitution for individual consumers is an additional condition of probation in the DHCC's Disciplinary Guidelines and is included in stipulations or in an ALJ's decision after a hearing. To date, the DHCC has not had any reports of consumer harm to warrant a request for restitution for

individual consumers; however, there has been a case where restitution was sought from a licensee for subversion of the DHCC Law and Ethics Examination.

Tables 11 and 12 show the amount of cost recovery and restitution the DHCC has received over the respective years.

Table 11. Cost Recovery

	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Total Enforcement Expenditures	$205,498	$211,843	$212,240	$282,125
Potential Cases for Recovery *	1	1	1	3
Amount of Potential Cost Recovery	$474	$11,058	$1,715	$5,377
Cases Recovery Ordered	2	1	1	1
Amount of Cost Recovery Ordered	$7,709	$1,950	$6,332	$13,100
Amount Collected**	$2,450	$3,450	$250	$5,518

*"Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.
**Amount Collected could include Cost Recovery ordered from a prior year.

Table 12. Restitution

	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Amount Ordered	0	0	0	$10,000
Amount Collected	0	0	0	$2,616

Section 6
Public Information Policies

48. How does the board use the internet to keep the public informed of board activities?

The DHCC uses its website/internet to communicate the laws and regulations that govern the practice of dental hygiene and posts any new information or announcements to both the public and licensees on the homepage of the website. The latest information from the DHCC that is contained in the newsletter and final meeting minutes are on the website and staff occasionally use email blasts to notify email subscribers of new and updated information.

Does the board post board meeting materials online? When are they posted? How long do they remain on the website?

The DHCC posts its meeting materials and agenda on its website/online within five to 10 calendar days prior to each meeting complying with the Bagley-Keene Open Meetings Act. The current meeting materials remain on the website/online for approximately a year, and then are moved to an archived meeting materials folder where the materials stay indefinitely so that the public or any other interested party has access. A link is posted on the DHCC's meeting calendar to access the archived meeting materials at any time.

When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?

The draft meeting minutes for the prior meeting are contained in the materials for the next meeting to be approved and are posted five to 10 calendar days prior to the meeting. After the draft minutes from the prior meeting have been approved at the subsequent meeting, the final version of the minutes are posted on the website/internet meeting calendar under the same meeting date

and are available at any time. Eventually, the minutes will be moved into the archive file where the minutes remain indefinitely and are still accessible on the website.

49. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings?

The DHCC fully supports webcasting and has webcast two of its meetings in the past. The DCA webcast team was low on staff and availability, but has recently hired new videographers and is available to schedule meetings to be webcast. As such, the DHCC plans to arrange and provide webcast for future meetings. The most recent webcast meetings for all DCA boards and committees over the past year are posted on the DCA website and prior webcasts are archived for a year before being removed completely from the site.

50. Does the board establish an annual meeting calendar, and post it on the board's web site?

The DHCC establishes an annual meeting calendar approved by the DHCC at its annual December meeting for the next calendar year. The meeting calendar is posted on the DHCC's website for access to interested stakeholders and the public.

51. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*?

The DHCC uses the 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)?

The DHCC posts accusations and disciplinary actions against its licensees in accordance with the DCA's Web Site Posting of Accusations and Disciplinary Actions.

52. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

The DHCC provides the following information about its licensees so the public can be informed that the individual performing dental hygiene procedures is licensed and has no enforcement action taken against their license. The DHCC releases through its website the licentiate name, license type, license number, license status, license expiration date, license issue date, the county the licentiate indicated for their address of record, and whether there are any formal disciplinary actions against the license. There is also a section to list any related licenses, registrations, or permits, if applicable. The DHCC website is updated on a daily basis to capture any new information on an existing licentiate and those individuals who have recently become licensed.

53. What methods are used by the board to provide consumer outreach and education?

The DHCC uses a variety of methods to provide consumer outreach and education to interested stakeholders. The DHCC has presented at student regional meetings, visited many of the dental hygiene schools throughout the state, attended both dental and dental hygiene association events and meetings, participated in health fairs, public health events, and educational institution outreach functions, issues email blasts to the DHCC email subscribers and educational program directors, and has a newsletter that is readily available electronically or hardcopy to inform the public, students, associations, and educational institutions about the DHCC programs and authority.

Section 7
Online Practice Issues

54. 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?

The DHCC believes the prevalence of online practice is emerging and there have been no reports of unlicensed activity. There are no legal prohibitions to using technology in the practice of dental hygiene, as long as the practice is done by a California licensed dental hygienist. Telehealth is not a telephone conversation, email/instant messaging conversation, or fax; it typically involves the application of videoconferencing or "store and forward" technology to provide or support health care delivery. Teledentistry is growing in popularity and the DHCC is aware of some RDHs and RDHAPs who are participating in a health manpower pilot project studying the delivery of patient care utilizing this technology. Currently, the data from this study has led to proposed legislation in Assembly Bill 1174 (Bocanegra). This bill has been introduced and is a two year bill.

Section 8
Workforce Development and Job Creation

55. What actions has the board taken in terms of workforce development?

The DHCC has been very proactive in seeking ways to implement BPC, Section 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 that limit the services that dental hygienists are allowed to provide, and the inability for dental hygiene practitioners such as the RDHAP to obtain payment for the services rendered.

Restrictive supervision levels have been removed for other dental healthcare providers. With the statutory revision of the dental practice act in recent years, determining the appropriate level of supervision for unlicensed dental assistants and registered dental assistants, language has been changed. Prior to the changes, the laws stipulated which services were to be completed under direct supervision (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 new laws allow the dentist employer to determine the level of supervision necessary for the performance of the services that assistants are legally allowed to provide.

Although BPC, Sections 1912 – 1914 allow for general supervision for most services performed by dental hygienists, some services are still only authorized under direct supervision which limits the

full utilization of the dental hygienist services. The DHCC has approved to seek legislation to remove the direct supervision restrictions.

The DHCC worked actively with the CDHA on SB 1202 (Ch. 331, Statutes of 2012) which allows RDHAP's to own and operate mobile clinics. By allowing RDHAP's to own and operate mobile clinics, more of the state's underserved populations will have access to dental hygiene services.

In addition to working towards the legislative changes needed to support the full utilization of dental hygienists; the DHCC has approved regulatory language to allow for additional programs to offer coursework in administration of soft tissue curettage, local anesthesia, and nitrous oxide-oxygen analgesia. Due to the fact that most states do not allow dental hygienists to perform these functions, dental hygienists seeking licensure in California are required to successfully pass a course in these procedures to be licensed. By expanding the number of courses available, there will be increased access which will lead to an increase in the number of licensed dental hygienists.

The DHCC supported legislation to allow registered RDHAPs to own mobile clinics to provide dental hygiene services to the public who are not part of the traditional dental delivery system. In addition, the DHCC collects data on workforce characteristics pursuant to BPC, Section 1902.2 that includes employment status of the licensee, practice location, and information regarding a licensee's cultural background and foreign language proficiency. This information is published annually on the DHCC website. The DHCC currently monitors the number of RDHAPs that take the required additional training and subsequent licensing exam. The DHCC plans to also monitor the number of entry level dental hygiene graduates in the state compared with the number of initial California licenses issued. The DHCC will use this information to determine how to best serve the public relating to workforce development.

56. Describe any assessment the board has conducted on the impact of licensing delays.

The DHCC is fortunate to not have experienced any licensing delays. The DHCC is currently issuing licenses within 30 days of receipt of a complete application package which is well within the 120 days the DHCC is allowed to issue a license.

57. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

The DHCC sends email blasts to the dental hygiene educational program directors for all of the dental hygiene programs in California with information that pertains to potential licensees (students) regarding examination and licensure. Through networking with professional organizations, CDHA, and the California Dental Hygiene Educator's Association (CDHEA), the DHCC has attended meetings for students and educators and presented information regarding licensing requirements and the licensing process.

In addition, the DHCC posts updates pertaining to licensing requirements and the licensing process on the webpage, as well as having a link to this information. The DHCC has also developed a newsletter that is emailed to all subscribers, potential licentiates, and all interested parties.

58. Provide any workforce development data collected by the board, such as:

a. Workforce shortages

The DHCC monitors reports from the Office of Statewide Health Planning and Development (OSHPD) and the industry on workforce shortages. Current data indicates there is no longer a shortage of dental hygienists in the state. There continues to be a mal-distribution of dental hygienists due to practice limitations that require dental hygienists to work for a dentist. The category RDHAP was enacted by the legislature to increase access to dental hygiene services in dental shortage areas. The number of RDHAP's has increased by 87% from 2009 (238 licensees) to 2013 (445 licensees). However, the requirement for a prescription from a dentist or physician has hindered the RDHAP's ability to provide dental hygiene services in some of these areas due to a lack of dentists and physicians in the area and/or the unwillingness of the dentist or physician to sign a prescription allowing the RDHAP to provide care.

b. Successful training programs.

The most successful training program has been the programs for the RDHAP license. These programs allow RDH's with additional education to provide services in residences for the homebound, in schools, residential care facilities, and other institutions and dental health professional shortage areas. There are currently two RDHAP programs in the state. These programs are providing the necessary additional education to qualify an individual for licensure.

Currently, the DHCC is monitoring Health Workforce Pilot Project 172. This project utilizes dental hygienists as intake personnel providing assessments via exams and the taking of radiographs (X-rays). The dental hygienist then is able to send the assessment electronically records via the teledentistry model to a dentist for review and dental diagnosis. The project also has a training component to allow the dental hygienists in the project to place interim therapeutic restorations (ITR's). By allowing dental hygienists to place ITRs, patients with no access to a dentist can receive palliative care to arrest decay and alleviate pain until the patient can have treatment from a dentist.

Section 9
Current Issues

59. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

The DHCC has worked diligently to implement the Uniform Standards, pursuing regulations in the form of Disciplinary Guidelines containing language that specifies that the DHCC will require a clinical diagnostic evaluation of a licensee to determine if there is a substance abuse problem. In the meantime, the licensee is required to cease practice until the results are received. The Guidelines require a probationary licensee to provide the name, address(es), and phone numbers of all employers or supervisors, and authorize the DHCC to communicate with the supervisor or employer regarding the probationer's work status, performance, and monitoring. The Guidelines specify a testing schedule and exceptions that conform to #4 of the Uniform Standards, and if a probationer tests positive for a banned substance, the Guidelines specify that the probationer must cease practice and the DHCC notify the probationer's employer. The Guidelines specify criteria mirroring Uniform Standards #11 and #12 that a probationer must meet to petition to return

to practice and for reinstatement of an unrestricted license, and allows group meeting participation and any inpatient or outpatient treatment to be considered as evidence of sustained compliance and rehabilitation. The Guidelines specify requirements for worksite monitoring, to ensure that probationers comply with the terms of their probation. Several of the Uniform Standards relate to a diversion program, which the DHCC does not have.

Proposed CCR, Section 1138 states that the Disciplinary Guidelines apply to all disciplinary matters and the uniform standards describe the consequences that apply to a substance abuser. A public hearing was held and no public comments were received on the regulations and the rulemaking file is currently in the review process at the Business, Consumer Services, and Housing Agency.

60. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

The DHCC has addressed some items through statute and some in both statute and Disciplinary Guidelines. The DHCC successfully sought legislation to require denial of a dental hygiene license to a registered sex offender and permanent revocation of a license for sexual misconduct. The DHCC pursued legislation that imposes substantial fines on licensees and health care facilities that fail to comply with a court order to provide documents and has proposed regulatory language within its Disciplinary Guidelines that specifies penalties for a licensee's failure to cooperate with an investigation. Regulatory language has been drafted to specify the DHCC may delegate stipulated settlements to its EO and require a medical or psychological evaluation of an applicant. Although licensees are currently required to certify at the time of each license renewal, penalties for failure to report an arrest or conviction will be the subject of upcoming regulations, as will a prohibition of confidentiality agreements.

61. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

To date, the DHCC has provided program specifics to the DCA Office of Information Services (OIS) in order to develop the correct program parameters that meet the DHCC needs. The DHCC staff has also participated in multiple training programs and exercises to identify programmatic issues during the development of the BreEZe system. The DHCC also "loaned" a staff person, who is very knowledgeable in the creation and implementation of these types of complex computer systems, to OIS for about a year. This staff person was subsequently offered a position in OIS to continue the work of implementing the BreEZe system.

Section 10
Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the board.

The DHCC was created upon the recommendation of the JLSRC in 2002 for the establishment of an entity to regulate the profession of dental hygiene. The recommendation came as a result of the 2002 Sunset Review for the DBC and the Committee on Dental Auxiliaries (COMDA). According to the Background Paper for the Hearing for the DBC (DBC = Board for this section):

The JLSRC and the DCA identified a number of issues and problem areas concerning this Board. There had been longstanding dissatisfaction with the deliberations and actions of the Board by the various organizations representing dental auxiliaries and others for a variety of reasons. The complaints and concerns expressed were virtually the same as when the Board was reviewed by the JLSRC in 1996. Some of these concerns or problems have been noted in audits by the California State Auditor and by an independent review of the Board's investigative program and the need for sworn peace officers. The Board was criticized for being controlled by its dentist majority and favorable to their interests over those of the public and the licensed dental auxiliaries. It was accused of being unduly absorbed with minutiae – extensive deliberations on whether or not particular duties or functions may be performed by one or more of the categories of dental auxiliaries – the so-called "duty of the month" debate over the scopes of practice of dental auxiliaries.

As a result of the findings from the JLSRC, legislation was enacted to create the Dental Hygiene Committee of California.

2. Short discussion of recommendations made by the Committee/Joint Committee during prior sunset review.

   The JLSRC recommendation to form a separate entity to oversee the profession of dental hygiene was incorporated into the language for SB 853 (Ch. 31, Statutes of 2008) which was chaptered June 13, 2008.

3. What action the board took in response to the recommendation or findings made under prior sunset review.

   The DHCC, since its inception, has been the regulatory entity for all aspects of dental hygiene licensure, education, examination, and enforcement in the interest of consumer protection. The creation of the DHCC has improved consumer access to dental hygiene services, reduced the barriers to changes in the practice of dental hygiene, and the regulation of dental hygienists.

4. Any recommendations the board has for dealing with the issue, if appropriate.

   The DHCC recommends that the jurisdiction language in BPC, Section 1901 be removed. The DHCC has functioned as an independent agency since it was created in 2009. The use of language that states that the DHCC is under the jurisdiction of the DBC has led to confusion as to the authority of the DHCC to act as a self-regulating agency. Licentiates, the public, and other nationally recognized associations and governing entities view the jurisdiction language as restricting the ability of the DHCC to act independently in matters pertaining to the regulation of dental hygienists. Per the definition of the functions of an independent agency, the DHCC is not subject to restrictions set by the DBC and does act independent of the DBC. Furthermore, the DBC has no statutory authority to regulate the practice of dental hygiene.

There has been considerable concern on the part of the California Dental Association regarding removal of jurisdiction language. However, the JLSRC Background Paper for the Dental Board of California Sunset Review dated March 14, 2011 (cf., Section 12, Attachment F) made the following recommendation:

> "*It would appear as if the intent of the Legislature was that the Dental Hygiene Committee was created so that it could make independent decisions on issues related to the regulation of the hygienist profession unless it involved scope of practice changes which would need to be worked out between both the dentistry and hygienist professions. Clarification may be needed to assure that the Dental Hygiene Committee maintains its independence over that of DBC.*"

Due to the ambiguity of language that implies jurisdiction, when there is no statutory authority for the DBC to have any control over the functioning of the DHCC, the DHCC recommends the amendment of Section 1901 as follows:

> 1901. (a) There is hereby created ~~within the jurisdiction of the Dental Board of California a~~ the Dental Hygiene ~~Committee~~ Board of California in which the administration of this article is vested.
>
> (b) This article may be hereby known as the Dental Hygiene Practice Act.
>
> ~~(b)~~ (c) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the committee subject to review by the appropriate policy committees of the Legislature.

The DHCC has the full responsibilities of a board and should be called a board rather than a committee. Therefore, the DHCC recommends that its designation should be changed to the Dental Hygiene Board of California (DHBC). As with the legislation changing the Physician's Assistant Committee to a Board, legislation needs to be enacted for this change to occur.

The DHCC also recommends that the language in BPC, Sections 1905. (a)(8) and 1905.2 be removed. BPC, Section 1905 (a)(8) and Section 1905.2 require the DHCC to make recommendations to the DBC regarding dental hygiene scope of practice issues. As an independent regulatory agency, the DHCC should not have to make recommendations to the DBC on issues that impact the practice of dental hygiene. In addition, the DBC has no authority over the dental hygiene scope of practice. Inclusion of this language in the statute creates the same problems that existed when dental hygiene was regulated by the DBC. The dentist majority on the DBC has been criticized in being supportive of their interests over those of the consumer.

Senator Don Perata in his July 23, 2010 letter of intent (cf., Section 12, Attachment G) sent to the chair of the DHCC and the president of the DBC stated the following in regard to these sections:

> "…BPC, Section 1905.2 is also causing some confusion. In my investigation of this section I realized that, inadvertently, this language, which represents old Dental Auxiliaries language, was left in SB 853. It is my recommendation that it be removed, as the sections immediately preceding BPC, Section 1905.2, as well as the sections after BPC, Section 1905.2 clearly delineate the charge of the DHCC, which includes setting regulations, licensure and enforcement for dental hygienists. The DHCC is to carry out these functions autonomously."

Scope of practice changes have to be done through the legislature and are often brought to the Boards by the professional organizations representing the stakeholders. The DHCC should not have to submit recommendations supporting scope of practice changes if the DBC does not have the authority to restrict decisions made by the DHCC. This would be time consuming and serve no useful purpose. It would be through the legislative process, the DBC would be able to provide input. The legislature would then have the ability to determine if a change in the scope of practice for dental hygienists would be warranted taking into the consideration whether the change would fulfill the legislative intent for full utilization of registered dental hygienists without compromising the need for consumer protection.

The DHCC further recommends that BPC, Section 1905(a) to add:

(10) The board shall have and use a seal bearing the name, "Dental Hygiene Board of California."

Section 11
New Issues

This is the opportunity for the board to inform the Committee of solutions to issues identified by the board and by the Committee. 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., legislative changes, policy direction, and budget changes) for each of the following:

1. Issues that were raised under prior Sunset Review that have not been addressed.

   All of the issues raised under prior Sunset Review have been addressed in Section 10.

2. New issues that are identified by the board in this report.

   - Increase to the License Renewal Fee Ceiling to allow additional future revenue collection, when warranted and justified, especially if the DHCC fund is threatened with insolvency.
   - Increase the RDH, RDHAP, RDHEF, and FNP license and delinquent renewal fees.
   - Additional managerial staff to oversee the daily programmatic operations and program staff to alleviate the EO from direct office oversight and be allowed to concentrate on EO functions.
   - Additional staff to appropriately implement the CE review, audit, and provider review programs.
   - Additional office space to accommodate more staff and resources to address an increased workload in support of the DHCC programs.
   - Implement a Statute of Limitations for enforcement actions.
   - Implement penalties for Failure to Report unprofessional conduct (BPC, Section 1950.5).
   - Full Utilization of all categories of dental hygienists to meet the needs of all of the State's Citizens:

     Ensuring full utilization of dental hygiene services is a concern of the DHCC. There are statutory restrictions which have been imposed that restrict the full utilization of dental hygienists. Removal of these restrictions would allow for greater access to care for the consumer and would enable the skills of the dental hygienists to be used to their full extent

without jeopardizing the health and safety of the consumer. The following restrictions have a significant impact of the consumers access to care and to the full utilization of the dental hygienist (BPC, Section 1909): the delineation of services that are to be performed under direct supervision, and the language in BPC, Section 1926 (d) which requires that the RDHAP practice in a dental health professional area as certified by the OSHPD.

BPC, Section 1909 requires that following duties are to be performed under the direct supervision of a dentist who must be in the office while the procedure is being performed: administration of soft tissue curettage, local anesthesia, and nitrous oxide-oxygen analgesia. Currently, there are seven states that allow dental hygienists to administer local anesthesia under general supervision (the dentist does not have to be in the office). In these states, there have been no reported instances of consumer harm. In three states, nitrous oxide-oxygen analgesia is administered under general supervision-again with no reported incidences of consumer harm. Changing the supervision level from direct to general would allow dental hygienists to provide these services without the restriction of having the dentist in the office, allowing patients to have access to these services, but still as directed by the supervising dentist. These services would continue to be provided on patients of record as required by statute. The absence of reported incidences of consumer harm supports the DHCC's contention that these procedures can be performed safely under general supervision. Soft tissue curettage is performed as an adjunct therapy to scaling and root planing which is performed under general supervision and therefore, should not require direct supervision by the dentist. It is important to note that the change in the level of supervision would not allow dental hygienists to perform these services unsupervised. These patient care services would be then moved to BPC, Section 1910, which lists the procedures dental hygienists are authorized to perform under general supervision.

BPC, Section 1926(d) allows an RDHAP to open a practice in a dental health professional shortage area as designated by OSHPD. Problems have arisen when an RDHAP sets up a practice in a dental health shortage area and over time the designation of the area changes. The law would require the RDHAP to close down the practice as the practice is no longer in a dental health professional shortage area. Closure of the practice would leave the patients with no access to dental hygiene services due to a lack of provider. It seems counterproductive for the law to allow RDHAP practitioners to establish practices in shortage areas to meet the needs of the consumers, becoming a part of the solution, only to have to close down their practices when the area is no longer considered a shortage area. The DHCC would recommend that the language in BPC, Section 1926(d) be amended to read:

> (d) Dental health professional shortage areas, as certified by the Office of Statewide Health Planning and Development in accordance with existing office guidelines. <u>An alternative dental hygiene practice established within a designated shortage area will remain in full effect regardless of designation.</u>

- <u>Continued Competency</u>

The complex world of oral healthcare delivery is changing and evolving at a revolutionary rate. Dental hygienists' knowledge and skills must adapt to the constant change of landscape and issues facing professionals. As evidence-based decision making for patient care is now the hallmark of dental hygiene practice, the question has been raised of whether evidence of professional knowledge and skills should also be expected from practicing dental hygienists. This issue of continued competency has been raised by the DHCC and the profession of dental hygiene. Although it may appear continued competence is new to dental hygiene, it is

not new to healthcare. In 1995, the Citizen Advocacy Center asked the question, "Can the public be confident that health care professionals who demonstrated minimum levels of competence when they earned their licenses continue to be competent years and decades after they have been in practice?" In 2001, the Institute of Medicine (IOM) stated in their report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (cf., Section 12, Attachment H), "There are no consistent methods for ensuring the continued competence of health professionals within the current state licensing functions or other processes" (p. 217). In April 2003, the IOM produced an additional report entitled *Health Professions Education—A Bridge to Quality* (cf., Section 12, Attachment I). In this document, professional competency was deemed as a shared responsibility of both the public and private sectors and "health profession boards need to require demonstration of continued competence" (p. 8). A critical regulatory issue that has been discussed among many healing arts boards across the country and is emerging in California is the issue of continued competence.

As a regulatory agency, the DHCC impacts professional competence at three levels: (1) the education process whereby regulation ensures dental hygiene programs produce candidates for licensure that meet national & state competency standards; (2) clinical testing that measures competence for entry into practice; and (3) ongoing monitoring, licensure, and removal of those who cease to be deemed competent from practice. In the interest of public protection, the DHCC has strict requirements for obtaining initial licensure. However, requirements for licensure renewal are much less stringent. For most healing arts boards, as with DHCC, those licensed dental hygienists who are removed from practice because of incompetency are removed through the disciplinary process. There is currently no process in place that speaks to the assurance to the public and the DHCC that dental hygiene practitioners continue to be competent and safe years after completing their education and first becoming licensed. Because licensure is a privilege, the licensee has a responsibility to the DHCC and to the public who receives dental hygiene services including the duty to attain and maintain licensure.

At this time, CE requirements could be viewed as an avenue to ensure continued competence; however, it has been debated that CE does little to ensure that licensees remain competent and provide quality care. Continued competence moves beyond CE and speaks to the ongoing application of professional knowledge, skills, and abilities, which relate to the occupational performance objectives in a range of possible encounters that is defined by the individual scope of practice and practice setting. The DHCC would like to explore other approaches to assure continuing competence in today's environment where technology and practice are continually changing, new health care systems are evolving, and consumers are pressing for providers who are competent. Because of this, the DHCC believes that statutory authority should be in place to allow for implementation of continued competence in the future. This could be accomplished by amending BPC, Section 1936.1 by adding:

> (c) The committee may also, as a condition of license renewal, establish a measure of continued competency as adopted in regulations by the committee.

During the regulatory process, all of the questions and concerns surrounding implementing continued competency can be vetted and addressed.

3. New issues not previously discussed in this report.

- Payment for Services Rendered

  RDHAPs have provided quality preventive oral health care services to underserved communities throughout California. In recent years, it has come to our attention that consumer insurance companies based outside of California are refusing payment of services rendered by the RDHAP to California consumers. Their reasoning is that not all states have the RDHAP provider status and therefore, in their opinion, RDHAPs are not eligible for reimbursement.

  In a report prepared by the Center for Health Professions entitled *Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California,* the research suggests:

  > "Contrary to original legislative intent, many recent proposals have sought to restrict RDHAPs from full independent practice, inevitably creating barriers to access. Policy-makers should instead focus on the purpose of the RDHAP profession – to improve access to dental care. The profession's capacity to improve access is inherently tied to reimbursement policies for treating the underserved, including the elderly and developmentally disabled. Legislators may therefore want to consider expanding public financial support structures for RDHAPs" (Mertz, 2008, p. 14)
  > (cf., Section 12, Attachment J).

  The DHCC has the statutory authority to make a change to existing language. It is recommended that BPC, Section 1928 be amended to include:

  > BPC, Section 1928. Registered dental hygienist in alternative practice, submitting of insurance and reimbursement of providers:
  >
  > a) A registered dental hygienist in alternative practice may submit or allow to be submitted any insurance or third-party claims for patient services performed as authorized pursuant to this article.
  >
  > b) Whenever any such insurance policy or plan provides for reimbursement for any service which that may be lawfully performed by a person licensed in this state for the practice of dental hygiene, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.
  >
  > c) Nothing in this article shall preclude an insurance company from setting different fee schedules in an insurance policy for different services performed by different professions, but the same fee schedule shall be used for those portions of health services which are substantially identical although performed by different professions.

- Alternative licensure options

  The utilization of a clinical examination process has been the backbone of assessment and qualification for initial licensure of dental hygienists for many decades.

  Although the use of patients as part of the examination process continues to be the pathway to licensure for all dental hygienists, there are several emerging alternative platforms in dentistry that do not include the use of human subjects. The DHCC has identified the need to explore alternative pathways for licensure. To that end, the DHCC will require statutory authority to

implement any of these alternative pathways. This will require amending BPC, Section 1917 (b) to read:

> Satisfactory performance on the state clinical examination, or satisfactory completion of the dental hygiene examination given by the Western Regional Examining Board or any other ~~clinical~~ dental hygiene examination approved by the committee.

4. New issues raised by the Committee.

   Change the DHCC from a committee to a board since the DHCC already functions similarly to a board. Some of the functions that the DHCC already performs within the DCA are:

   - Appointed multiple (nine) individuals by the Governor consisting of both professional and public members that will discuss, deliberate, and act upon issues that affect the DHCC in the interest of consumer protection;
   - Create standing committees to deal with examinations, enforcement, licensing, and other subject matter the DHCC deems appropriate;
   - Has the authority to request regulatory and legislative changes;
   - Mandates that the protection of the public is the highest priority in exercising its licensing, regulatory, examination, and disciplinary functions; and
   - Oversees the examination, licensing, enforcement, and administration programmatic functions for the dental hygiene profession including legislation and regulations.

   With the DHCC performing the functions listed above autonomously, it stands to reason that the nomenclature of the DHCC be changed from a committee to a board. The DHCC is a special fund agency that generates revenue from its fees. As such, the DHCC would have no impact on the state's General Fund.

Section 12
Attachments

Please provide the following attachments: ***NOTE*** – ***ALL*** attachments are located after Section 13.

A. Board's administrative manual and Business and Professions Code Sections.

Attachment A – DHCC Administrative Procedural Manual.

Attachment A1 – BPC, Sections 1900 – 1966.6.

B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).

Attachment B – DHCC Organizational Chart including Subcommittees.

C. Major studies, if any (cf., Section 1, Question 4).

Attachment C – Regional Exam Survey Questionnaire.

D. Year-end organization charts for last four fiscal years. E ach chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 3, Question 14).

Attachment D – DHCC Year-end Staff Organization Charts

E. Performance Measures (cf., Section 5, Question 30).

Attachment E – DHCC Performance Measures for the last three (3) years.

F. JLSRC Background Paper for the Dental Board of California (dated March 14, 2011)

(cf., Section 10, Question 4).

Attachment F – JLSRC Background Paper for the Dental Board of California (dated March 14, 2011) (p. 8 – 9)

G. President Pro Tempore Letter of Support (dated July 23, 2010)(cf., Section 10, Question 4).

Attachment G – Letter of DHCC Support from President Pro Tempore (Don Perata).

H. Crossing the Quality Chasm: A New Health System for the 21st Century (cf., Section 11, Question 2)

Attachment H (p. 217)

I. Health Professions Education: A Bridge to Quality (National Academy of Sciences)

(cf., Section 11, Question 2)

Attachment I (p. 8)

J. Center for Health Professions "Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California" (Mertz 2008)(cf., Section 11, Question 3)

Attachment J – Report from the Center for Health Professions- "Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California" - Mertz (dated May 2008) (p. 14)

This section only applies to the specific boards indicated below.

Section 13
Board Specific Issues

Diversion

Discuss the board's diversion program, the extent to which it is used, the outcomes of those who participate, the overall costs of the program compared with its successes

Diversion Evaluation Committees (DEC) (for BRN, Dental, Osteo and VET only)

1. DCA contracts with a vendor to perform probation monitoring services for licensees with substance abuse problems, why does the board use DEC?

   The DHCC uses the DEC to rehabilitate licensees under the influence of drugs or alcohol and returns them to safe practice.

   What is the value of a DEC?

   The value of the DEC is that an affected licensee can be reviewed by a select group of their peers or similar professionals with professional expertise and specific training to handle cases and issues pertaining to drug and/or alcohol problems. The DEC is created under the direction of the diversion program manager who has the primary responsibility to review and evaluate recommendations from the DEC regarding the licensee.

   Each DEC has the following duties and responsibilities:

   a) Evaluates licentiates who request to participate in the diversion program according to the diversion program guidelines and make recommendations to the diversion program manager.

   b) Reviews and designates those treatment facilities to which licentiates in a diversion program may be referred.

   c) Receives and reviews information concerning a licentiate participating in the diversion program.

   d) Considers in the case of each licentiate participating in a diversion program whether he or she may continue or resume with safety the practice of dental hygiene.

2. What is the membership/makeup composition?

   As per CCR, Section 1020.4, the composition of a DEC consists of six members: three licensed dentists, one licensed dental auxiliary (e.g., dental hygienist), one public member, and one licensed physician or psychologist.

3. Did the board have any difficulties with scheduling DEC meetings? I f so, describe why and how the difficulties were addressed.

   To date, there has not been any difficulty in scheduling the quarterly DEC meetings as scheduled by the current diversion program vendor. The reason there are no difficulties with scheduling DEC meetings is because the meeting dates are scheduled a year in advance and approved by all of the parties involved prior to finalization.

4. Does the DEC comply with the Open Meetings Act?

   The DEC meetings do comply with the Open Meetings Act. Every DEC meeting is open to the public during the first half-hour of each meeting to hear issues and encourage public participation.

5. How many meetings held in each of the last three fiscal years?

   In the last three fiscal years, the DEC met eight times per year (four in Northern California and four in Southern California) on a quarterly basis for a total of 24 meetings over three years to review and make recommendations on diversion participants.

6. Who appoints the members?

   The current DEC members and the diversion program manager interview potential DEC member candidates and bring forth their final selection(s) for appointment.

7. How many cases (average) at each meeting?

   The number of diversion cases the DEC will review at each meeting varies. The DHCC currently has only one participant in the diversion program.

8. How many pending?

   The DHCC has no pending cases.

   Are there backlogs?

   There are currently no backlogs identified for the diversion program.

   What is the cost per meeting?

   There is no cost to the diversion participant per meeting. For staff, the cost consists of the normal travel costs payable at the state rate of reimbursement for each expenditure category.

   Annual cost?

   The annual cost for a diversion participant begins at $3,672 ($306/month uniform charge) plus body fluid testing and collection expenses, treatment costs, health support group(s), healthcare costs associated with outpatient visits, psychological examination, counseling, therapy, etc., and an administrative fee co-pay.

9. How is DEC used?

   A DEC is used as per CCR, Section 1020.5. Diversion Evaluation Committee Duties and Responsibilities where it states:

   > A Diversion Evaluation Committee shall have the following duties and responsibilities in addition to those set forth in CCR, Section 1695.6 of the Code:
   >
   > - To consider recommendations from the diversion program manager and any consultant to the committee; and

- To set forth in writing for each licensee in a program a treatment and rehabilitation program established for that licensee with the requirements for supervision and surveillance.

What types of cases are seen by the DECs?

The DEC reviews and sees cases of substance use disorders, e.g., drug and/or alcohol related abuse.

10. How many DEC recommendations have been rejected by the board in the past four fiscal years (broken down by year)?

    In the past four fiscal years, there have not been any DEC recommendations rejected by the DHCC.

Disciplinary Review Committees (Board of Barbering and Cosmetology and BSIS only)

1. What is a DRC and how is a DRC used? What types of cases are seen by the DRCs?
2. What is the membership/makeup composition?
3. Does the DRC comply with the Open Meetings Act?
4. How many meeting held in last three fiscal years?
5. Did the board have any difficulties with scheduling DRC meetings? I f so, describe why and how the difficulties were addressed.
6. Who appoints the members?
7. How many cases (average) at each meeting?
8. How many pending? Are there backlogs?
9. What is the cost per meeting? Annual cost?
10. Provide statistics on DRC actions/outcomes.

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APPENDIX

Attachment A –
DHCC Member Guidelines and Procedural Manual (December 2011)

Attachment A1 –
Business and Professions Code (BPC) Sections 1900 – 1966.6

Attachment B –
Current Organization Chart Showing Relationship of Committee and Membership of Each Subcommittee

Attachment C –
Copy of Cover Letter and Regional Examination Survey Questionnaire sent to Regional Examination Boards

Attachment D –
DHCC Year-end Organization Charts for the Last Four Fiscal Years

Attachment E –
DHCC Performance Measures for the Last Three Fiscal Years

Attachment F –
Copy of the Joint Legislative Sunset Review Committee Background Paper for the Dental Board of California (dated March 14, 2011) (p. 8 – 9)

Attachment G –
Letter of DHCC Support from President Pro Tempore Don Perata (dated July 23, 2010)

Attachment H –
Crossing the Quality Chasm: A New Health System for the 21st Century
Chapter 9 – Preparing the Workforce (p. 217)

Attachment I –
Health Profession Education: A Bridge to Quality
Executive Summary (p. 8)

Attachment J –
Registered Dental Hygienists in Alternative Practice (RDHAP):
Increasing Access to Dental Care in California (p. 14)
(dated May 2008)

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SECTION 12 - ATTACHMENT A:

DHCC Member Guidelines and Procedural Manual

(December 2011)

DHCC
Dental Hygiene
Committee
of California

DHCC Member Guidelines and Procedure Manual

December 2011

CONTENTS

Chapter 1- INTRODUCTION

The Dental Hygiene Committee of California (DHCC) was established by legislation passed in 2008 to become operational by 1 July 2009. The DHCC is one of many agencies within the Department of Consumer Affairs (DCA), part of the State and Consumer Services Agency under the aegis of the Governor. The DCA is responsible for consumer protection and representation through the regulation of licensed professionals and the provision of consumer services. While the DCA provides administrative oversight and support services, the DHCC has policy autonomy and sets its own policies, procedures, and regulations.

This procedure manual is provided to members as a ready reference of important laws, regulations, and policies in order to guide the actions of the members and ensure DHCC effectiveness and efficiency. The policies in this Manual can be amended by four affirmative votes of DHCC members.

Chapter 2
DENTAL HYGIENE COMMITTEE OF CALIFORNIA (DHCC)

COMPOSITION

The DHCC shall consist of nine members appointed by the Governor. Four shall be public members, one member shall be a practicing general or public health dentist who holds a current license in California and four members shall be registered dental hygienists who hold current licenses in California. Of the registered dental hygienists members, one shall be licensed either in alternative practice or in extended functions, one shall be a dental hygiene educator, and two shall be registered dental hygienists. No public member shall have been licensed under this chapter within five years of the date of appointment or have any current financial interest in a dentally related business

Members shall be appointed for a term of four years. All appointments will expire January 1, 2014 except two of the appointments, including the RDH educator or RDHAP or RDHEF members' appointments, which will extend through 2016.

The DHCC shall elect a President, a Vice President, and a Secretary from its membership. No person shall serve as an officer for more than two consecutive terms unless extenuating circumstances prevail and it is the will of the majority of the members to do so.

A vacancy shall be filled by appointment to the unexpired term.

SALARY PER DIEM

Each member of the DHCC shall receive a per diem and expenses as provided in Section 103 of the Business and Professions Code. Members fill non-salaried positions, but are paid $100 per day for each meeting day they attend and are reimbursed travel expenses. Committee members are paid out of the funds of the Dental Hygiene Committee.

In relevant part, B&P Code Section 103 provides for the payment of salary per diem for Members "for each day actually spent in the discharge of official duties," and provides that the Member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Accordingly, the following general guidelines shall be adhered to in the payment of salary per diem or reimbursement for travel:

1. No salary per diem or reimbursement for travel-related expenses shall be paid to Board members except for attendance at official meetings, unless a substantial official service is performed by the Member.

   Attendance at gatherings, events, hearings, conferences or meetings other than official DHCC or subcommittee meetings in which a substantial official service is performed, the Executive Officer shall be notified and approval shall be obtained from the DHCC President prior to the Member's attendance.

2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a subcommittee or committee meeting until that meeting is adjourned. Travel time is not included in this component.

3. For DHCC-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, hearings or conferences.

4. Reimbursable work does not include miscellaneous reading and information gathering for business not related to any meeting, preparation time for a presentation and participation at meetings not related to official duties of the DHCC.

The Governor shall have the power to remove any member from the DHCC for neglect of a duty required by law, for incompetence, unprofessional or dishonorable conduct.

GENERAL RULES OF CONDUCT

All members shall act in accordance with their oath of office, and shall conduct themselves in a courteous, professional and ethical manner at all times. Members serve at the pleasure of the Governor, and shall conduct their business in an open manner so that the public that they serve shall be both informed and involved, consistent with the provisions of the Bagley-Keene Open Meeting Act and all other governmental and civil codes applicable to similar agencies within the State of California.

- Members shall comply with all provisions of the Bagley-Keene Open Meeting Act. (Attached)
- Members shall not speak or act for the DHCC without proper authorization.
- Members shall not privately or publicly lobby for or publicly endorse, or otherwise engage in any personal efforts that would tend to promote their own personal or political views or goals, when those are in direct opposition to an official position adopted by the DHCC.
- Members shall not discuss personnel or enforcement matters outside of their official capacity in properly noticed and agendized meetings or with members of the public or the profession.
- Committee members shall never accept gifts from applicants, licensees, or members of the profession while serving on the DHCC.
- Members shall maintain the confidentiality of confidential documents and information related to DHCC business.
- Members shall commit the time and prepare for DHCC responsibilities including the reviewing of meeting notes, administrative cases to be reviewed and discussed, and the review of any other materials provided to the members by staff, which is related to official business.
- Members shall recognize the equal role and responsibilities of all DHCC members.
- Members shall act fairly, be nonpartisan, impartial, and unbiased in their role of protecting the public and enforcing the laws governing the practice of dental hygiene in California.

- Members shall treat all consumers, applicants and licensees in a fair, professional, courteous and impartial manner.

- Members' actions shall serve to uphold the principle that the DHCC's primary mission is to protect the public.

- Members shall not participate in test development for examinations. A member can observe at an examination with the permission of the DHCC President as long as they only observe and in no way participate. If the member is associated with a school, they should not observe an examination if one of their students is taking the examination. Note: this is not to say that members are precluded from involvement with examination issues. Quite the contrary, members should be knowledgeable about the examination development process, occupational analysis, any exam security issues that arise, and so forth. This can be done by having those who develop and administer the examination present at committee meetings.

- Members shall not sit on advisory committees for any of the California RDH educational programs in any capacity due to a conflict of interest.

OFFICERS OF THE COMMITTEE

The DHCC shall annually elect, from its members, a President, a Vice-President and a Secretary each of whom shall hold office for a term of one year. An officer shall not serve in a particular office position for more than two consecutive terms unless extenuating circumstances prevail and it is the will of the majority of the members to do so.

Elections shall take place each year. All officers may be elected on one motion or ballot as a slate of officers unless objected to by a member.

If the office of the President becomes vacant, the Vice President shall assume the office of the President. If the office of the Vice-President becomes vacant, an election shall be held at the next scheduled meeting. Elected officers shall then serve the remainder of the term.

DHCC MEMBERS

ETHICS TRAINING

Each member shall attend a course offered by the Department of Consumer Affairs in ethics upon appointment. Thereafter members shall attend an ethics course at least once during every two years of their appointment.

DHCC MEMBER ORIENTATION

Every member shall complete a training and orientation program offered by the DCA within one year of assuming office.

SEXUAL HARASSMENT PREVENTION TRAINING

Pursuant to the Department of Fair Employment and Housing laws, all newly appointed board, committee and commission members must complete the required training within six months of their assumption of office.

DHCC MEMBER REMOVAL

The Governor has the power to remove from office, at any time, any member appointed by him for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct.

RESIGNATION OF COMMITTEE MEMBERS

In the event that a member resigns, the resigning member shall send a letter to the appointing authority, the Governor, with the effective date of the resignation. State law requires written notification. A copy of this letter shall also be sent to the Director of DCA, the DHCC President and the Executive Officer.

CONFLICT OF INTEREST

No DHCC member may make, participate in making, in any way attempt to use their official position to influence a governmental decision in which there is a direct financial interest or the potential of such.

Any DHCC member who has a direct financial interest shall disqualify themselves from making or attempting to use their official position to influence the decision. Any DHCC 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 the DHCC's legal counsel.

DHCC COMMITTEE MEETINGS

The DHCC shall meet at least two times each calendar year and shall conduct additional meetings in appropriate locations that are necessary to transact its business

The DHCC shall make every effort to hold meetings in different geographical areas throughout the state as a convenience to the public and licensees.

Member Attendance at DHCC Meetings
DHCC Members shall attend each scheduled meeting. If a member is unable to attend a meeting the DHCC President or the Executive Officer shall be contacted prior to the meeting to ensure a quorum can be established.

Member Participation at DHCC Meetings
The President may ascertain from members whose level of participation is below standard whether or not the member is no longer able or willing to continue serving as an active member. A 50% or greater absence rate shall constitute below-standard participation.

Quorum
Five members of the DHCC constitute a quorum. When a quorum of is not present, members may discuss items of business but may not take any action. A majority of the entire DHCC shall constitute a quorum for purposes of acting on noticed agenda items.

Agenda Items
Any member may submit items for a meeting agenda to the Executive Officer 30 days prior to the meeting. The items placed on a meeting agenda will be reviewed and approved by the President and Executive Officer prior to receipt of same by the Members.

The meeting agenda will be provided to all members ten days prior to the meeting and the agenda packet will be provided no later than seven days prior to the meeting.

Record of Meetings
Meeting minutes are a summary and not a transcript of the proceedings. Minutes are prepared for every meeting. The minutes and assignments of action items shall be prepared by staff.

The minutes shall be approved at the next scheduled meeting and serve as the official record of the previous meeting.

Approved minutes of the open session are available for distribution to the public and shall be posted on the website within ten working days following approval.

Audio or Video Recordings (Government Code Section 11124.1)

All public meetings are either audio or video recorded. Recordings shall be retained until either 30 days from the meeting or after the approval of the minutes whichever is the latter.

MEETING ON DISCIPLINARY MATTERS

Disciplinary Cases held for DHCC Meeting Closed Sessions

1. When voting on mail ballots for proposed disciplinary decisions or stipulations, a member may wish to discuss a particular aspect of the decision or stipulation before voting. If this is the case, the ballot must be marked "hold for discussion," and the reason for the hold must be provided on the mail ballot.

2. If two votes are cast to hold a case for discussion, the case is set aside and not processed regardless of whether a majority voted to either accept or reject the decision. Instead the case is scheduled for a discussion during a closed session at the next meeting and a new vote is taken.

Mail Ballots (Government Code Section 11500)
See Sample Mail Ballot on Page 17

1. The DHCC must approve any proposed decision or stipulation before the formal discipline becomes final and the penalty can take effect.

2. Proposed stipulations and decisions are mailed to each member for his or her vote. For stipulations, a background memorandum from the assigned deputy attorney general accompanies the mail ballot. A two-week deadline generally is given for the mail ballots for stipulations and proposed decisions to be completed and returned to the DHCC's office.

3. 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.

4. If a member is comfortable voting on the matter, but wishes to discuss the policy behind the decision or case, the ballot should be marked with their vote. The Executive Officer should then be contacted directly requesting clarification of DHCC's policy. If, after discussion, the policy issue is still unresolved the issue will be placed on the agenda for discussion and any appropriate action at the next Enforcement Meeting.

DHCC MEMBER COMMUNICATIONS

The President or the Executive Officer shall serve as spokesperson with the media on Committee actions or policies.

Any written or oral communications concerning matters of a sensitive nature shall be made only by the President or the Executive Officer.

All written communications of the President on behalf of the DHCC shall be copied to the Executive Officer. The Executive Officer shall forward the communication to all members.

The President may not represent the entire DHCC in any communication unless given express authority by a majority of the DHCC to do so unless reiterating a previous position taken. The President may speak for the DHCC if requested to testify to the Legislature or Administration on behalf of the DHCC without advance approval.

CHAPTER 3 – DHCC PRESIDENT DUTIES

SUPERVISION OF THE EXECUTIVE OFFICER

The President is the immediate supervisor of the Executive Officer. Specific instructions for work on policy matters by the Executive Officer from Committee members shall be coordinated through the President.

The incoming President shall assume all delegated duties at the close of the annual election meeting, including supervision of the Executive Officer.

PERFORMANCE APPRAISAL OF THE EXECUTIVE OFFICER

The President shall request from each member input to the annual performance appraisal and salary administration of the Executive Officer prior to compiling draft preparations.

The performance appraisal of the Executive Officer shall be presented in draft form to the DHCC by the DHCC President annually and shall be noticed on the meeting agenda.

Matters relating to the performance of the Executive Officer shall be discussed in closed session unless the Executive Officer requests that it be discussed in open session.

APPOINTMENTS

The President shall appoint the members or qualified persons to fill positions of oversight or representation for DHCC as delineated in statute, regulation or official capacity, regarding CODA or other entities acting on behalf of DHCC.

CHAPTER 4 - EXECUTIVE OFFICER

APPOINTMENT

The DHCC shall appoint an Executive Officer who is exempt from civil service and who shall serve at the pleasure of the DHCC. The Executive Officer shall exercise the powers and perform the duties delegated by the DHCC. The appointment of the Executive Officer is subject to approval of the Director of the Department of Consumer Affairs.

ROLE

The Executive Officer is the chief administrative officer responsible for implementing the policies developed by the DHCC.

EXECUTIVE OFFICER RECRUITMENT

The DHCC shall institute an open recruitment plan to maintain a pool of qualified candidates. The DHCC shall also work with the DCA's Human Resources Office for recruitment procedures.

SELECTION

The selection of an Executive Officer shall be included as an item of business which must be included in a written agenda and transacted at a public meeting.

DHCC STAFF

Employees of the DHCC, with the exception of the Executive Officer, are civil service employees. Their employment, pay, benefits, discipline, terminations, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, the Executive Officer has the authority and responsibility of overseeing the civil service staff.

No member may provide direction to civil service staff, unless consent of the majority is obtained during a public meeting. When consent of the majority is obtained, direction must go through the Executive Officer. Members shall not intervene or become involved in specific day-to-day personnel transactions or activities.

CHAPTER 5 – SUBCOMMITTEES

FUNCTION

Subcommittees are advisory and their purpose is to recommend actions on specific subject matter. The composition of the subcommittees may change as

needed. Recommendations and reports shall be submitted to DHCC for consideration and approval.

APPOINTMENTS

The President shall appoint the members to fill positions of each standing subcommittee. DHCC members may volunteer to serve on a specific subcommittee.

STANDING SUBCOMMITTESS

- Licensing and Examination Subcommittee
- Enforcement Subcommittee
- Legislative and Regulatory Subcommittee
- Education and Outreach Subcommittee

LICENSING AND EXAMINATION SUBCOMMITTEE

The purpose of the Licensing and Examination Subcommittee is to advise the DHCC on policy matters relating to the examining and licensing of individuals who want to practice dental hygiene in California. The subcommittee may also provide information and recommendations on issues relating to curriculum and school approval, exam appeals, laws and regulations.

ENFORCEMENT SUBCOMMITTEE

The purpose of the Enforcement Subcommittee is to advise the DHCC on policy matters that relate to protecting the health and safety of consumers. This includes maintenance of disciplinary guidelines, and other recommendations on the enforcement of the statutes and regulations.

LEGISLATIVE AND REGULATORY SUBCOMMITTEE

The purpose of the Legislative and Regulatory Subcommittee is to review and track legislation which affects the DHCC and recommends positions on legislation. It also provides information and recommendations to the full committee on regulatory additions or changes.

EDUCATION AND OUTREACH SUBCOMMITTEE

The purpose of the Education and Outreach Subcommittee is to provide recommendations on the development of informational brochures and other publications, planning of outreach events for consumers and licensees, preparing articles for submission in trade magazines and attending trade shows.

AD HOC COMMITTEES

The President may establish ad hoc Subcommittees as needed. Any member may request, subject to approval of the full DHCC, that an ad hoc committee be established. The ad hoc committee will be charged with an in depth review of a specific issue and a final recommendation to the full DHCC.

DHCC AGENDAS

Agendas shall focus on the specific tasks assigned by the DHCC and include:

- Public Comment
- Time for members to recommend new areas of study to be brought to the DHCC's attention for possible assignment.
- Time for lunch break
- Only those information items dealing with subjects assigned to the respective subcommittee.

Subcommittee chairs shall confer with the President prior to including any agenda item that is not clearly within that subcommittee's assigned purview.

If more than two members are to attend a committee meeting, the agenda shall contain the statement: "Notice of Committee meeting indicates that three or more members of the Committee are present. While the law requires the DHCC to notice this also as a Committee meeting, it is not the intent to take action as a Committee at this meeting".

ATTENDANCE AT SUBCOMMITTEE MEETINGS

Members who attend a subcommittee meeting when not appointed to that subcommittee shall sit in the audience and not participate in the meeting discussion.

DUAL MEMBERSHIP

A member may serve on multiple subcommittees.

RECORD OF SUBCOMMITTEE MEETINGS

The minutes are a summary, not a transcript of each committee meeting.

Minutes shall be prepared by staff and submitted for review by the Subcommittee.

Subcommittee minutes shall be approved at the next scheduled meeting and serve as the official record of the meeting.

Approved minutes of the open session are available for distribution to the public and shall be posted on website.

STAFF ASSISTANCE
Staff provides advice, consultation, and support to subcommittees. Members shall contact the Executive Officer to request staff assistance.

CHAPTER 6 - TRAVEL PROCEDURES

TRAVEL
Members shall notify the President and Executive Officer of all travel except for regularly scheduled meetings. The President shall relay any travel approvals to the Executive Officer.

No member shall attend any function at which the member is representing the DHCC without approval from the President and the Executive Officer. This includes speaking engagements, etc.

Travel Arrangements
Members are responsible for making their own travel arrangements. However, staff can assist in making necessary hotel and airline reservations for regularly scheduled meetings. When assistance with travel arrangements is needed, the Executive Officer should be contacted.

Out-of-State Travel
For out-of-state travel, members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the state of California is controlled and must be approved by the Governor's Office.

Travel Claims
Rules governing reimbursement of travel expenses for members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The staff maintains these forms and completes them as needed.

The Executive Officer's travel and per diem reimbursement claims shall be submitted to the DHCC President for approval.

It is advisable for members to submit their travel expense forms immediately following a meeting. If a travel claim requires amending, staff will make the amendment and submit the corrected claim to DCA's Travel Unit and provide members with a corrected copy.
Travel reimbursement processing time is approximately four to six weeks.

CHAPTER 7- SECURITY PROCEDURES

REQUEST FOR RECORDS ACCESS

No member may access a licensee's or candidate's file.

CONTACT WITH CANDIDATES, LICENSEES OR COMPLAINTANTS

Members shall not intervene on behalf of a licensee or candidate for any reason. They should forward all contacts or inquiries to the Executive Officer. Members shall not directly participate in complaint handling and resolution or investigations. If a member is contacted by a respondent, or respondent's attorney, that individual shall be referred to the Executive Officer.

GIFTS FROM CANDIDATES

A gift of any kind to members or staff from dental hygiene candidates for licensure is not permitted and is considered to be a conflict of interest.

DEFINITION OF ACRONYMS

Agencies

DHCC	Dental Hygiene Committee of California
DCA	Department of Consumer Affairs
AGO	Attorney General's Office
OAH	Office of Administrative Hearings
OAL	Office of Administrative Law
OPES	Office of Professional Examination Services
PSI	Psychological Services Incorporated

Codes

B&P	Business and Professions Code
CAC	California Administrative Code
CCR	California Code of Regulations
CGC	California Government Code

Organizations

ADHA	American Dental Hygienists Association
CDHA	California Dental Hygiene Association
CDA	California Dental Association
CDHEA	California Dental Hygiene Educators Association
CAPS	California Association of Private Post Secondary Schools
CCC	California Community Colleges
WREB	Western Regional Examination Board

Titles

AG	Attorney General
ALJ	Administrative Law Judge
DA	District Attorney
DAG	Deputy Attorney General
EO	Executive Officer

Licenses

LBC	Licensure by Credential
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienist in Alternative Practice
RDHEF	Registered Dental Hygienist in Extended Functions
SLN	Certification in Soft Tissue Curretage, Local Anesthetic, and Nitrous Oxide.

SAMPLE MAIL BALLOT MODEL WITH SEPARATE HOLD PROVISIONS

To: All Board Members

From: Enforcement Staff

Date:

Re: Mail Ballot for [**FIRST] [LAST], LICENSE NO. _____,**
Case No. _____

THIS MAIL BALLOT MUST BE RETURNED NO LATER THAN _____
(If not timely returned, your vote may not count or the DHCC 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. You may also email your vote to DHCC's Legal Desk, but be sure to include the person's name, license number (if any) and case number involved along with your vote.

The decision presented is a:

___ Proposed Decision
The board will lose jurisdiction to act on _____. Gov't Code § 11517(d)

___ Stipulated Decision

___ Default Decision

If you have procedural questions about the decision, please contact DHCC's Legal Desk. For all other questions, please contact _____, the Committee's assigned attorney, at (916) 574-8220.

_____

BOARD MEMBER BALLOT

(Part A: Choose one option)

____ I VOTE TO ADOPT. Choose this option if you accept the decision as written.

____ I VOTE TO REJECT (NON-ADOPT). Choose this option if you have questions or concerns about the decision. Record your questions or concerns to facilitate any closed session discussion:

_____

____ I RECUSE MYSELF from this case because _____.

(Part B: Optional)

____ HOLD FOR DISCUSSION at the next board meeting. Mark your ballot above regardless of whether you request to hold. If you voted to reject, you may also wish to hold the case. If you did not do so above, record your questions or concerns here:

_____

_____

_____ _____

Date Board Member's Signature

_____

Printed Name

EXPLANATION OF MAIL BALLOT TERMS

PROPOSED DECISION:
Following a hearing, the administrative law judge drafts a proposed decision recommending an outcome based on the facts and the board's disciplinary guidelines. At its discretion, the board may impose a lesser penalty than that in the proposed decision. If the board 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.

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 the respondent petitions for reconsideration before the effective date of the decision and the board grants the petition.

STIPULATED DECISION:
At any time during the disciplinary process, the parties to the matter (the Executive Officer and the respondent) can agree to a disposition of the case. With the Executive Officer's consent, the Deputy Attorney General can negotiate a stipulated decision (also referred to as a stipulated agreement) based on the board's disciplinary guidelines. The board 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 counter-offer, the case continues in the standard disciplinary process.

ADOPT:
A vote to adopt the proposed action means that you accept the action as presented.

REJECT (NON-ADOPT):
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 board'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.

If a **proposed decision** is rejected, the transcript will be ordered and the case scheduled for argument according to board policy. After reviewing the record, the board 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 counter offer is made during a closed session. If a **default decision** is rejected, the case will be set for hearing.

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 assigned board counsel.

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 board 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 staff can explain why they entered into the agreement. If the case is either other type, you may contact the board's assigned counsel to discuss the merits of the case.

THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT A1:

Business and Professions Code (BPC) Sections 1900 – 1966.6

BUSINESS AND PROFESSIONS CODE SECTION 1900-1966.6

1900. 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.

1901. (a) There is hereby created within the jurisdiction of the Dental Board of California a Dental Hygiene Committee of California in which the administration of this article is vested.

(b) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the committee subject to review by the appropriate policy committees of the Legislature.

1902. For purposes of this article, the following definitions apply:

(a) "Committee" means the Dental Hygiene Committee of California.

(b) "Dental board" means the Dental Board of California.

(c) "Direct supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is required to be physically present in the treatment facility during the performance of those procedures.

(d) "General supervision" means 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 those procedures.

(e) "Oral prophylaxis" means preventive and therapeutic dental procedures that include bacterial debridements with complete removal, supra and subgingivally, of calculus, soft deposits, plaque, and stains, and the smoothing of tooth surfaces. The objective of this treatment is to create an environment in which the patient can maintain healthy hard and soft tissues.

1902.1. Protection of the public shall be the highest priority for the committee in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

1902.2. (a) A licensee shall report, upon his or her initial licensure and any subsequent application for renewal or inactive license, the practice or employment status of the licensee, designated as one of the following:

(1) Full-time practice or employment in a dental or dental hygiene practice of 32 hours per week or more in California.
(2) Full-time practice or employment in a dental or dental hygiene practice of 32 hours or more outside of California.
(3) Part-time practice or employment in a dental or dental hygiene practice for less than 32 hours per week in California.
(4) Part-time practice or employment in a dental or dental hygiene practice for less than 32 hours per week outside of California.
(5) Dental hygiene administrative employment that does not include direct patient care, as may be further defined by the committee.
(6) Retired.
(7) Other practice or employment status, as may be further defined by the committee.
(b) Information collected pursuant to subdivision (a) shall be posted on the Internet Web site of the committee.
(c) (1) A licensee may report on his or her application for renewal, and the committee, as appropriate, shall collect, information regarding the licensee's cultural background and foreign language proficiency.
(2) Information collected pursuant to this subdivision shall be aggregated on an annual basis, based on categories utilized by the committee in the collection of the data, into both statewide totals and ZIP Code of primary practice or employment location totals.
(3) Aggregated information under this subdivision shall be compiled annually, and reported on the Internet Web site of the committee as appropriate, on or before July 1 of each year.
(d) It is the intent of the Legislature to utilize moneys in the State Dental Hygiene Fund to pay any cost incurred by the committee in implementing this section.

1902.3. A registered dental hygienist licensed in another state may teach in a dental hygiene college without being licensed in this state if he or she has a special permit. The committee may issue a special permit to practice dental hygiene in a discipline at a dental hygiene college in this state to any person who submits an application and satisfies all of the following eligibility requirements:
(a) Furnishing satisfactory evidence of having a pending contract with a California dental hygiene college approved by the committee as a full-time or part-time professor, associate professor, assistant professor, faculty member, or instructor.
(b) Furnishing satisfactory evidence of having graduated from a dental hygiene college approved by the committee.
(c) Furnishing satisfactory evidence of having been certified as a diplomate of a specialty committee or, in lieu thereof, establishing his or her qualifications to take a specialty committee examination or furnishing satisfactory evidence of having completed an advanced educational program in a discipline from a dental hygiene college approved by the committee.
(d) Furnishing satisfactory evidence of having successfully completed an examination in California law and ethics developed and administered by the committee.
(e) Paying an application fee, subject to a biennial renewal fee, as provided by Section 1944.

1903. (a) (1) The committee shall consist of nine members appointed by the Governor. Four shall be public members, one member shall be a

practicing general or public health dentist who holds a current license in California, and four members shall be registered dental hygienists who hold current licenses in California. Of the registered dental hygienists members, one shall be licensed either in alternative practice or in extended functions, one shall be a dental hygiene educator, and two shall be registered dental hygienists. No public member shall have been licensed under this chapter within five years of the date of his or her appointment or have any current financial interest in a dental-related business.

(2) For purposes of this subdivision, a public health dentist is a dentist whose primary employer or place of employment is in any of the following:

(A) A primary care clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code.

(B) A primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(C) A clinic owned or operated by a public hospital or health system.

(D) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

(b) (1) Except as specified in paragraph (2), members of the committee shall be appointed for a term of four years. Each member shall hold office until the appointment and qualification of his or her successor or until one year shall have lapsed since the expiration of the term for which he or she was appointed, whichever comes first.

(2) For the term commencing on January 1, 2012, two of the public members, the general or public health dentist member, and two of the registered dental hygienist members, other than the dental hygiene educator member or the registered dental hygienist member licensed in alternative practice or in extended functions, shall each serve a term of two years, expiring January 1, 2014.

(c) Notwithstanding any other provision of law and subject to subdivision (e), the Governor may appoint to the committee a person who previously served as a member of the committee even if his or her previous term expired.

(d) The committee shall elect a president, a vice president, and a secretary from its membership.

(e) No person shall serve as a member of the committee for more than two consecutive terms.

(f) A vacancy in the committee shall be filled by appointment to the unexpired term.

(g) Each member of the committee shall receive a per diem and expenses as provided in Section 103.

(h) The Governor shall have the power to remove any member from the committee for neglect of a duty required by law, for incompetence, or for unprofessional or dishonorable conduct.

(i) The committee, with the approval of the director, may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the committee and vested in him or her by this article.

(j) This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.

1904. The committee shall meet at least two times each calendar year and shall conduct additional meetings in appropriate locations that are necessary to transact its business.

1905. (a) The committee shall perform the following functions:

(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 committee. Any such educational programs approved by the dental board on or before June 30, 2009, shall be deemed approved by the committee. Any dental hygiene program accredited by the Commission on Dental Accreditation 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 committee. The committee 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.

(3) Review and evaluate all registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions applications for licensure to ascertain whether the applicant meets the appropriate licensing requirements specified by statute and regulations, maintain application records, cashier application fees, issue and renew licenses, and perform any other tasks that are incidental to the application and licensure processes.

(4) Determine the appropriate type of license examination consistent with the provisions of this article, and develop or cause to be developed and administer examinations in accordance with regulations adopted by the committee.

(5) Determine the amount of fees assessed under this article, not to exceed the actual cost.

(6) Determine and enforce the continuing education requirements specified in Section 1936.1.

(7) Deny, suspend, or revoke a license under this article, or otherwise enforce the provisions of this article. Any such proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the committee shall have all of the powers granted therein.

(8) Make recommendations to the dental board regarding dental hygiene scope of practice issues.

(9) Adopt, amend, and revoke rules and regulations to implement the provisions of this article, including the amount of required supervision by a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions of a registered dental assistant.

(b) The committee may employ employees and examiners that it deems necessary to carry out its functions and responsibilities under this article.

1905.1. Until January 1, 2010, the committee may contract with the dental board to carry out any of the provisions of this article. On and after January 1, 2010, the committee may contract with the dental board to perform investigations of applicants and licensees under

this article.

1905.2. Recommendations by the committee regarding scope of practice issues, as specified in paragraph (8) of subdivision (a) of Section 1905, shall be approved, modified, or rejected by the board within 90 days of submission of the recommendation to the board. If the board rejects or significantly modifies the intent or scope of the recommendation, the committee may request that the board provide its reasons in writing for rejecting or significantly modifying the recommendation, which shall be provided by the board within 30 days of the request.

1906. (a) The committee shall adopt, amend, and revoke regulations to implement the requirements of this article.

(b) All regulations adopted by the committee shall comply with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) No regulation adopted by the committee shall impose a requirement or a prohibition directly upon a licensed dentist or on the administration of a dental office, unless specifically authorized by this article.

(d) Unless contrary to the provisions of this article, regulations adopted by the dental board shall continue to apply to registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions until other regulations are adopted by the committee. All references in those regulations to "board" shall mean the committee, which shall solely enforce the regulations with respect to registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions.

1907. The following functions may be performed by a registered dental hygienist, in addition to those authorized pursuant to Sections 1908 to 1914, inclusive:

(a) All functions that may be performed by a registered dental assistant.

(b) All persons holding a license as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions as of December 31, 2005, are authorized to perform the duties of a registered dental assistant specified in this chapter. All persons issued a license as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions on or after January 1, 2006, shall qualify for and receive a registered dental assistant license prior to performance of the duties of a registered dental assistant specified in this chapter.

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.

(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.

1909. A registered dental hygienist is authorized to perform the following procedures under direct supervision of a licensed dentist, after submitting to the committee evidence of satisfactory completion of a course of instruction, approved by the committee, 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.

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.

1911. (a) A registered dental hygienist may provide, without supervision, educational services, oral health training programs, and oral health screenings.
(b) A registered dental hygienist shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan.
(c) In any public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity, a registered dental hygienist may provide, without supervision, dental hygiene preventive services in addition to oral screenings, including, but not limited to, the application of fluorides and pit and fissure sealants. A registered dental hygienist employed as described in this subdivision may submit, or allow to be submitted, any insurance or third-party claims for patient services performed as authorized in this article.

1912. Any procedure performed or service provided by a registered dental hygienist that does not specifically require direct

supervision shall require general supervision, so long as it does not give rise to a situation in the dentist's office requiring immediate services for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable dental conditions that, if not immediately diagnosed and treated, would lead to serious disability or death.

1913. Unless otherwise specified in this chapter, a registered dental hygienist may perform any procedure or provide any service within the scope of his or her practice in any setting, so long as the procedure is performed or the service is provided under the appropriate level of supervision required by this article.

1914. A registered dental hygienist may use any material or device approved for use in the performance of a service or procedure within his or her scope of practice under the appropriate level of supervision, if he or she has the appropriate education and training required to use the material or device.

1915. No person other than a registered dental hygienist, registered dental hygienist in alternative functions, or registered dental hygienist in extended functions or a licensed dentist may engage in the practice of dental hygiene or perform dental hygiene procedures on patients, including, but not limited to, supragingival and subgingival scaling, dental hygiene assessment, and treatment planning, except for the following persons:

(a) A student enrolled in a dental or a dental hygiene school who is performing procedures as part of the regular curriculum of that program under the supervision of the faculty of that program.

(b) A dental assistant acting in accordance with the rules of the dental board in performing the following procedures:

(1) Applying nonaerosol and noncaustic topical agents.

(2) Applying topical fluoride.

(3) Taking impressions for bleaching trays.

(c) A registered dental assistant acting in accordance with the rules of the dental board in performing the following procedures:

(1) Polishing the coronal surfaces of teeth.

(2) Applying bleaching agents.

(3) Activating bleaching agents with a nonlaser light-curing device.

(4) Applying pit and fissure sealant.

(d) A registered dental assistant in extended functions acting in accordance with the rules of the dental board in applying pit and fissure sealants.

(e) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions licensed in another jurisdiction, performing a clinical demonstration for educational purposes.

1916. (a) An applicant for licensure under this article shall furnish electronic fingerprint images for submission to state and federal criminal justice agencies, including, but not limited to, the

Federal Bureau of Investigation, in order to establish the identity of the applicant and for the other purposes described in this section.

(b) The committee shall submit the fingerprint images to the Department of Justice for the purposes of obtaining criminal offender record information regarding state and federal level convictions and arrests, including arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance pending trial or appeal.

(c) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this section. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate the response to the committee.

(d) The Department of Justice shall provide a response to the committee pursuant to subdivision (p) of Section 11105 of the Penal Code.

(e) The committee shall request from the Department of Justice subsequent arrest notification service, as provided pursuant to Section 11105.2 of the Penal Code.

(f) The information obtained as a result of the fingerprinting shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure pursuant to Division 1.5 (commencing with Section 475) or Section 1943.

(g) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section.

1917. The committee shall grant initial licensure as a registered dental hygienist to a person who satisfies all of the following requirements:

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

(b) Satisfactory performance on the state clinical examination, or satisfactory completion of the dental hygiene examination given by the Western Regional Examining Board or any other clinical dental hygiene examination approved by the committee.

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

(d) Satisfactory completion of the examination in California law and ethics as prescribed by the committee.

(e) Submission of a completed application form and all fees required by the committee.

(f) Satisfactory completion of committee-approved instruction in gingival soft tissue curettage, nitrous oxide-oxygen analgesia, and local anesthesia.

1917.1. (a) The committee may grant a license as a registered dental hygienist to an applicant who has not taken a clinical examination before the committee, if the applicant submits all of the following to the committee:

(1) A completed application form and all fees required by the

committee.

(2) Proof of a current license as a registered dental hygienist issued by another state that is not revoked, suspended, or otherwise restricted.

(3) Proof that the applicant has been in clinical practice as a registered dental hygienist or has been a full-time faculty member in an accredited dental hygiene education program for a minimum of 750 hours per year for at least five years immediately preceding the date of his or her application under this section. The clinical practice requirement shall be deemed met if the applicant provides proof of at least three years of clinical practice and commits to completing the remaining two years of clinical practice by filing with the committee a copy of a pending contract to practice dental hygiene in any of the following facilities:

(A) A primary care clinic licensed under subdivision (a) of Section 1204 of the Health and Safety Code.

(B) A primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(C) A clinic owned or operated by a public hospital or health system.

(D) A clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

(4) Satisfactory performance on a California law and ethics examination and any examination that may be required by the committee.

(5) Proof that the applicant has not been subject to disciplinary action by any state in which he or she is or has been previously issued any professional or vocational license. If the applicant has been subject to disciplinary action, the committee shall review that action to determine if it warrants refusal to issue a license to the applicant.

(6) Proof of graduation from a school of dental hygiene accredited by the Commission on Dental Accreditation.

(7) Proof of satisfactory completion of the National Dental Hygiene Board Examination and of a state clinical examination, regional clinical licensure examination, or any other clinical dental hygiene examination approved by the committee.

(8) Proof that the applicant has not failed the state clinical examination, the examination given by the Western Regional Examining Board, or any other clinical dental hygiene examination approved by the committee for licensure to practice dental hygiene under this chapter more than once or once within five years prior to the date of his or her application for a license under this section.

(9) Documentation of completion of a minimum of 25 units of continuing education earned in the two years preceding application, including completion of any continuing education requirements imposed by the committee on registered dental hygienists licensed in this state at the time of application.

(10) Any other information as specified by the committee to the extent that it is required of applicants for licensure by examination under this article.

(b) The committee may periodically request verification of compliance with the requirements of paragraph (3) of subdivision (a), and may revoke the license upon a finding that the employment requirement or any other requirement of paragraph (3) of subdivision (a) has not been met.

(c) The committee shall provide in the application packet to each out-of-state dental hygienist pursuant to this section the following information:

(1) The location of dental manpower shortage areas in the state.

(2) Any not-for-profit clinics, public hospitals, and accredited dental hygiene education programs seeking to contract with licensees for dental hygiene service delivery or training purposes.

(d) The committee shall review the impact of this section on the availability of actively practicing registered dental hygienists in California and report to the appropriate policy and fiscal committees of the Legislature by January 1, 2012. The report shall include a separate section providing data specific to registered dental hygienists who intend to fulfill the alternative clinical practice requirements of subdivision (a). The report shall include, but shall not be limited to, the following:

(1) The number of applicants from other states who have sought licensure.

(2) The number of registered dental hygienists from other states licensed pursuant to this section, the number of licenses not granted, and the reason why the license was not granted.

(3) The practice location of registered dental hygienists licensed pursuant to this section. In identifying a registered dental hygienist's location of practice, the committee shall use medical service study areas or other appropriate geographic descriptions for regions of the state.

(4) The number of registered dental hygienists licensed pursuant to this section who establish a practice in a rural area or in an area designated as having a shortage of practicing registered dental hygienists or no registered dental hygienists or in a safety net facility identified in paragraph (3) of subdivision (a).

(5) The length of time registered dental hygienists licensed pursuant to this section practiced in the reported location.

1917.2. (a) The committee shall license as a registered dental hygienist a third- or fourth-year dental student who is in good standing at an accredited California dental school and who satisfies the following requirements:

(1) Satisfactorily performs on a clinical examination and an examination in California law and ethics as prescribed by the committee.

(2) Satisfactorily completes a national written dental hygiene examination approved by the committee.

(b) A dental student who is granted a registered dental hygienist license pursuant to this section may only practice in a dental practice that serves patients who are insured under Denti-Cal, the Healthy Families Program, or other government programs, or a dental practice that has a sliding scale fee system based on income.

(c) Upon receipt of a license to practice dentistry pursuant to Section 1634, a registered dental hygienist license issued pursuant to this subdivision is automatically revoked.

(d) The dental hygienist license is granted for two years upon passage of the dental hygiene examination, without the ability for renewal.

(e) Notwithstanding subdivision (d), if a dental student fails to remain in good standing at an accredited California dental school, or fails to graduate from the dental program, a registered dental hygienist license issued pursuant to this section shall be revoked. The student shall be responsible for submitting appropriate verifying documentation to the committee.

(f) The provisions of this section shall be reviewed pursuant to Division 1.2 (commencing with Section 473). However, the review shall

be limited to the fiscal feasibility and impact on the committee.
(g) This section shall become inoperative as of January 1, 2014.

1917.3. Notwithstanding Section 135, an examinee for a registered dental hygienist license who either fails to pass the clinical examination required by Section 1917 after three attempts or fails to pass the clinical examination as a result of a single incidence of imposing gross trauma on a patient shall not be eligible for further reexamination until the examinee has successfully completed remedial education at an approved dental hygiene program or a comparable organization approved by the committee.

1918. The committee shall license as a registered dental hygienist in extended functions a person who meets all of the following requirements:
(a) Holds a current license as a registered dental hygienist in California.
(b) Completes clinical training approved by the committee in a facility affiliated with a dental school under the direct supervision of the dental school faculty.
(c) Performs satisfactorily on an examination required by the committee.
(d) Completes an application form and pays all application fees required by the committee.

1920. (a) A person who holds a current and active license as a registered dental hygienist in extended functions or a registered dental hygienist in alternative practice on July 1, 2009, shall automatically be issued a license as a registered dental hygienist, unless the person holds a current and active registered dental hygienist license.
(b) A registered dental hygienist license issued pursuant to this section shall expire on the same date as the person's registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions license, and shall be subject to the same renewal and other requirements imposed by law or regulation on a license.

1921. In addition to any other duties or functions authorized by law, a registered dental hygienist in extended functions or a registered dental hygienist in alternative practice may perform any of the duties or functions authorized to be performed by a registered dental hygienist.

1922. The committee shall license as a registered dental hygienist in alternative practice a person who demonstrates satisfactory performance on an examination in California law and ethics required by the committee and who completes an application form and pays all application fees required by the committee and meets either of the following requirements:

(a) Holds a current California license as a registered dental hygienist and meets the following requirements:

(1) Has been engaged in the practice of dental hygiene, as defined in Section 1908, as a registered dental hygienist in any setting, including, but not limited to, educational settings and public health settings, for a minimum of 2,000 hours during the immediately preceding 36 months.

(2) Has successfully completed a bachelor's degree or its equivalent from a college or institution of higher education that is accredited by a national or regional accrediting agency recognized by the United States Department of Education, and a minimum of 150 hours of additional educational requirements, as prescribed by the committee by regulation, that are consistent with good dental and dental hygiene practice, including, but not necessarily limited to, dental hygiene technique and theory including gerontology and medical emergencies, and business administration and practice management.

(b) Has received a letter of acceptance into the employment utilization phase of the Health Manpower Pilot Project No. 155 established by the Office of Statewide Health Planning and Development pursuant to Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 of the Health and Safety Code.

1924. A person licensed as a registered dental hygienist who has completed the prescribed classes through the Health Manpower Pilot Project (HMPP) and who has established an independent practice under the HMPP by June 30, 1997, shall be deemed to have satisfied the licensing requirements under Section 1922, and shall be authorized to continue to operate the practice he or she presently operates, so long as he or she follows the requirements for prescription and functions as specified in Sections 1922, 1925, 1926, 1927, 1928, 1930, and 1931, and subdivision (b) of Section 1929, and as long as he or she continues to personally practice and operate the practice or until he or she sells the practice to a licensed dentist.

1925. A registered dental hygienist in alternative practice may practice, pursuant to subdivision (a) of Section 1907, subdivision (a) of Section 1908, and subdivisions (a) and (b) of Section 1910, as an employee of a dentist or of another registered dental hygienist in alternative practice, as an independent contractor, as a sole proprietor of an alternative dental hygiene practice, as an employee of a primary care clinic or specialty clinic that is licensed pursuant to Section 1204 of the Health and Safety Code, as an employee of a primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code, as an employee of a clinic owned or operated by a public hospital or health system, or as an employee of a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

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.

1926.1. Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate a mobile dental hygiene clinic provided by his or her property and casualty insurer as a temporary substitute site for the practice registered by him or her pursuant to Section 1926.3, if both of the following requirements are met:
(a) The licensee's registered place of practice has been rendered and remains unusable due to loss or calamity.
(b) The licensee's insurer registers the mobile dental hygiene clinic with the committee in compliance with Section 1926.3.

1926.2. (a) Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate one mobile dental hygiene clinic registered as a dental hygiene office or facility. The owner or operator of the mobile dental hygiene clinic or unit shall be registered and operated in accordance with regulations established by the committee, which regulations shall not be designed to prevent or lessen competition in service areas, and shall pay the fees described in Section 1944.
(b) A mobile service unit, as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, and a mobile unit operated by an entity that is exempt from licensure pursuant to subdivision (b), (c), or (h) of Section 1206 of the Health and Safety Code, are exempt from this article and Article 3.5 (commencing with Section 1658). Notwithstanding this exemption, the owner or operator of the mobile unit shall notify the committee within 60 days of the date on which dental hygiene services are first delivered in the mobile unit, or the date on which the mobile unit's application pursuant to Section 1765.130 of the Health and Safety Code is approved, whichever is earlier.
(c) A licensee practicing in a mobile unit described in subdivision (b) is not subject to subdivision (a) as to that mobile unit.

1926.3. Every person who is now or hereafter licensed as a registered dental hygienist in alternative practice in this state shall register with the executive officer, on forms prescribed by the committee, his or her place of practice, or, if he or she has more than one place of practice pursuant to Section 1926.4, all of the places of practice. If he or she has no place of practice, he or she shall so notify the executive officer. A person licensed by the committee shall register with the executive officer within 30 days after the date of the issuance of his or her license as a registered dental hygienist in alternative practice.

1926.4. When a registered dental hygienist in alternative practice desires to have more than one place of practice, he or she shall, prior to the opening of the additional office, apply to the committee, pay the fee required by Section 1944, and obtain permission in writing from the committee to have the additional place of practice, subject to a biennial renewal fee described in Section 1944.

1927. A registered dental hygienist in alternative practice shall not do any of the following:

(a) Infer, purport, advertise, or imply that he or she is in any way able to provide dental services or make any type of dental diagnosis beyond evaluating a patient's dental hygiene status, providing a dental hygiene treatment plan, and providing the associated dental hygiene services.

(b) Hire a registered dental hygienist to provide direct patient services other than a registered dental hygienist in alternative practice.

1928. A registered dental hygienist in alternative practice may submit or allow to be submitted any insurance or third-party claims for patient services performed as authorized pursuant to this article.

1929. (a) A registered dental hygienist in alternative practice may hire other registered dental hygienists in alternative practice to assist in his or her practice.

(b) A registered dental hygienist in alternative practice may hire and supervise dental assistants performing intraoral retraction and suctioning.

1930. A registered dental hygienist in alternative practice shall provide to the committee documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services.

1931. (a) (1) A dental hygienist in alternative practice may provide services to a patient without obtaining written verification that the patient has been examined by a dentist or physician and surgeon licensed to practice in this state.

(2) If the dental hygienist in alternative practice provides services to a patient 18 months or more after the first date that he or she provides services to a patient, he or she shall obtain written verification that the patient has been examined by a dentist or physician and surgeon licensed to practice in this state. The verification shall include a prescription for dental hygiene services as described in subdivision (b).

(b) A registered dental hygienist in alternative practice may provide dental hygiene services for a patient who presents to the registered dental hygienist in alternative practice a written prescription for dental hygiene services issued by a dentist or physician and surgeon licensed to practice in this state. The prescription shall be valid for a time period based on the dentist's or physician and surgeon's professional judgment, but not to exceed

two years from the date it was issued.

(c) (1) The committee may seek to obtain an injunction against any registered dental hygienist in alternative practice who provides services pursuant to this section, if the committee has reasonable cause to believe that the services are being provided to a patient who has not received a prescription for those services from a dentist or physician and surgeon licensed to practice in this state.

(2) Providing services pursuant to this section without obtaining a prescription in accordance with subdivision (b) shall constitute unprofessional conduct on the part of the registered dental hygienist in alternative practice, and reason for the committee to revoke or suspend the license of the registered dental hygienist in alternative practice pursuant to Section 1947.

1932. (a) The committee may, in its sole discretion, issue a probationary license to an applicant who has satisfied all requirements for licensure as a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions. The committee may require, as a term or condition of issuing the probationary license, that the applicant comply with certain additional requirements, including, but not limited to, the following:

(1) Successfully completing a professional competency examination.

(2) Submitting to a medical or psychological evaluation.

(3) Submitting to continuing medical or psychological treatment.

(4) Abstaining from the use of alcohol or drugs.

(5) Submitting to random fluid testing for alcohol or controlled substance abuse.

(6) Submitting to continuing participation in a committee-approved rehabilitation program.

(7) Restricting the type or circumstances of practice.

(8) Submitting to continuing education and coursework.

(9) Complying with requirements regarding notifying the committee of any change of employer or employment.

(10) Complying with probation monitoring.

(11) Complying with all laws and regulations governing the practice of dental hygiene.

(12) Limiting his or her practice to a supervised, structured environment in which his or her activities are supervised by a specified person.

(b) The term of a probationary license is three years. During the term of the license, the licensee may petition the committee for a modification of a term or condition of the license or for the issuance of a license that is not probationary.

(c) The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the committee shall have all the powers granted in that chapter.

1933. A licensee shall be issued a substitute license upon request and payment of the required fee. The request shall be accompanied by an affidavit or declaration containing satisfactory evidence of the loss or destruction of the license certificate.

1934. A licensee who changes his or her physical address of record or email address shall notify the committee within 30 days of the change. A licensee who changes his or her legal name shall provide the committee with documentation of the change within 10 days.

1935. If not renewed, a license issued under the provisions of this article, unless specifically excepted, expires at 12 midnight on the last day of the month of the legal birth date of the licensee during the second year of a two-year term. To renew an unexpired license, the licensee shall, before the time at which the license would otherwise expire, apply for renewal on a form prescribed by the committee and pay the renewal fee prescribed by this article.

1936. Except as otherwise provided in this article, an expired license may be renewed at any time within five years after its expiration by filing an application for renewal on a form prescribed by the committee and payment of all accrued renewal and delinquency fees. If the license is renewed after its expiration, the licensee, as a condition precedent of renewal, shall also pay the delinquency fee prescribed by this article. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect until the expiration date provided in Section 1935 that next occurs after the effective date of the renewal.

1936.1. (a) If the committee determines that the public health and safety would be served by requiring all holders of licenses under this article to continue their education after receiving a license, the committee may require, as a condition of license renewal, that licensees submit assurances satisfactory to the committee that they will, during the succeeding 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 committee, or by other means deemed equivalent by the committee. The committee shall adopt, amend, and revoke regulations providing for the suspension of the licenses at the end of the two-year period until compliance with the assurances provided for in this section is accomplished.

(b) The committee may also, as a condition of license renewal, require licensees to successfully complete a portion of the required continuing education hours in specific areas adopted in regulations by the committee. The committee may prescribe this mandatory coursework within the general areas of patient care, health and safety, and law and ethics. The mandatory coursework prescribed by the committee shall not exceed seven and one-half hours per renewal period. Any mandatory coursework required by the committee shall be credited toward the continuing education requirements established by the committee pursuant to subdivision (a).

(c) The providers of courses referred to in this section shall be approved by the committee. Providers approved by the dental board

shall be deemed approved by the committee.

1937. A suspended license is subject to expiration and shall be renewed as provided in this article. The renewal does not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity or in any other activity or conduct in violation of the order or judgment by which the license was suspended.

1938. A revoked license is subject to expiration as provided in this article. A revoked license may not be renewed. If it is reinstated after its expiration, the licensee, as a condition precedent to its reinstatement, shall pay a reinstatement fee in an amount equal to the renewal fee in effect on the last regular renewal date before the date on which it is reinstated and the delinquency fee, if any, accrued at the time of its revocation.

1939. A license that is not renewed within five years after its expiration may not be renewed, restored, reinstated, or reissued. The holder of the license may apply for and obtain a new license upon meeting all of the requirements of a new applicant prescribed in this article.

1940. (a) A licensee who desires an inactive license shall submit an application to the committee on a form provided by the committee.

(b) In order to restore an inactive license to active status, the licensee shall submit an application to the committee on a form provided by the committee, accompanied by evidence that the licensee has completed the required number of hours of approved continuing education in compliance with this article within the last two years preceding the date of the application.

(c) The holder of an inactive license shall continue to pay to the committee the required biennial renewal fee.

(d) Within 30 days of receiving a request either to restore an inactive license or to inactivate a license, the committee shall inform the applicant in writing whether the application is complete and accepted for filing or is deficient and, if so, the specific information required to complete the application.

1941. (a) The committee shall grant or renew approval of only those educational programs for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions 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 committee.

(b) A new educational program for registered dental hygienists shall submit a feasibility study demonstrating a need for a new educational program and shall apply for approval from the committee prior to seeking approval for initial accreditation from the

Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the committee. The committee may approve, provisionally approve, or deny approval of any such new educational program.

(c) For purposes of this section, a new educational program for registered dental hygienists 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 committee.

1942. (a) As used in this article "extramural dental facility" means any clinical facility that has contracted with an approved dental hygiene educational program for instruction in dental hygiene, that exists outside or beyond the walls, boundaries, or precincts of the primary campus of the approved program, and in which dental hygiene services are rendered.

(b) An approved dental hygiene educational program shall register an extramural dental facility with the committee. That registration shall be accompanied by information supplied by the dental hygiene program pertaining to faculty supervision, scope of treatment to be rendered, name and location of the facility, date on which the operation will commence, discipline of which the instruction is a part, and a brief description of the equipment and facilities available. The foregoing information shall be supplemented by a copy of the agreement between the approved dental hygiene educational program or parent university, and the affiliated institution establishing the contractual relationship. Any change in the information initially provided to the committee shall be communicated to the committee.

1943. (a) The committee may deny an application to take an examination for licensure as a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions at any time prior to licensure for any of the following reasons:

(1) The applicant committed an act that is a ground for license suspension or revocation under this code or that is a ground for the denial of licensure under Section 480.

(2) The applicant committed or aided and abetted the commission of any act for which a license is required under this chapter.

(3) Another state or territory suspended or revoked the license that it had issued to the applicant on a ground that constitutes a basis in this state for the suspension or revocation of licensure under this article.

(b) The proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the committee shall have all of the powers granted therein.

1944. (a) The committee shall establish by resolution the amount of

the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the committee. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for issuance of an original license shall not exceed two hundred fifty dollars ($250).

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) For third- and fourth-year dental students, the fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(5) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(6) The biennial renewal fee shall not exceed one hundred sixty dollars ($160).

(7) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(8) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater.

(9) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(10) The fee for each curriculum review and site evaluation for educational programs for dental hygienists who are not accredited by a committee-approved agency shall not exceed two thousand one hundred dollars ($2,100).

(11) The fee for each review of courses required for licensure that are not accredited by a committee-approved agency, the Council for Private Postsecondary and Vocational Education, or the Chancellor's Office of the California Community Colleges shall not exceed three hundred dollars ($300).

(12) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars ($500).

(13) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(b) The renewal and delinquency fees shall be fixed by the committee by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars ($5).

(c) Fees fixed by the committee by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the committee and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund shall, upon appropriation by the Legislature in the annual Budget Act, be used to implement the provisions of this article.

(e) No fees or charges other than those listed in this section shall be levied by the committee in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars ($250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars ($150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars ($250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars ($250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars ($250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(l) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out the provisions of this article.

1947. A license issued under this article and a license issued under this chapter to a registered dental hygienist, to a registered dental hygienist in alternative practice, or to a registered dental hygienist in extended functions may be revoked or suspended by the committee for any reason specified in this article for the suspension or revocation of a license to practice dental hygiene.

1949. A licensee may have his or her license revoked or suspended, or may be reprimanded or placed on probation by the committee for unprofessional conduct, incompetence, gross negligence, repeated acts of negligence in his or her profession, receiving a license by mistake, or for any other cause applicable to the licentiate provided in this article. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the committee shall have all the powers granted therein.

1950. (a) A licensee may have his or her license revoked or suspended, or may be reprimanded or placed on probation by the committee, for conviction of a crime substantially related to the licensee's qualifications, functions, or duties. The record of conviction or a copy certified by the clerk of the court or by the judge in whose court the conviction occurred shall be conclusive evidence of conviction.

(b) The committee shall undertake proceedings under this section upon the receipt of a certified copy of the record of conviction. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge of a felony or of any misdemeanor substantially related to the licensee's qualifications, functions, or duties is deemed to be a conviction within the meaning of this section.

(c) The committee may reprimand a licensee or order a license suspended or revoked, or placed on probation or may decline to issue a license, when any of the following occur:

(1) The time for appeal has elapsed.

(2) The judgment of conviction has been affirmed on appeal.

(3) An order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under any provision of the Penal Code, including, but not limited to, Section 1203.4 of the Penal Code, allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

1950.5. Unprofessional conduct by a person licensed under this article is defined as, but is not limited to, any one of the following:

(a) The obtaining of any fee by fraud or misrepresentation.

(b) The aiding or abetting of any unlicensed person to practice dentistry or dental hygiene.

(c) The aiding or abetting of a licensed person to practice dentistry or dental hygiene unlawfully.

(d) The committing of any act or acts of sexual abuse, misconduct, or relations with a patient that are substantially related to the practice of dental hygiene.

(e) The use of any false, assumed, or fictitious name, either as an individual, firm, corporation, or otherwise, or any name other than the name under which he or she is licensed to practice, in advertising or in any other manner indicating that he or she is practicing or will practice dentistry, except that name as is specified in a valid permit issued pursuant to Section 1962.

(f) The practice of accepting or receiving any commission or the rebating in any form or manner of fees for professional services, radiographs, prescriptions, or other services or articles supplied to patients.

(g) The making use by the licensee or any agent of the licensee of any advertising statements of a character tending to deceive or mislead the public.

(h) The advertising of either professional superiority or the advertising of performance of professional services in a superior manner. This subdivision shall not prohibit advertising permitted by subdivision (h) of Section 651.

(i) The employing or the making use of solicitors.

(j) Advertising in violation of Section 651.

(k) Advertising to guarantee any dental hygiene service, or to perform any dental hygiene procedure painlessly. This subdivision shall not prohibit advertising permitted by Section 651.

(l) The violation of any of the provisions of this division.

(m) The permitting of any person to operate dental radiographic equipment who has not met the requirements to do so, as determined by the committee.

(n) The clearly excessive administering of drugs or treatment, or the clearly excessive use of treatment procedures, or the clearly

excessive use of treatment facilities, as determined by the customary practice and standards of the dental hygiene profession.

Any person who violates this subdivision is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) or more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days or more than 180 days, or by both a fine and imprisonment.

(o) The use of threats or harassment against any patient or licensee for providing evidence in any possible or actual disciplinary action, or other legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of this chapter or to aid in the compliance.

(p) Suspension or revocation of a license issued, or discipline imposed, by another state or territory on grounds that would be the basis of discipline in this state.

(q) The alteration of a patient's record with intent to deceive.

(r) Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental hygiene profession.

(s) The abandonment of the patient by the licensee, without written notice to the patient that treatment is to be discontinued and before the patient has ample opportunity to secure the services of another registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions and provided the health of the patient is not jeopardized.

(t) The willful misrepresentation of facts relating to a disciplinary action to the patients of a disciplined licensee.

(u) Use of fraud in the procurement of any license issued pursuant to this article.

(v) Any action or conduct that would have warranted the denial of the license.

(w) The aiding or abetting of a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions to practice dental hygiene in a negligent or incompetent manner.

(x) The failure to report to the committee in writing within seven days any of the following: (1) the death of his or her patient during the performance of any dental hygiene procedure; (2) the discovery of the death of a patient whose death is related to a dental hygiene procedure performed by him or her; or (3) except for a scheduled hospitalization, the removal to a hospital or emergency center for medical treatment for a period exceeding 24 hours of any patient as a result of dental or dental hygiene treatment. Upon receipt of a report pursuant to this subdivision, the committee may conduct an inspection of the dental hygiene practice office if the committee finds that it is necessary.

(y) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions shall report to the committee all deaths occurring in his or her practice with a copy sent to the dental board if the death occurred while working as an employee in a dental office. A dentist shall report to the dental board all deaths occurring in his or her practice with a copy sent to the committee if the death was the result of treatment by a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions.

1951. The committee may discipline a licensee by placing him or her on probation under various terms and conditions that may include,

but are not limited to, the following:

(a) Requiring the licensee to obtain additional training or pass an examination upon completion of training, or both. The examination may be a written or oral examination, or both, and may be a practical or clinical examination, or both, at the option of the committee.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians appointed by the committee, if warranted by the physical or mental condition of the licensee. If the committee requires the licensee to submit to an examination, the committee shall receive and consider any other report of a complete diagnostic examination given by one or more physicians of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee.

(d) Requiring restitution of fees to the licensee's patients or payers of services, unless restitution has already been made.

(e) Providing the option of alternative community service in lieu of all or part of a period of suspension in cases other than violations relating to quality of care.

1952. It is unprofessional conduct for a person licensed under this article to do any of the following:

(a) Obtain or possess in violation of law, or except as directed by a licensed physician and surgeon, dentist, or podiatrist, a controlled substance, as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Section 4022.

(b) Use a controlled substance, as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or a dangerous drug as defined in Section 4022, or alcoholic beverages or other intoxicating substances, to an extent or in a manner dangerous or injurious to himself or herself, to any person, or the public to the extent that the use impairs the licensee's ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a charge of violating any federal statute or rules, or any statute or rule of this state, regulating controlled substances, as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug, as defined in Section 4022, or be convicted of more than one misdemeanor, or any felony, involving the use or consumption of alcohol or drugs, if the conviction is substantially related to the practice authorized by his or her license.

(1) The record of conviction or a copy certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of a violation of this section. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(2) The committee may order the license suspended or revoked, or may decline to issue a license, when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under any provision of the Penal Code, including, but not limited to, Section 1203.4 of the Penal Code, allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

1953. (a) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions who performs a service on a patient in a dental office shall identify himself or herself in the patient record by signing his or her name or identification number and initials next to the service performed, and shall date those treatment entries in the record.

(b) A repeated violation of this section constitutes unprofessional conduct.

1954. (a) It is unprofessional conduct for a person licensed under this article to perform, or hold himself or herself out as able to perform, professional services beyond the scope of his or her license and field of competence, as established by his or her education, experience, and training. This includes, but is not limited to, using an instrument or device in a manner that is not in accordance with the customary standards and practices of the dental hygiene profession.

(b) This section shall not apply to research conducted by accredited dental schools or dental hygiene schools, or to research conducted pursuant to an investigational device exemption issued by the United States Food and Drug Administration.

1955. (a) (1) A licensee who fails or refuses to comply with a request for a patient's dental or dental hygiene records that is accompanied by that patient's written authorization for release of the records to the committee, within 15 days of receiving the request and authorization, shall pay to the committee a civil or administrative penalty or fine up to a maximum of two hundred fifty dollars ($250) per day for each day that the documents have not been produced after the 15th day, up to a maximum of five thousand dollars ($5,000) unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the dental or dental hygiene records of a patient that is accompanied by that patient's written authorization for release of records to the committee together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's dental hygiene records to the committee within 30 days of receiving this request, authorization, and notice shall subject the health care facility to a civil or administrative penalty or fine, payable to the committee, of up to a maximum of two hundred fifty dollars ($250) per day for each day that the documents have not been produced after the 30th day, up to a maximum of five thousand dollars ($5,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the committee in obtaining the patient's authorization. The committee shall pay the reasonable cost of copying the dental hygiene records.

(b) (1) A licensee who fails or refuses to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the committee shall pay to the committee a civil

penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the committee shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) A licensee who fails or refuses to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the committee is guilty of a misdemeanor punishable by a fine payable to the committee not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the committee shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order issued in the enforcement of a subpoena mandating the release of patient records to the committee, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the committee a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the committee against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the committee is guilty of a misdemeanor punishable by a fine payable to the committee not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the committee against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or permit.

(d) A failure or refusal to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the committee constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil or administrative penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For the purposes of this section, a "health care facility" means a clinic or health care facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

1956. It is unprofessional conduct for a person licensed under this article to require, either directly or through an office policy, or knowingly permit the delivery of dental hygiene care that discourages necessary treatment, or permits clearly excessive, incompetent, unnecessary, or grossly negligent treatment, or repeated negligent acts, as determined by the standard of practice in the community.

1957. (a) A person whose license has been revoked or suspended, who has been placed on probation, or whose license was surrendered pursuant to a stipulated settlement as a condition to avoid a disciplinary administrative hearing, may petition the committee for reinstatement or modification of the penalty, including modification or termination of probation, after a period of not less than the following minimum periods have elapsed from the effective date of the decision ordering disciplinary action:

(1) At least three years for reinstatement of a license revoked for unprofessional conduct or surrendered pursuant to a stipulated settlement as a condition to avoid an administrative disciplinary hearing.

(2) At least two years for early termination, or modification of a condition, of a probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination, or modification of a condition, of a probation of less than three years.

(b) The petition shall state any fact required by the committee.

(c) The petition may be heard by the committee, or the committee may assign the petition to an administrative law judge designated in Section 11371 of the Government Code.

(d) In considering reinstatement or modification or penalty, the committee or the administrative law judge hearing the petition may consider the following:

(1) All activities of the petitioner since the disciplinary action was taken.

(2) The offense for which the petitioner was disciplined.

(3) The petitioner's activities during the time the license or permit was in good standing.

(4) The petitioner's rehabilitative efforts, general reputation for truth, and professional ability.

(e) The hearing may be continued from time to time as the committee or the administrative law judge as designated in Section 11371 of the Government Code finds necessary.

(f) The committee or the administrative law judge may impose necessary terms and conditions on the licentiate in reinstating a license or permit or modifying a penalty.

(g) A petition shall not be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole.

(h) A petition shall not be considered while there is an accusation or petition to revoke probation pending against the person.

(i) The committee may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section. Nothing in this section shall be deemed to alter Sections 822 and 823.

1958. A person, company, or association is guilty of a misdemeanor, and upon conviction, shall be punished by imprisonment in a county jail not less than 10 days nor more than one year, or by a fine of not less than one hundred dollars ($100) nor more than one thousand five hundred dollars ($1,500), or by both that fine and imprisonment, who does any of the following:

(a) Assumes the title of "registered dental hygienist," "registered dental hygienist in alternative practice," or "registered dental hygienist in extended functions" or appends the letters "R.D.H.," "R.D.H.A.P.," or "R.D.H.E.F." to his or her name without having had the right to assume the title conferred upon him or her through licensure.

(b) Assumes any title, or appends any letters to his or her name, with the intent to represent falsely that he or she has received a dental hygiene degree or a license under this article.

(c) Engages in the practice of dental hygiene without causing to be displayed in a conspicuous place in his or her office his or her license under this article to practice dental hygiene.

(d) Within 10 days after demand is made by the executive officer of the committee, fails to furnish to the committee the name and address of all persons practicing or assisting in the practice of dental hygiene in the office of the person, company, or association, at any time within 60 days prior to the demand, together with a sworn statement showing under and by what license or authority this person, company, or association and any employees are or have been practicing or assisting in the practice of dental hygiene. This sworn statement shall not be used in any prosecution under this section.

(e) Is under the influence of alcohol or a controlled substance while engaged in the practice of dental hygiene in actual attendance on patients to an extent that impairs his or her ability to conduct the practice of dental hygiene with safety to patients and the public.

1958.1. (a) Notwithstanding any other law, with regard to an individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, under military law, or under federal law, all of the following shall apply:

(1) The committee shall deny an application by the individual for licensure pursuant to this article.

(2) If the individual is licensed under this article, the committee shall promptly revoke the license of the individual. The committee shall not stay the revocation nor place the license on probation.

(3) The committee shall not reinstate or reissue the individual's licensure under this article. The committee shall not issue a stay of license denial and place the license on probation.

(b) This section shall not apply to any of the following:

(1) An individual who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that requires his or her registration as a sex offender.

(2) An individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code. However,

nothing in this paragraph shall prohibit the committee from exercising its discretion to discipline a licensee under other provisions of state law based upon the licensee's conviction under Section 314 of the Penal Code.

(3) Any administrative adjudication proceeding under Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that is fully adjudicated prior to January 1, 2013. A petition for reinstatement of a revoked or surrendered license shall be considered a new proceeding for purposes of this paragraph, and the prohibition against reinstating a license to an individual who is required to register as a sex offender shall be applicable.

1959. A person who holds a valid, unrevoked, and unsuspended license as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions under this article may append the letters "R.D.H.," "R.D.H.A.P.," or "R.D.H.E.F.," respectively, to his or her name.

1960. For the first offense, a person is guilty of a misdemeanor and shall be punishable by a fine of not less than two hundred dollars ($200) nor more than three thousand dollars ($3,000), or by imprisonment in a county jail for not to exceed six months, or by both that fine and imprisonment, and for the second or a subsequent offense is guilty of a felony and upon conviction thereof shall be punished by a fine of not less than two thousand dollars ($2,000) nor more than six thousand dollars ($6,000), or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by both that fine and imprisonment, who does any of the following:

(a) Sells or barters or offers to sell or barter a dental hygiene degree or transcript or a license issued under, or purporting to be issued under, laws regulating licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(b) Purchases or procures by barter a diploma, license, or transcript with intent that it shall be used as evidence of the holder's qualification to practice dental hygiene, or in fraud of the laws regulating the practice of dental hygiene.

(c) With fraudulent intent, makes, attempts to make, counterfeits, or materially alters a diploma, certificate, or transcript.

(d) Uses, or attempts or causes to be used, any diploma, certificate, or transcript that has been purchased, fraudulently issued, counterfeited, or materially altered or in order to procure licensure as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions.

(e) In an affidavit required of an applicant for an examination or license under this article, willfully makes a false statement in a material regard.

(f) Practices dental hygiene or offers to practice dental hygiene, as defined in this article, either without a license, or when his or her license has been revoked or suspended.

(g) Under any false, assumed or fictitious name, either as an individual, firm, corporation or otherwise, or any name other than the name under which he or she is licensed, practices, advertises, or in any other manner indicates that he or she practices or will

practice dental hygiene, except a name specified in a valid permit issued pursuant to Section 1962.

1961. A person who willfully, under circumstances that cause risk of bodily harm, serious physical or mental illness, or death, practices, attempts to practice, advertises, or holds himself or herself out as practicing dental hygiene without having at the time of so doing a valid, unrevoked, and unsuspended license as provided in this article, is guilty of a crime, punishable by imprisonment in a county jail for up to one year. The remedy provided in this section shall not preclude any other remedy provided by law.

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 committee 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 committee under this section. The committee 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 committee 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," 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 committee 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.

(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.

1963. The committee may file a complaint for violation of any part of this article with any court of competent jurisdiction and may, by its officers, counsel and agents, assist in presenting the law or facts at the trial. The district attorney of each county in this state shall prosecute all violations of this article in their respective counties in which the violations occur.

1964. In addition to the other proceedings provided for in this article, on application of the committee, the superior court of any county shall issue an injunction to restrain an unlicensed person from conducting the practice of dental hygiene, as defined in this article.

1965. If a person has engaged in or is about to engage in an act that constitutes an offense against this chapter, the superior court of any county, on application of 10 or more persons holding licenses to practice dental hygiene issued under this article, may issue an injunction or other appropriate order restraining that conduct. Proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

1966. (a) It is the intent of the Legislature that the committee seek ways and means to identify and rehabilitate licensees whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licensees so afflicted may be treated and returned to the practice of dental hygiene in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the committee establish a diversion program as a voluntary alternative approach to traditional disciplinary actions.

(b) One or more diversion evaluation committees shall be established by the committee. The committee shall establish criteria for the selection of each diversion evaluation committee. Each member of a diversion evaluation committee shall receive per diem and expenses as provided in Section 103.

1966.1. (a) The committee shall establish criteria for the acceptance, denial, or termination of licensees in a diversion program. Unless ordered by the committee as a condition of a licensee's disciplinary probation, only those licensees who have voluntarily requested diversion treatment and supervision by a diversion evaluation committee shall participate in a diversion program.

(b) A licensee who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A licensee under current investigation by the committee may also request entry into a diversion program by contacting the

committee. The committee may refer the licensee requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licensee to enter into the diversion program, the committee may require the licensee, while under current investigation for any violations of this article or other violations, to execute a statement of understanding that states that the licensee understands that his or her violations of this article or other statutes, that would otherwise be the basis for discipline, may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a licensee are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1951, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the committee shall close the investigation without further action if the licensee is accepted into the committee's diversion program and successfully completes the requirements of the program. If the licensee withdraws or is terminated from the program by a diversion evaluation committee, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the committee.

(e) Neither acceptance nor participation in the diversion program shall preclude the committee from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licensee for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) All licensees shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when a diversion evaluation committee determines the licensee presents a threat to the public's health and safety shall result in the utilization by the committee of diversion treatment records in disciplinary or criminal proceedings.

(g) Any licensee terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the committee for acts committed before, during, and after participation in the diversion program. A licensee who has been under investigation by the committee and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the committee.

1966.2. Each diversion evaluation committee shall have the following duties and responsibilities:

(a) To evaluate those licensees who request to participate in the diversion program according to the guidelines prescribed by the committee and to consider the recommendations of any licensees designated by the committee to serve as consultants on the admission of the licensee to the diversion program.

(b) To review and designate those treatment facilities to which licensees in a diversion program may be referred.

(c) To receive and review information concerning a licensee participating in the program.

(d) To consider in the case of each licensee participating in a program whether he or she may safely continue or resume the practice of dental hygiene.

(e) To perform other related duties as the committee may by regulation require.

1966.3. Notwithstanding the provisions of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a diversion evaluation committee may convene in closed session to consider reports pertaining to any licentiate requesting or participating in a diversion program. A diversion evaluation committee shall only convene in closed session to the extent that it is necessary to protect the privacy of a licensee.

1966.4. Each licensee who requests participation in a diversion program shall agree to cooperate with the treatment program designed by a diversion evaluation committee and to bear all costs related to the program, unless the cost is waived by the committee. Any failure to comply with the provisions of a treatment program may result in termination of the licensee's participation in a program.

1966.5. (a) After a diversion evaluation committee, in its discretion, has determined that a licensee has been rehabilitated and the diversion program is completed, the diversion evaluation committee shall purge and destroy all records pertaining to the licensee's participation in the diversion program.

(b) Except as authorized by subdivision (f) of Section 1966.1, all committee and diversion evaluation committee records and records of proceedings pertaining to the treatment of a licensee in a program shall be kept confidential and are not subject to discovery or subpoena.

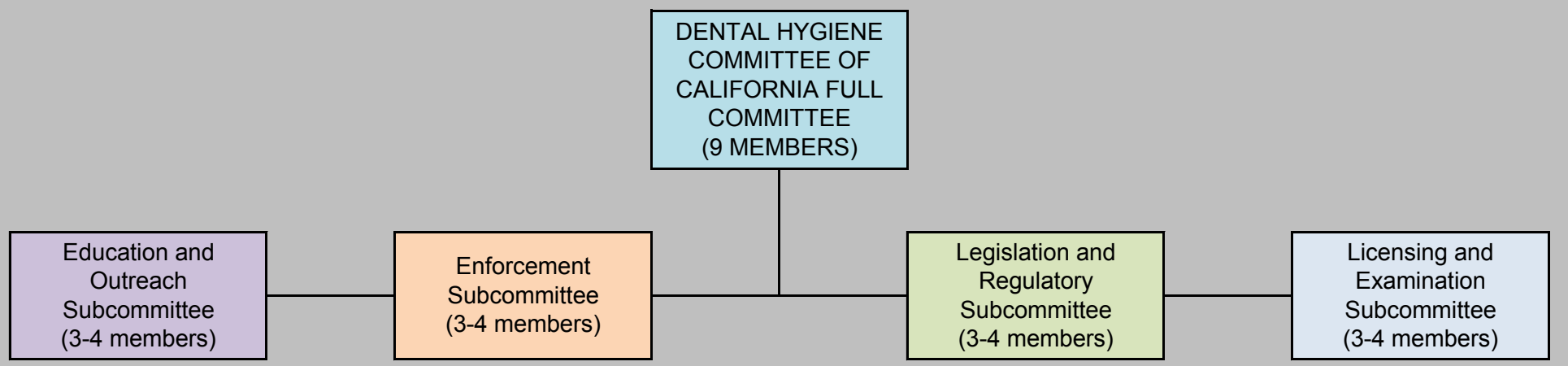
1966.6. The committee shall provide for the representation of any person making reports to a diversion evaluation committee or the committee under this article in any action for defamation for reports or information given to the diversion evaluation committee or the committee regarding a licensee's participation in the diversion program.

THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT B:

Current Organizational Chart Showing Relationship of Committees and Membership of Each Subcommittee

CURRENT DHCC ORGANIZATION CHART



THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT C:

Copy of Regional Examination Survey Questionnaire

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
Dental Hygiene Committee of California
2005 Evergreen Street, Suite 1050, Sacramento, CA 95815
P 916-263.1978 F 916.263.2688 | www.dhcc.ca.gov

September 18, 2012

[redacted] D.M.D
[redacted]reet
Carlsbad, CA 92008

Dear [redacted]

The Dental Hygiene Committee of California is exploring the possibility of accepting all five regional dental hygiene examinations:

- Council On interstate Testing Agencies (CITA)
- Central Regional Dental Testing Services (CRDTS)
- North East Regional Board of Dental Examiners (NERB)
- Southern Regional Testing Agency (SERTA)

for purposes of licensure in California. (Currently, California only accepts its own examination and the Western Regional Examining Board (WREB) examination).

To help us with this decision, we are asking each of the testing agencies to complete and return the attached survey. Any questions concerning the survey should be directed to Rick Wallinder of my staff. Mr. Wallinder can be contacted at: rick.wallinder@dca.ca.gov.

As we are attempting to have this information available for our December xx, 2012 meeting, we request that you complete and return this survey no later than October 18, 2012.

Sincerely,

Lori Hubble
Executive Officer
Dental Hygiene Committee

Clinical Examination Components

Does the (name of examination) include a patient? YES ◯ NO ◯

- If yes, please list qualifying patient criteria:

- Please list any patient exclusion criteria:

Does the examination include scaling and root planing of one or more quadrants of a patient? YES ◯ NO ◯

If YES, please list the requirements for scaling and root planning:

If quadrants are not used, what are the requirements used to be acceptable (Please list/describe)?:

- Please list the requirements to be considered acceptable for scaling and root planing:

If scaling and root planing is included in this exam, what is the expectation of the candidate (Please describe)?:

- What are the requirements regarding the presence of calculus (Please list)?:

If scaling and root planing is not included in this exam, what skill sets must the candidate demonstrate?

1. Periodontal Probing
   - Are periodontal probing skills assessed in the examination? YES ◯ NO ◯
     - If YES, when in the examination is this skill evaluated?

   - What is considered a probing error?

   - Are any points deducted for an error? YES ◯ NO ◯
     - If YES, how many points are deducted for each error?

2. Does this examination include charting of furcation involvement? YES ◯ NO ◯

   What is considered an error?

Are any points deducted for an error? YES ◯ NO ◯

- If YES, how many points are deducted for each error?

3. Scaling and Root Planing
   - Are points deducted for each supragingival calculus error? YES ◯ NO ◯
     - If YES, how many points are deducted for each error?

   - If there are 13-18 surfaces of subgingival calculus at check-in, how many points, if any, are deducted for each subgingival calculus error?

   - If there are 19-24 surfaces of subgingival calculus at check-in, how many points, if any, are deducted for each subgingival error?

   - Are points deducted for stain? YES ◯ NO ◯
     - If YES how many points are deducted for each error?

4. Trauma
   - What constitutes trauma?

   - How many points, if any, are deducted for each hard and/or soft tissue trauma error?

   - Is gross trauma defined? YES ◯ NO ◯
     - If YES, what is the definition?

   - If gross trauma is defined, is it grounds for dismissal from the examination? YES ◯ NO ◯
     - If a candidate is dismissed due to gross trauma, what type of follow-up is required for the candidate's patient?

   - Is soft tissue trauma defined? YES ◯ NO ◯
     - If it is defined, please provide the definition.

   - Are any points deducted for soft tissue trauma? YES ◯ NO ◯
     - If YES, how many points are deducted?

- Is hard tissue trauma defined? YES ◯ NO ◯
  - If it is defined, please provide the definition.

  - Are any points deducted for hard tissue trauma? YES ◯ NO ◯
  - If YES, how many points are deducted?

5. Other Test Components
   - Are there any components of your examination that do not include direct patient care? YES ◯ NO ◯
     - If YES, what component is still being examined?

6. Does the examination require ay specific instruments to be used by the candidate? YES ◯ NO ◯
   - If YES, please describe.

   - Are there any other components to the _____ examination (Please list)?
     (Please use a separate piece of paper if needed)

Examination History

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
# sitting											
# passing											
# failing											

7. How much time is allowed for the _____ examination?
8. Is there a limit to the number of attempts an applicant may take the_____ examination?
9. Is remediation ever required as a condition for re-examination? YES ◯ NO ◯
   - If YES, under what conditions is remediation required?

   - What must remediation consist of?

10. Under what conditions is a candidate dismissed from the examination?

11. If a candidate is dismissed, is there a penalty? YES ◯ NO ◯
    - If YES, what is the penalty?

Who may we contact for information concerning the _____ examination?

- Contact Name:
- Contact Phone Number:
- Contact e-mail Address:

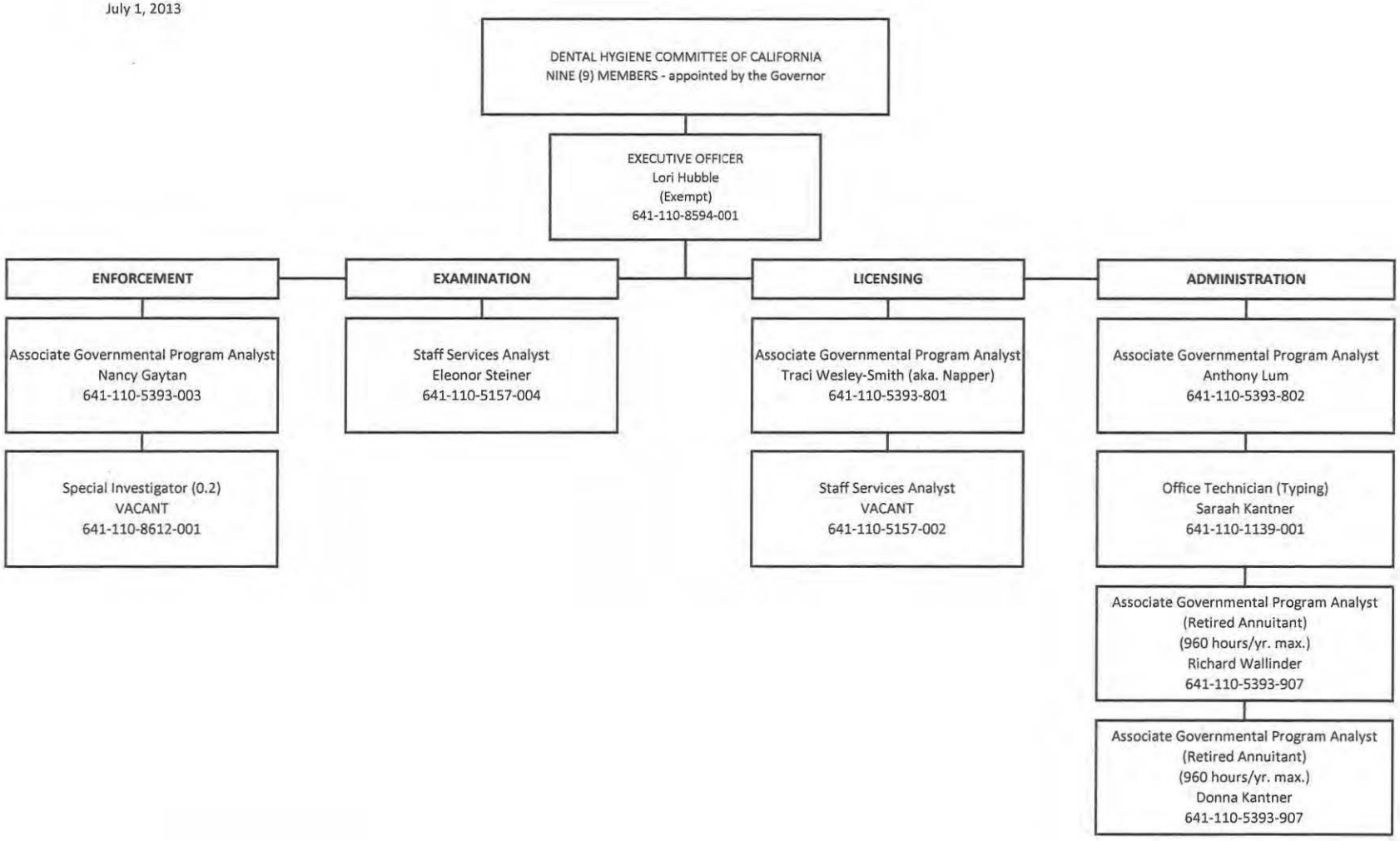
THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT D:

Year-End DHCC Organization Charts for the Last Four Fiscal Years

Org Chart
FY 2012-13
7.2 PY
July 1, 2013

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL HYGIENE COMMITTEE OF CALIFORNIA

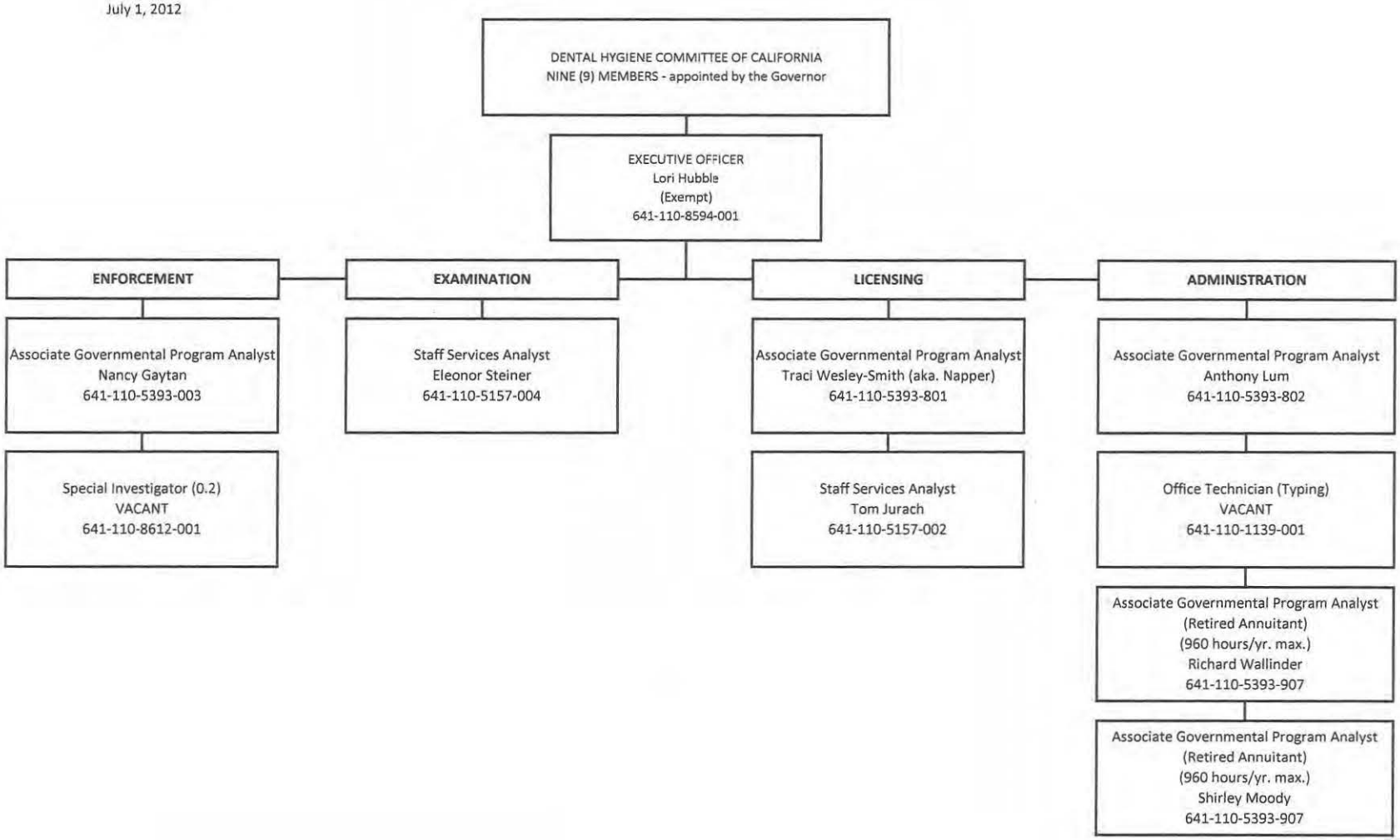


Lori Hubble, Executive Officer

Personnel Analyst

Org Chart
FY 2011-12
7.2 PY
July 1, 2012

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL HYGIENE COMMITTEE OF CALIFORNIA

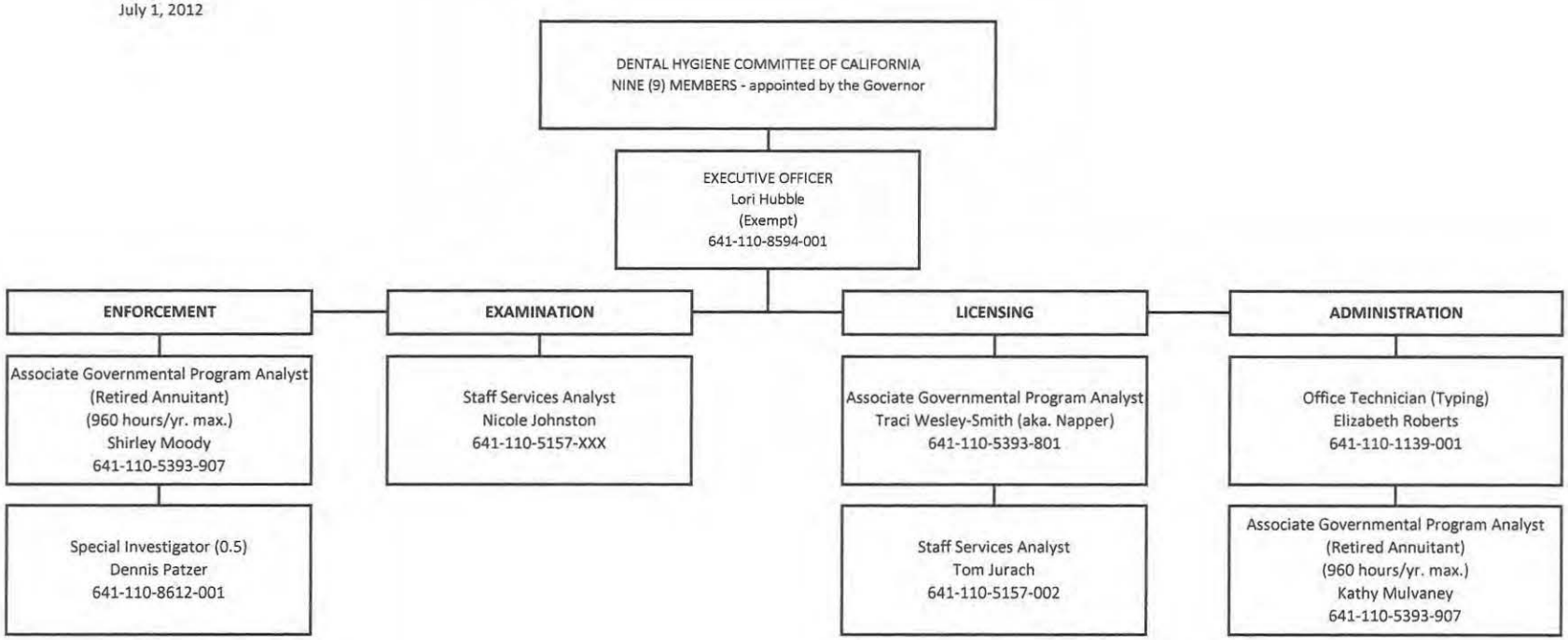


Lori Hubble, Executive Officer

Personnel Analyst

Org Chart
FY 2010-11
7.2 PY
July 1, 2012

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL HYGIENE COMMITTEE OF CALIFORNIA

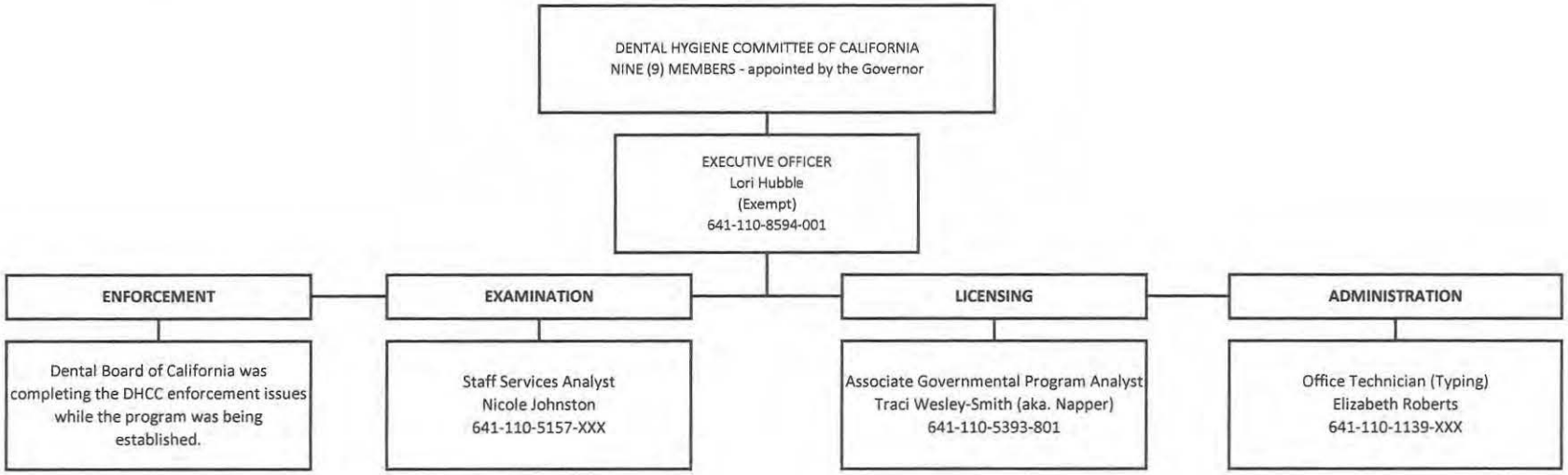


Lori Hubble, Executive Officer

Personnel Analyst

Org Chart
FY 2009-10
4.0 PY

DEPARTMENT OF CONSUMER AFFAIRS
DENTAL HYGIENE COMMITTEE OF CALIFORNIA



Lori Hubble, Executive Officer

Personnel Analyst

THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT E:

The DHCC Performance Measures for the Last Three Fiscal Years

Department of Consumer Affairs

Dental Hygiene
Committee of California

Performance Measures

Q1 Report *(July - Sept 2010)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement.

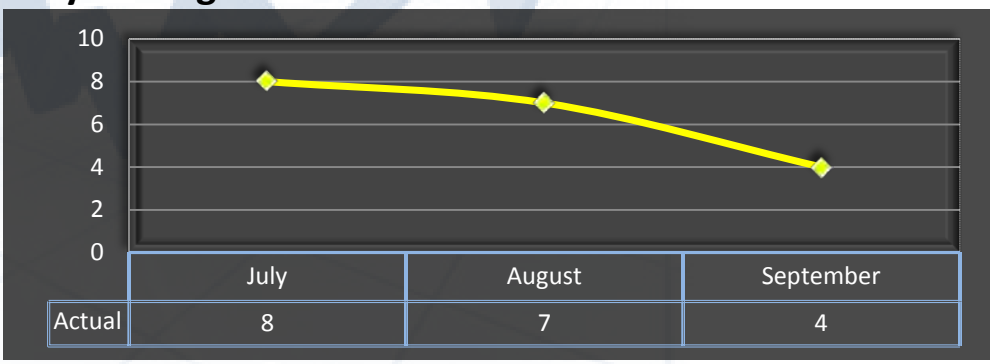
These measures will be posted publicly on a quarterly basis. In future reports, additional measures, such as consumer satisfaction and complaint efficiency, will also be added. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints received.*

Q1 Total: 19 ***(Complaints: 2 Convictions: 17)***

Q1 Monthly Average: 6



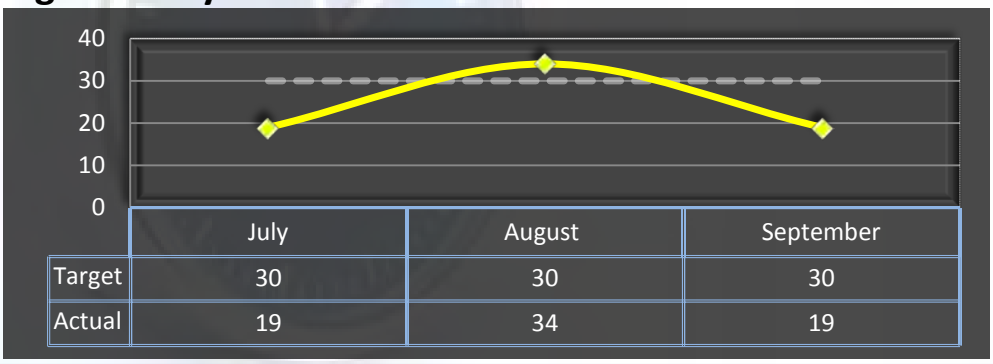
	July	August	September
Actual	8	7	4

Intake

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

Target: 30 Days

Q1 Average: 26 Days



	July	August	September
Target	30	30	30
Actual	19	34	19

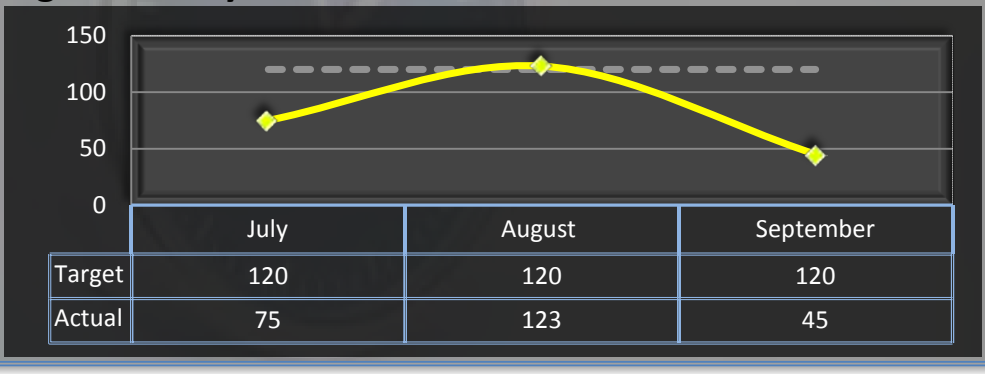
***"Complaints" in these measures include complaints, convictions, and arrest reports.**

Intake & Investigation

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

Target: 120 Days

Q1 Average: 102 Days



	July	August	September
Target	120	120	120
Actual	75	123	45

Formal Discipline

Average cycle time from complaint receipt to closure, for cases sent to the Attorney General or other forms of formal discipline.

Target: 540 Days

Q1 Average: 1,033 Days* **(Note: Only one data point available.)**

Probation Intake

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

Target: 10 Days

Q1 Average: N/A

The Board did not receive any new probationers this quarter.

***DHCC was not established until July of 2009. Data in PM4 represents a case which was submitted to the Department prior to DHCC's existence.**

Probation Violation Response

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

Target: 10 Days

Q1 Average: N/A

The Board did not receive any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q2 Report *(October - December 2010)*

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

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

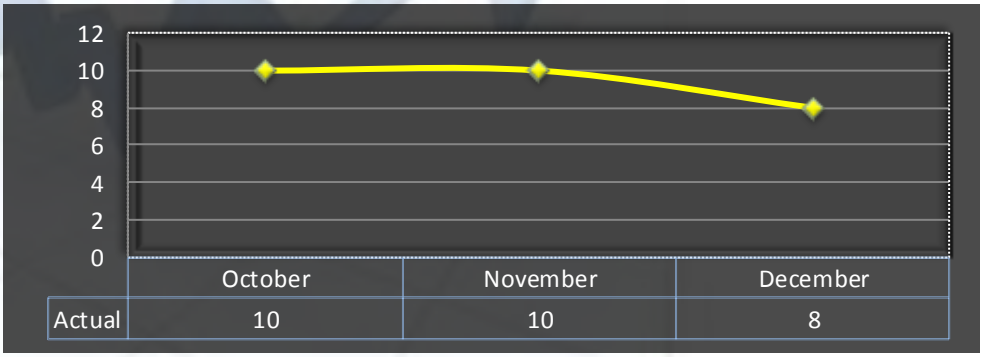
Volume

Number of complaints and convictions received.

Q2 Total: 28

Complaints: 9 Convictions: 19

Q2 Monthly Average: 9



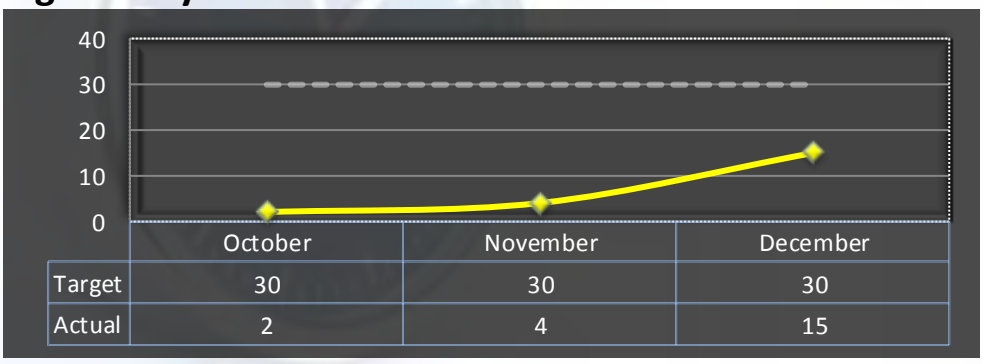
	October	November	December
Actual	10	10	8

Intake

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

Target: 30 Days

Q2 Average: 6 Days



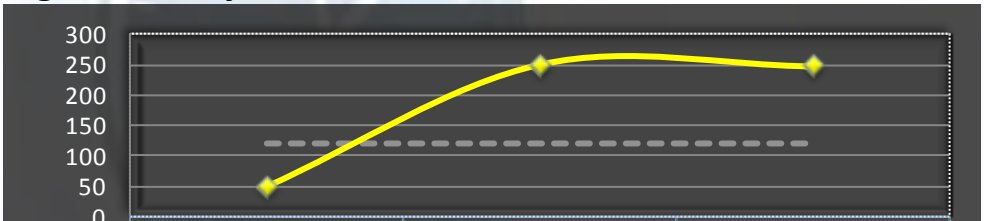
	October	November	December
Target	30	30	30
Actual	2	4	15

Intake & Investigation

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

Target: 120 Days

Q2 Average: 204 Days*



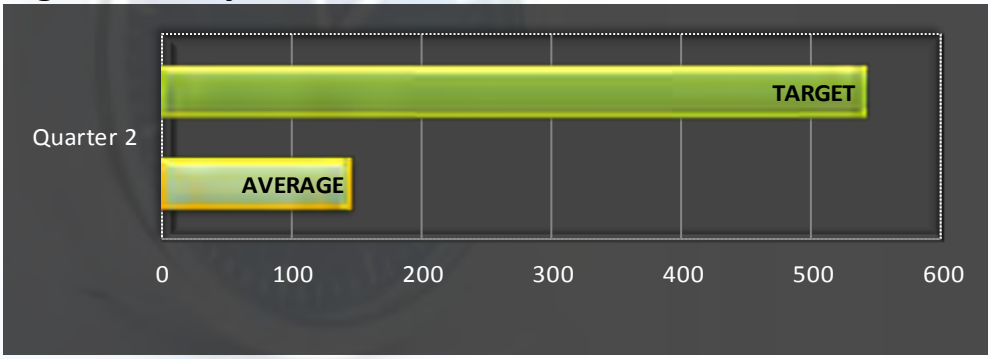
	October	November	December
Target	120	120	120
Actual	49	250	247

Formal Discipline

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

Target: 540 Days

Q2 Average: 143 Days



Probation Intake

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

Target: 10 Days

Q2 Average: N/A

The Committee did not contact any new probationers this quarter.

***DHCC was not established until July of 2009. Data in PM3 includes several cases which were submitted to the Department prior to DHCC's existence.**

Probation Violation Response

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

Target: 10 Days

Q2 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q3 Report *(January - March 2011)*

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

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

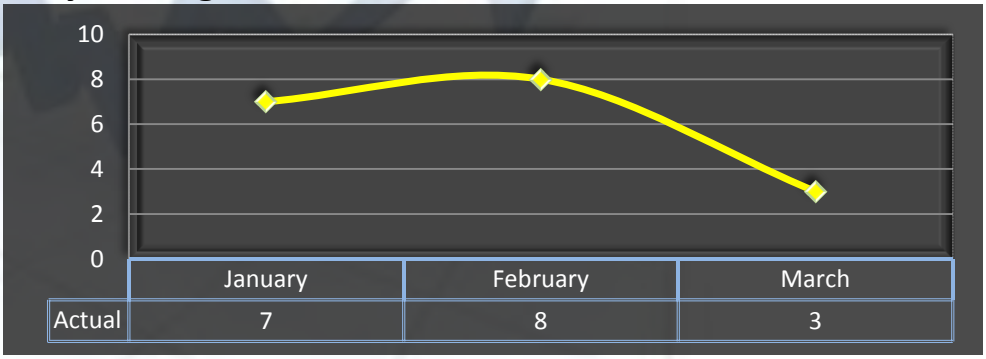
Volume

Number of complaints and convictions received.

Q3 Total: 18

Complaints: 6 Convictions: 12

Q3 Monthly Average: 6



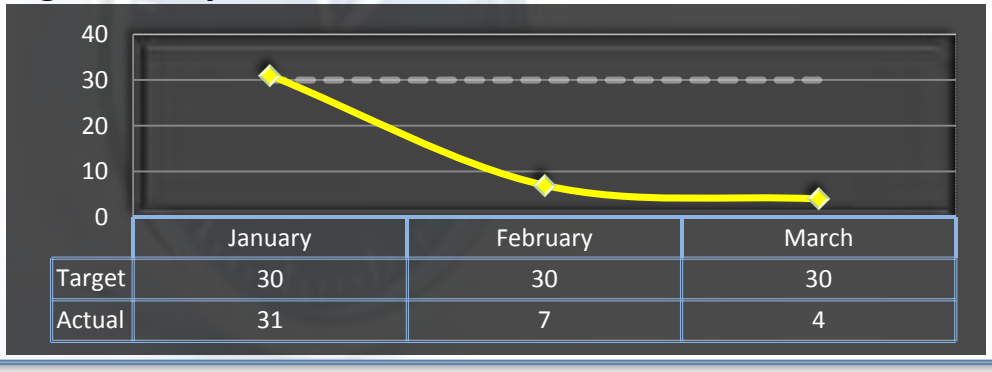
	January	February	March
Actual	7	8	3

Intake

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

Target: 30 Days

Q3 Average: 17 Days



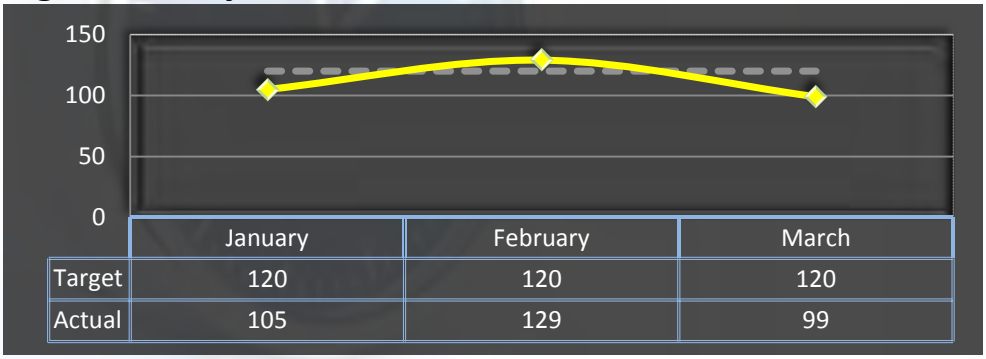
	January	February	March
Target	30	30	30
Actual	31	7	4

Intake & Investigation

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

Target: 120 Days

Q3 Average: 110 Days



	January	February	March
Target	120	120	120
Actual	105	129	99

Formal Discipline

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

Target: 540 Days

Q3 Average: 143 Days

The Committee did not close any formal discipline cases this quarter.

Probation Intake

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

Target: 10 Days

Q3 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q3 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q4 Report *(April - June 2011)*

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

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

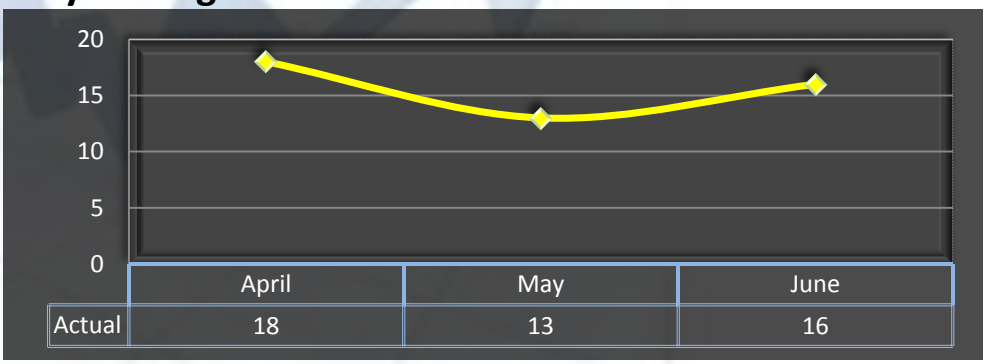
Volume

Number of complaints and convictions received.

Q4 Total: 47

Complaints: 0 Convictions: 47

Q4 Monthly Average: 16



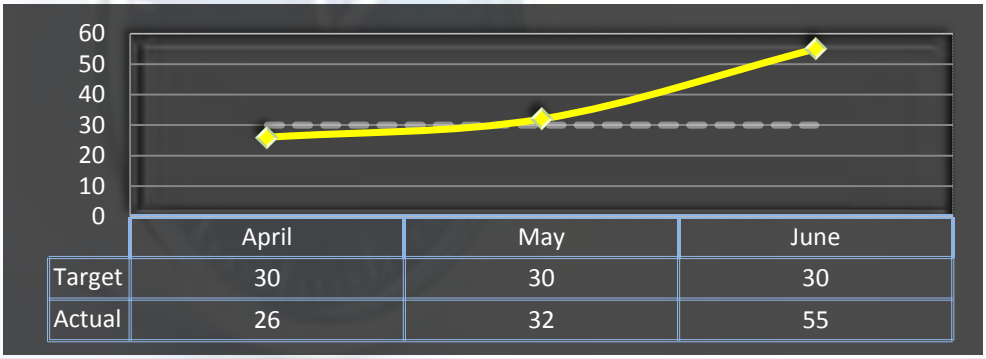
	April	May	June
Actual	18	13	16

Intake

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

Target: 30 Days

Q4 Average: 39 Days



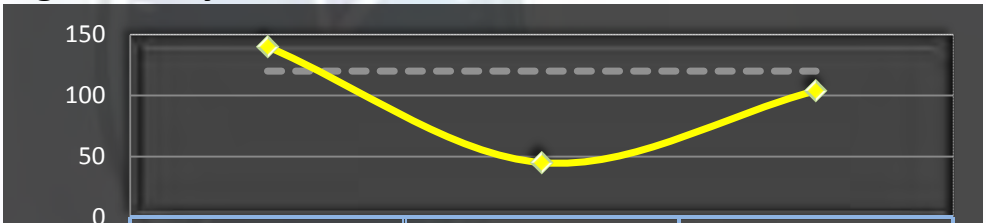
	April	May	June
Target	30	30	30
Actual	26	32	55

Intake & Investigation

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

Target: 120 Days

Q4 Average: 78 Days



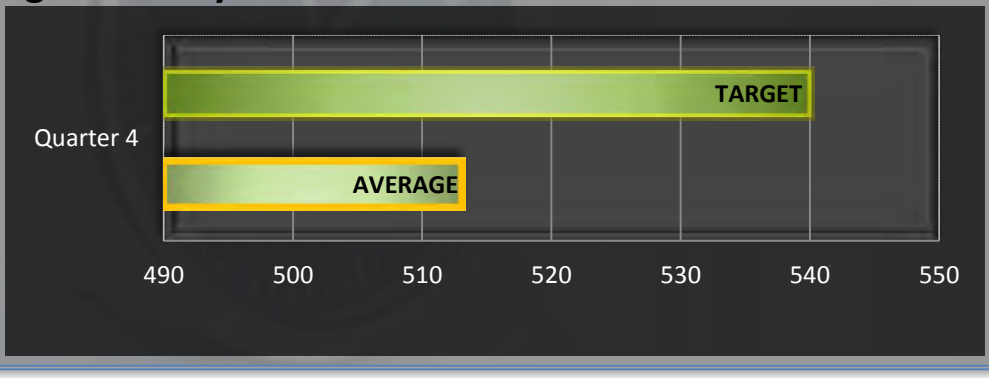
	April	May	June
Target	120	120	120
Actual	140	45	104

Formal Discipline

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

Target: 540 Days

Q4 Average: 513 Days



Probation Intake

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

Target: 10 Days

Q4 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q4 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Annual Report *(2010 – 2011 Fiscal Year)*

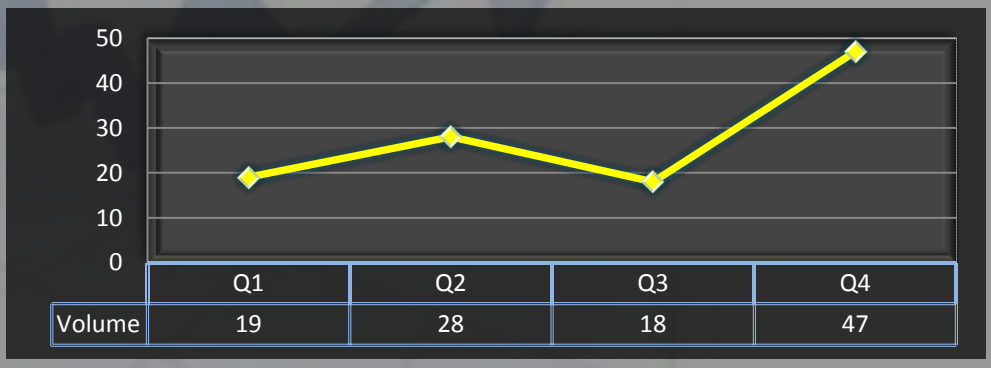
To ensure stakeholders can review the Committee's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the first four quarters worth of data.

Volume

Number of complaints and convictions received.

The Committee had an annual total of 112 this fiscal year.

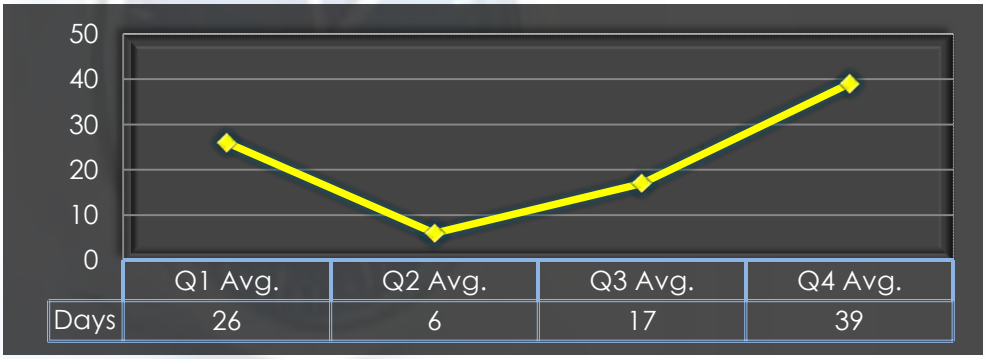


	Q1	Q2	Q3	Q4
Volume	19	28	18	47

Intake

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

The Committee has set a target of 30 days for this measure.

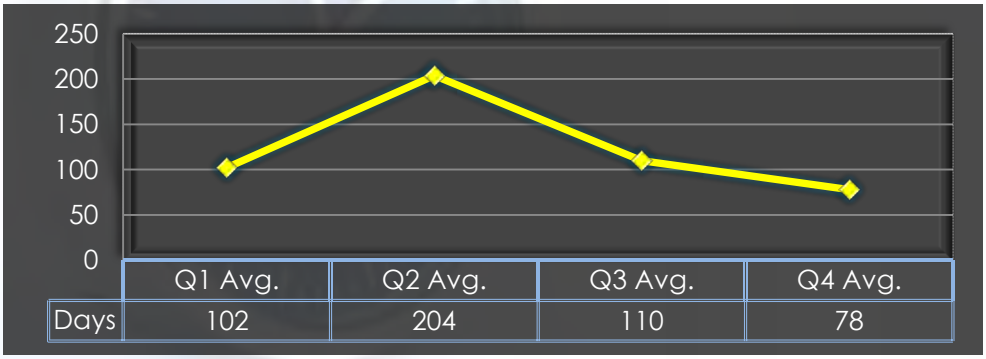


	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Days	26	6	17	39

Intake & Investigation

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

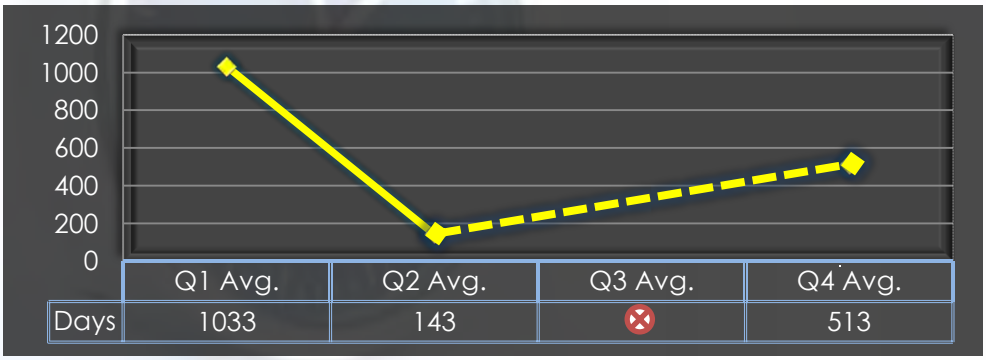
The Committee has set a target of 120 days for this measure.



Formal Discipline

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

The Committee has set a target of 540 days for this measure.



Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q1 Report *(July - September 2011)*

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

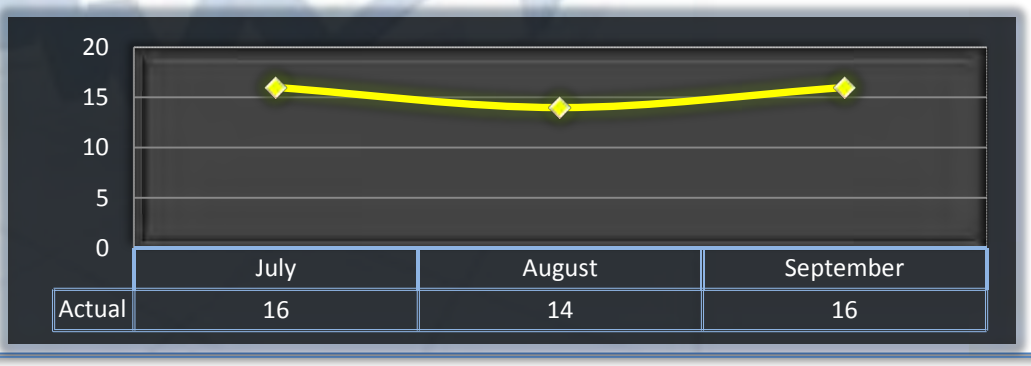
Volume

Number of complaints and convictions received.

Q1 Total: 46

Complaints: 2 Convictions: 44

Q1 Monthly Average: 15



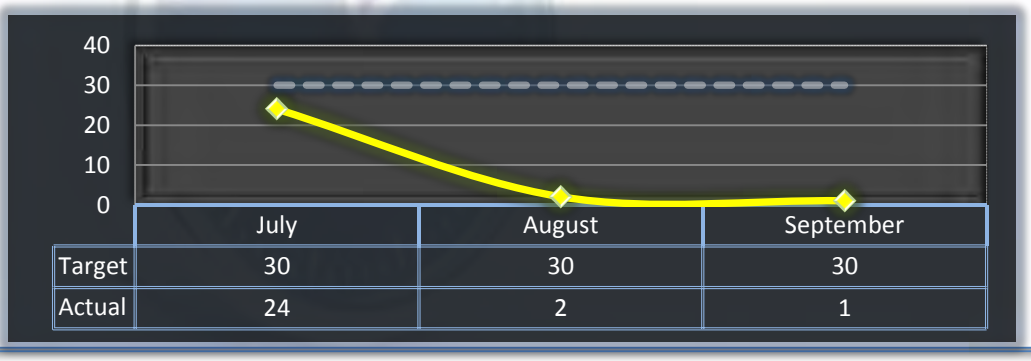
	July	August	September
Actual	16	14	16

Intake

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

Target: 30 Days

Q1 Average: 11 Days



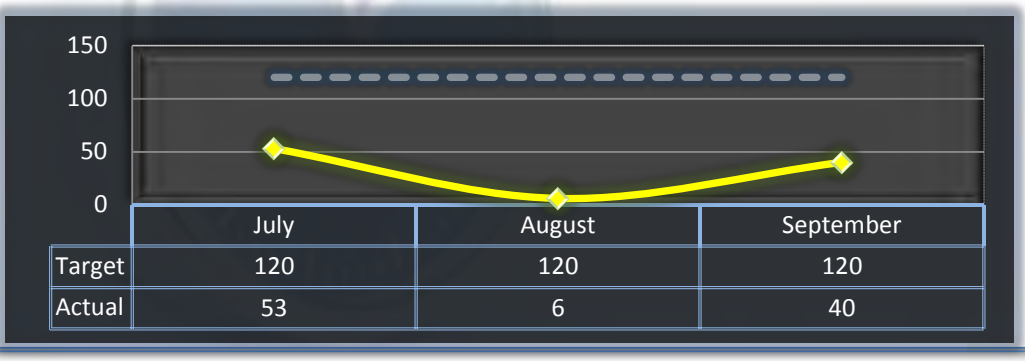
	July	August	September
Target	30	30	30
Actual	24	2	1

Intake & Investigation

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

Target: 120 Days

Q1 Average: 44 Days



	July	August	September
Target	120	120	120
Actual	53	6	40

Formal Discipline

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

Target: 540 Days

Q1 Average: N/A

The Committee did not close any disciplinary cases this quarter.

Probation Intake

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

Target: 10 Days

Q1 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q1 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q2 Report *(October - December 2011)*

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

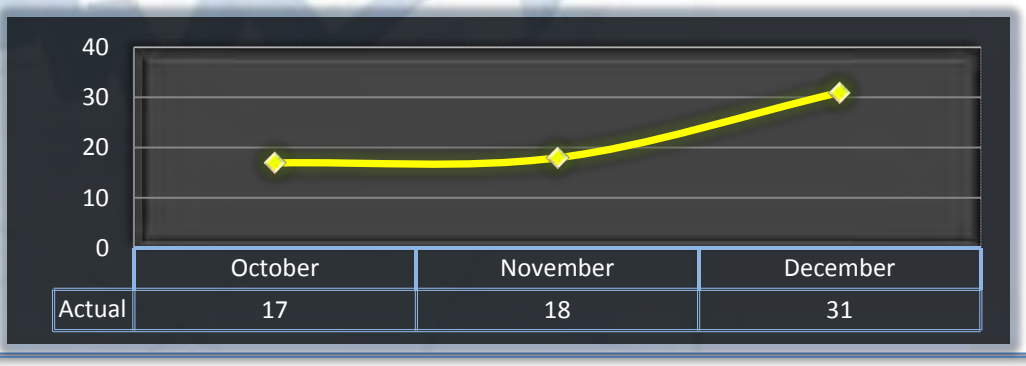
Volume

Number of complaints and convictions received.

Q2 Total: 46

Complaints: 2 Convictions: 44

Q2 Monthly Average: 15



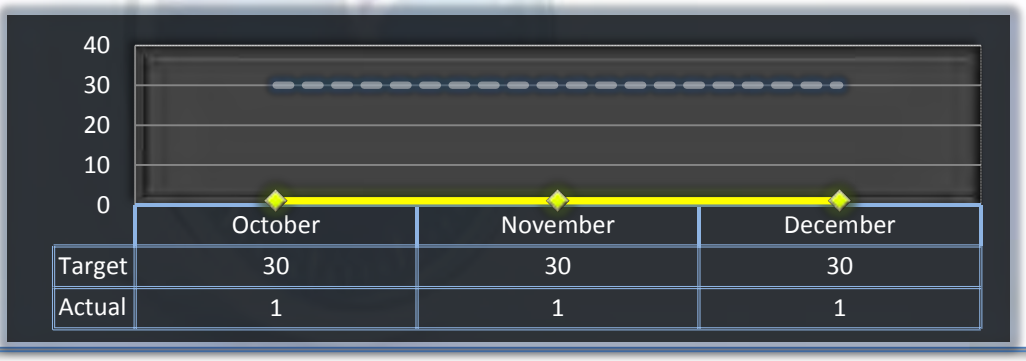
	October	November	December
Actual	17	18	31

Intake

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

Target: 30 Days

Q2 Average: 1 Day



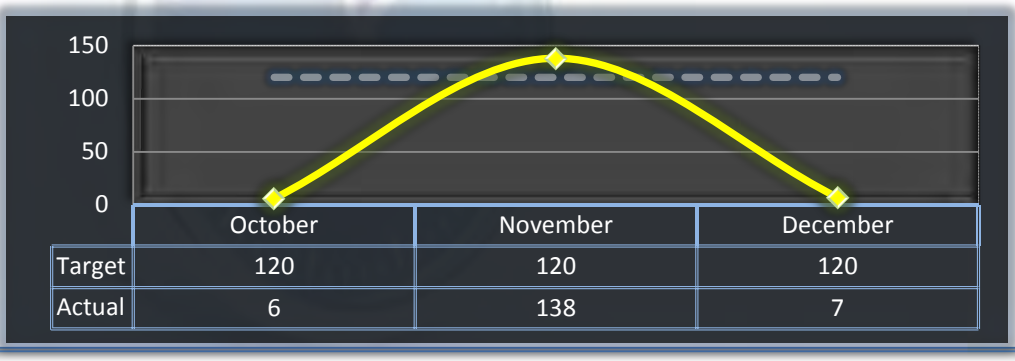
	October	November	December
Target	30	30	30
Actual	1	1	1

Intake & Investigation

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

Target: 120 Days

Q2 Average: 44 Days



	October	November	December
Target	120	120	120
Actual	6	138	7

Formal Discipline

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

Target: 540 Days

Q2 Average: N/A

The Committee did not close any disciplinary cases this quarter.

Probation Intake

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

Target: 10 Days

Q2 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q2 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q3 Report *(January - March 2012)*

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

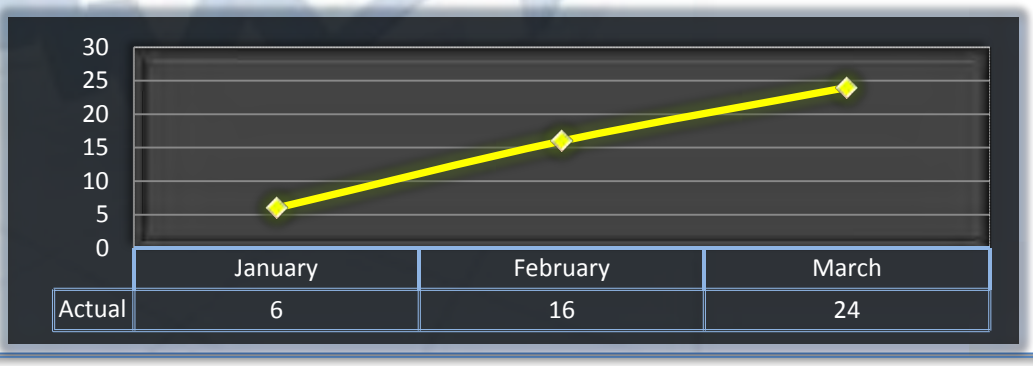
Volume

Number of complaints and convictions received.

Q3 Total: 46

Complaints: 3 Convictions: 43

Q3 Monthly Average: 15

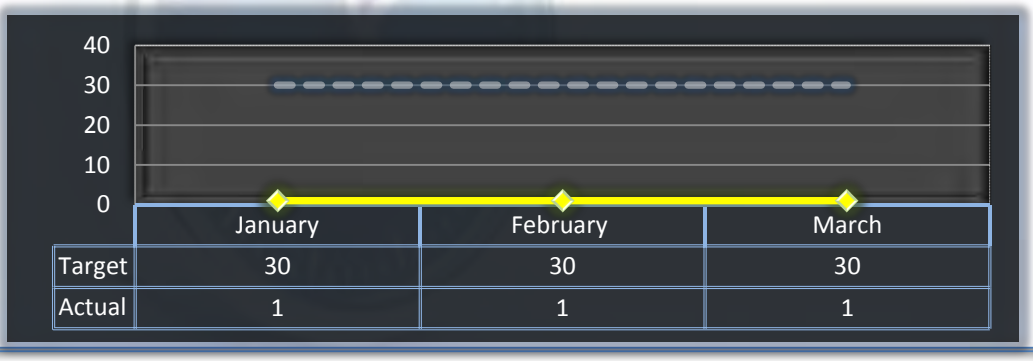


Intake

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

Target: 30 Days

Q3 Average: 1 Days

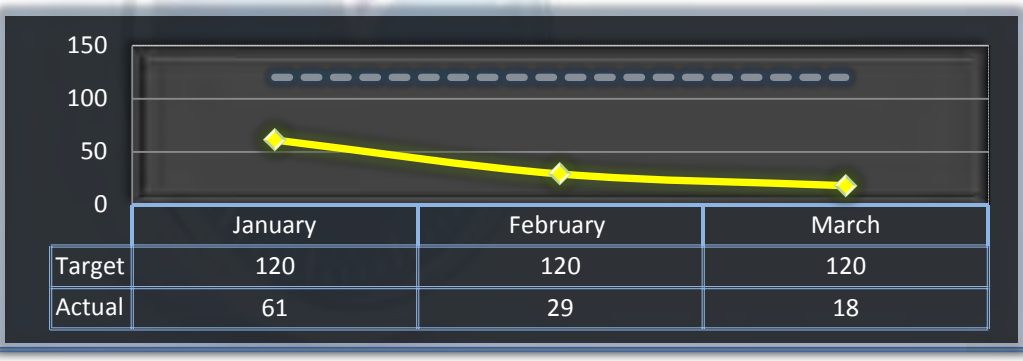


Intake & Investigation

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

Target: 120 Days

Q3 Average: 28 Days



	January	February	March
Target	120	120	120
Actual	61	29	18

Formal Discipline

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

Target: 540 Days

Q3 Average: N/A

The Committee did not close any disciplinary cases this quarter.

Probation Intake

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

Target: 10 Days

Q3 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q3 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene
Committee of California

Performance Measures

Q4 Report *(April - June 2012)*

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

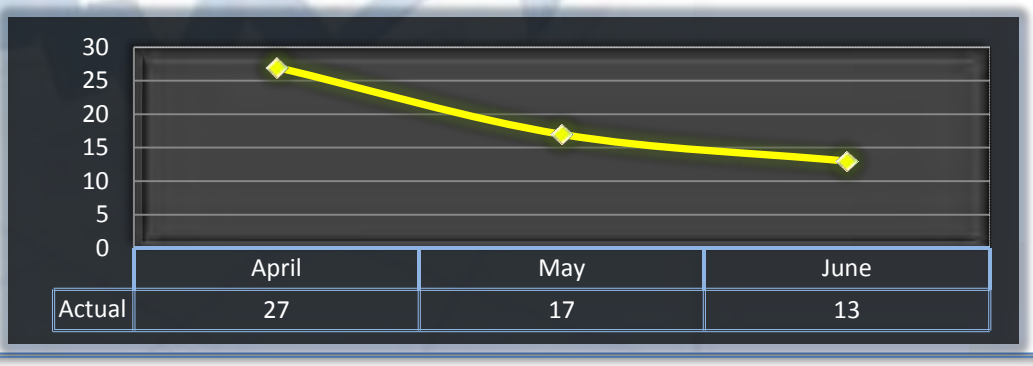
Volume

Number of complaints and convictions received.

Q4 Total: 57

Complaints: 5 Convictions: 52

Q4 Monthly Average: 19

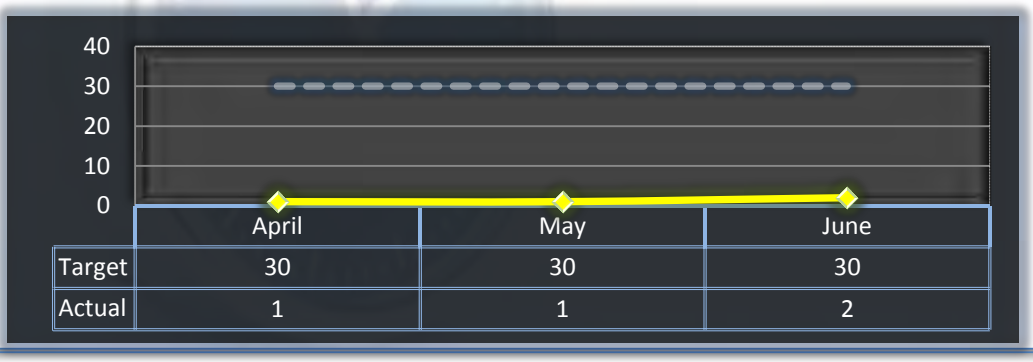


Intake

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

Target: 30 Days

Q4 Average: 1 Days



Intake & Investigation

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

Target: 120 Days

Q4 Average: 42 Days

Formal Discipline

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

Target: 540 Days

Q4 Average: 868 Days

Probation Intake

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

Target: 10 Days

Q4 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q4 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Annual Report *(2011 – 2012 Fiscal Year)*

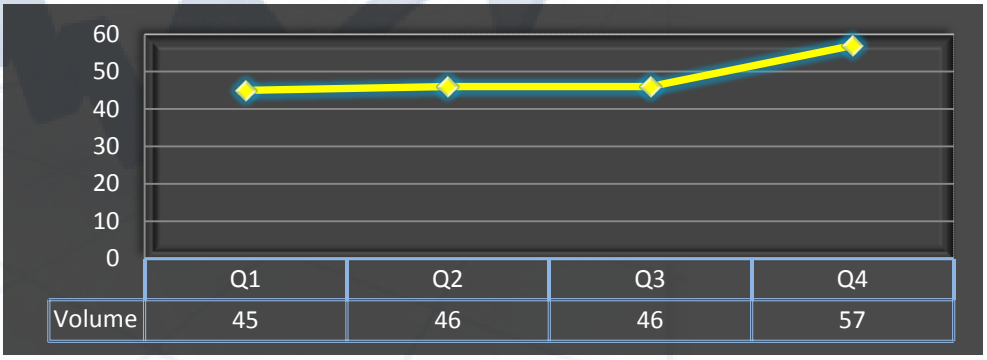
To ensure stakeholders can review the Committee's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the four quarters worth of data.

Volume

Number of complaints and convictions received.

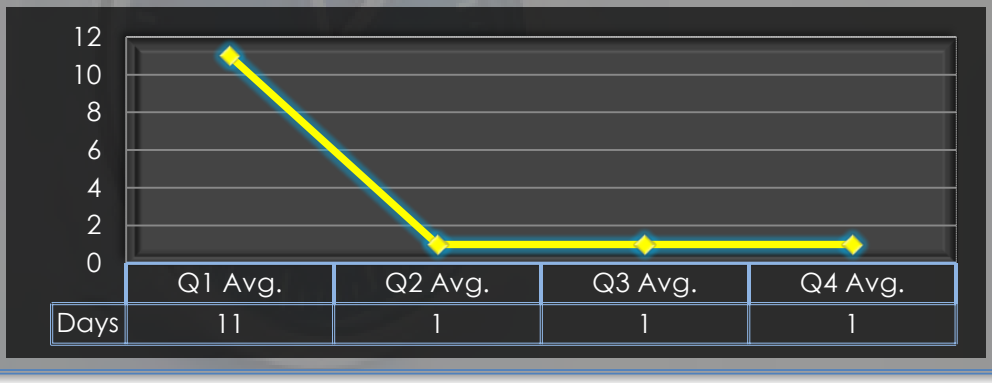
The Committee had an annual total of 194 this fiscal year.



Intake

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

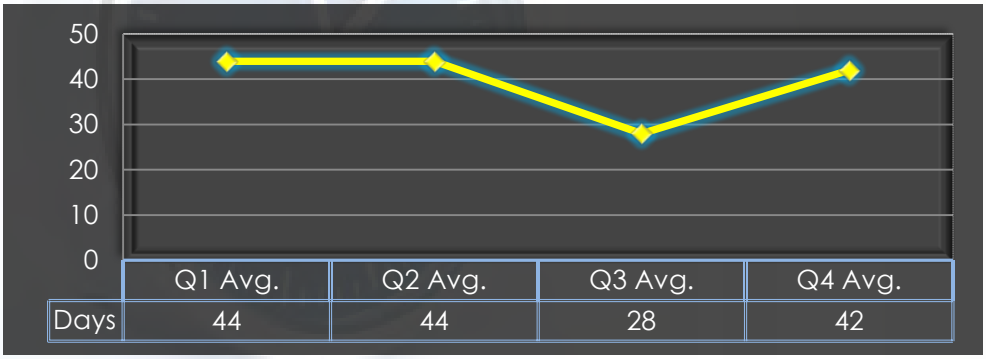
The Committee has set a target of 30 days for this measure.



Intake & Investigation

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

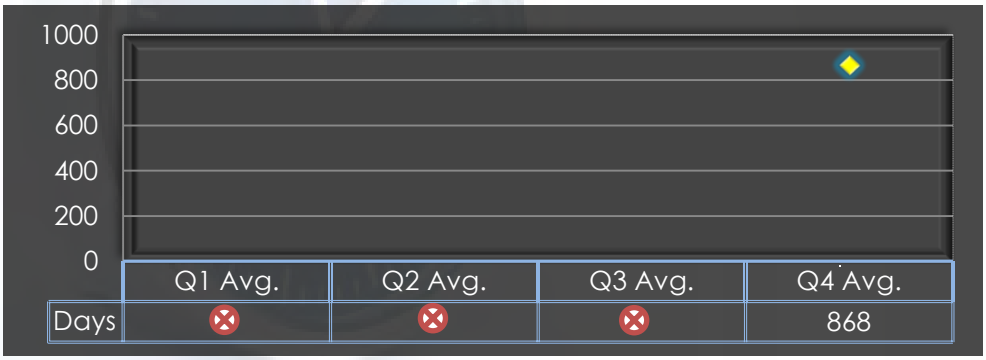
The Committee has set a target of 120 days for this measure.



Formal Discipline

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

The Committee has set a target of 540 days for this measure.



Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q1 Report *(July - September 2012)*

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

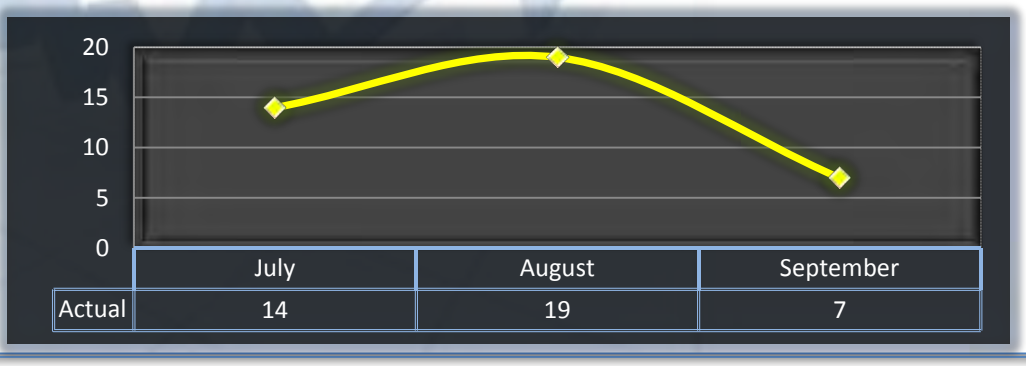
Volume

Number of complaints and convictions received.

Q1 Total: 40

Complaints: 6 Convictions: 34

Q1 Monthly Average: 13

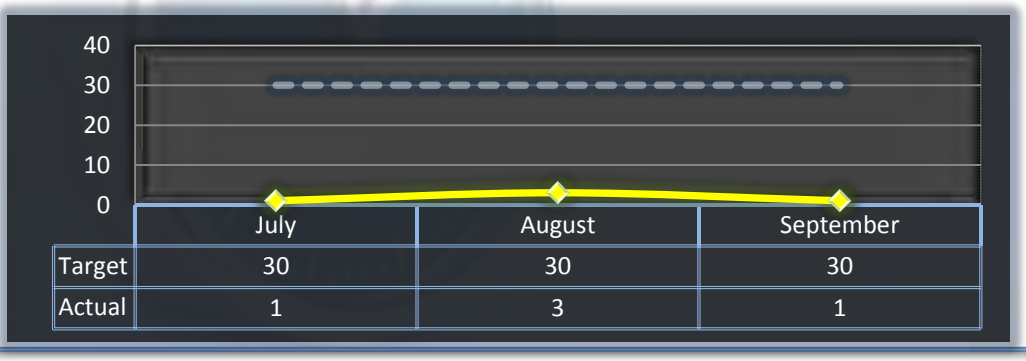


Intake

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

Target: 30 Days

Q1 Average: 2 Days



Intake & Investigation

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

Target: 120 Days

Q1 Average: 45 Days

Formal Discipline

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

Target: 540 Days

Q1 Average: 846 Days

Probation Intake

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

Target: 10 Days

Q1 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q1 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q2 Report *(October - December 2012)*

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

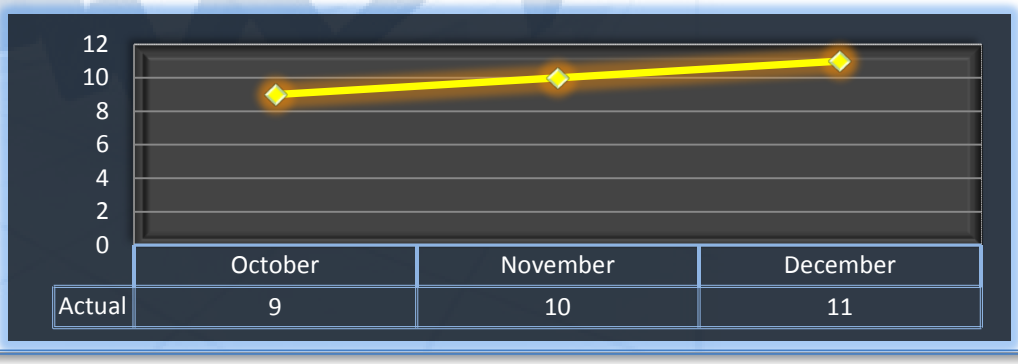
Volume

Number of complaints and convictions received.

Q2 Total: 30

Complaints: 6 Convictions: 24

Q2 Monthly Average: 10

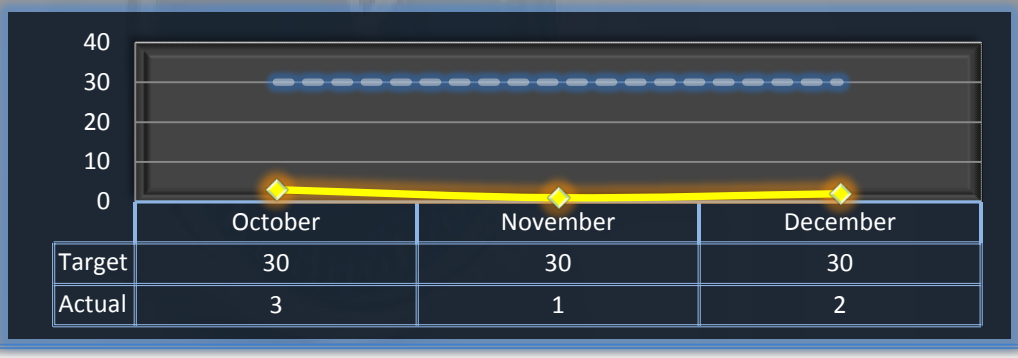


Intake

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

Target: 30 Days

Q2 Average: 2 Days

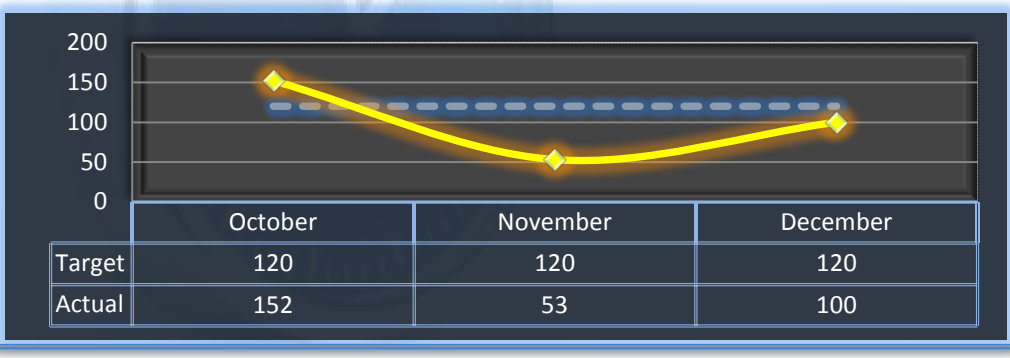


Intake & Investigation

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

Target: 120 Days

Q2 Average: 97 Days



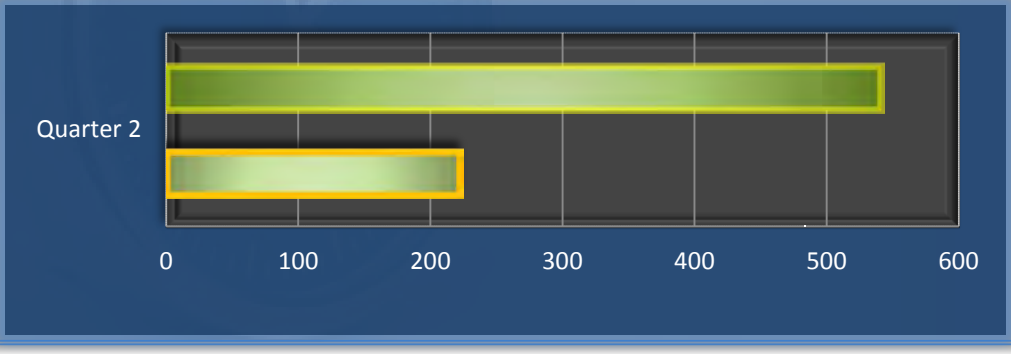
	October	November	December
Target	120	120	120
Actual	152	53	100

Formal Discipline

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

Target: 540 Days

Q2 Average: 221 Days



Probation Intake

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

Target: 10 Days

Q2 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q2 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q3 Report *(January - March 2013)*

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

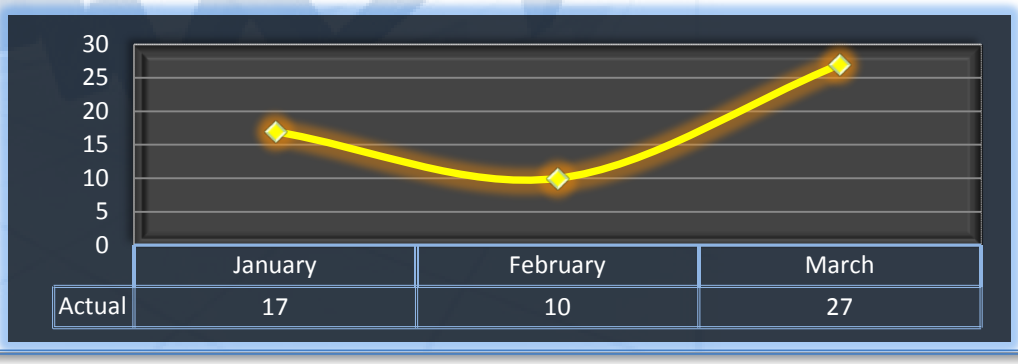
Volume

Number of complaints and convictions received.

Q3 Total: 54

Complaints: 2 Convictions: 52

Q3 Monthly Average: 18



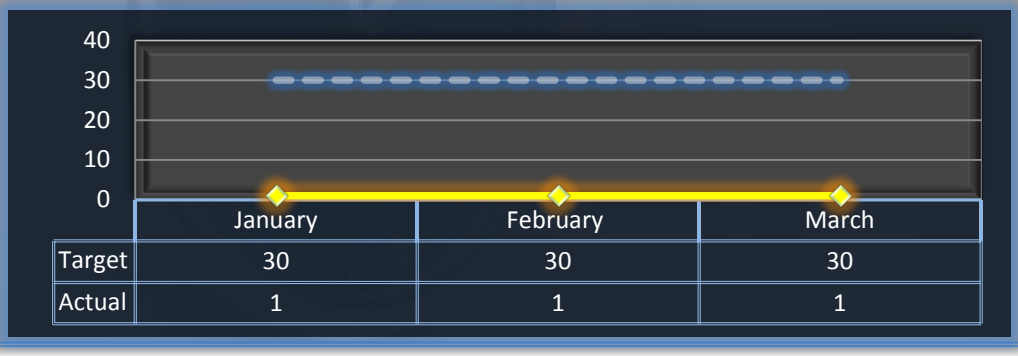
	January	February	March
Actual	17	10	27

Intake

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

Target: 30 Days

Q3 Average: 1 Day



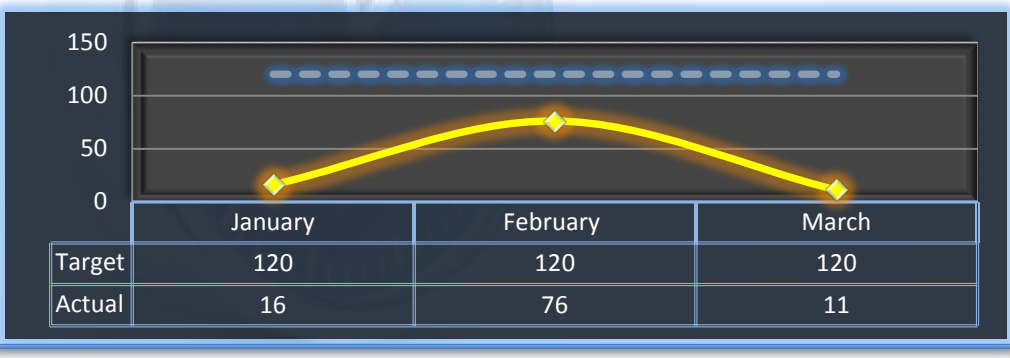
	January	February	March
Target	30	30	30
Actual	1	1	1

Intake & Investigation

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

Target: 120 Days

Q3 Average: 30 Days



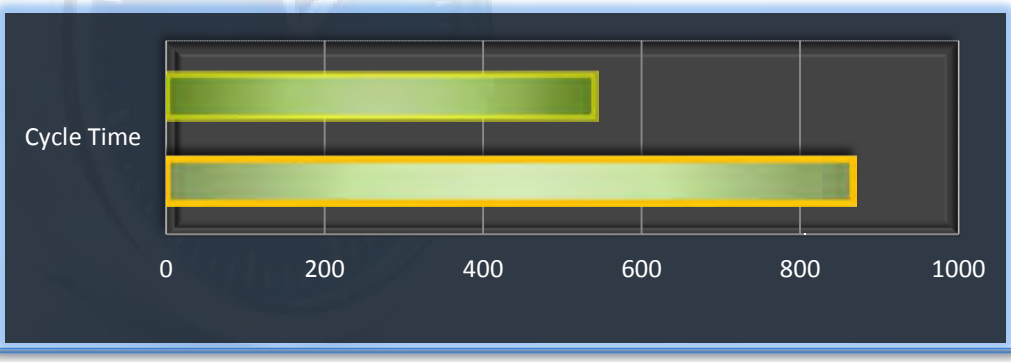
	January	February	March
Target	120	120	120
Actual	16	76	11

Formal Discipline

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

Target: 540 Days

Q3 Average: 865 Days



Probation Intake

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

Target: 10 Days

Q3 Average: N/A

The Committee did not contact any new probationers this quarter.

Probation Violation Response

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

Target: 10 Days

Q3 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

Q4 Report *(April - June 2013)*

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

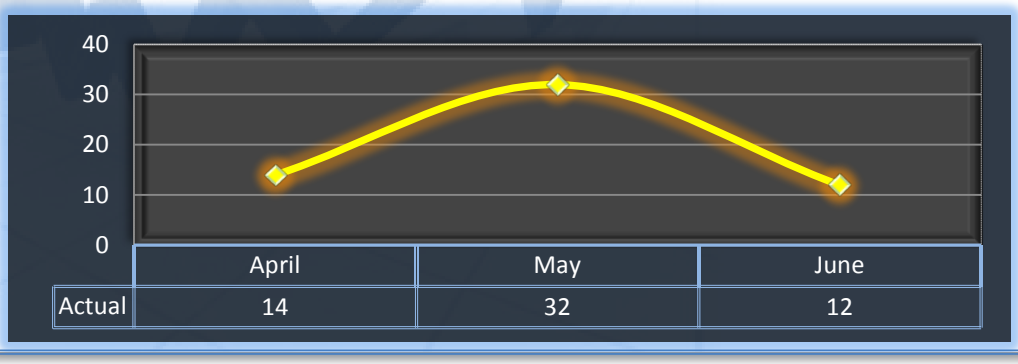
Volume

Number of complaints and convictions received.

Q4 Total: 58

Complaints: 5 Convictions: 53

Q4 Monthly Average: 19



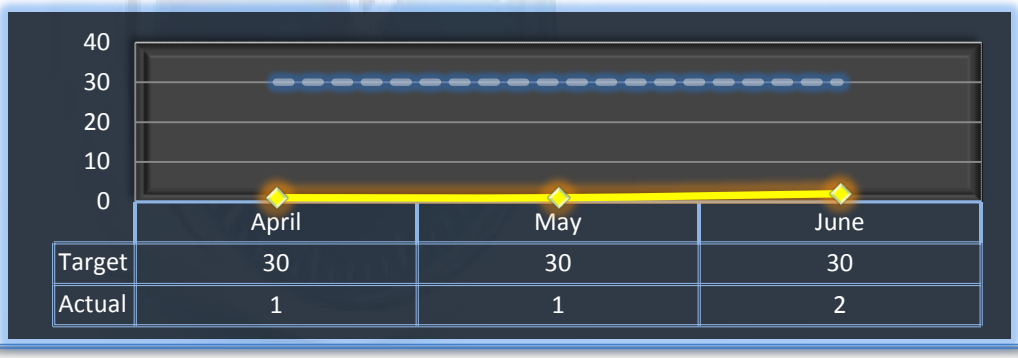
	April	May	June
Actual	14	32	12

Intake

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

Target: 30 Days

Q4 Average: 1 Days



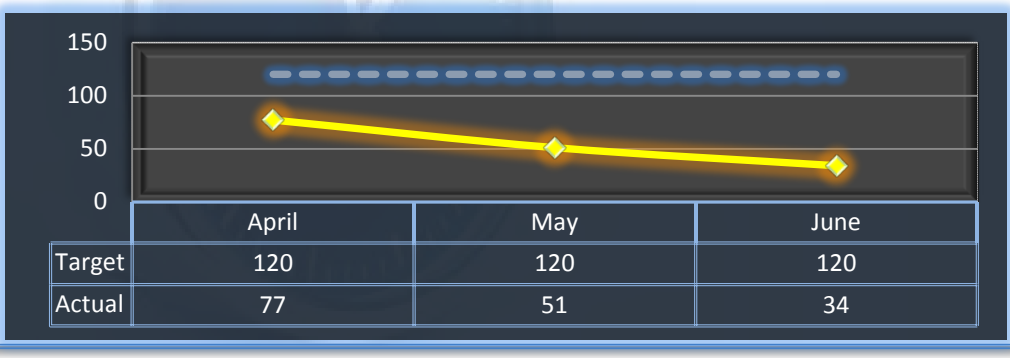
	April	May	June
Target	30	30	30
Actual	1	1	2

Intake & Investigation

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

Target: 120 Days

Q4 Average: 53 Days



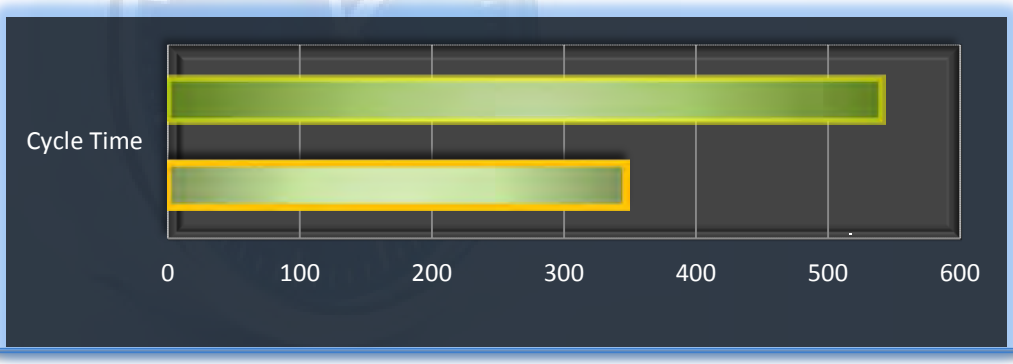
	April	May	June
Target	120	120	120
Actual	77	51	34

Formal Discipline

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

Target: 540 Days

Q4 Average: 346 Days

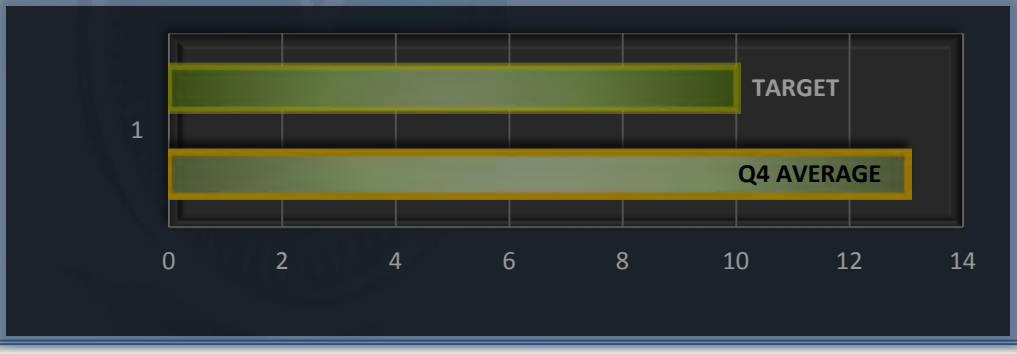


Probation Intake

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

Target: 10 Days

Q4 Average: 13 Days



Probation Violation Response

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

Target: 10 Days

Q4 Average: N/A

The Committee did not handle any probation violations this quarter.

Department of Consumer Affairs

Dental Hygiene Committee of California

Performance Measures

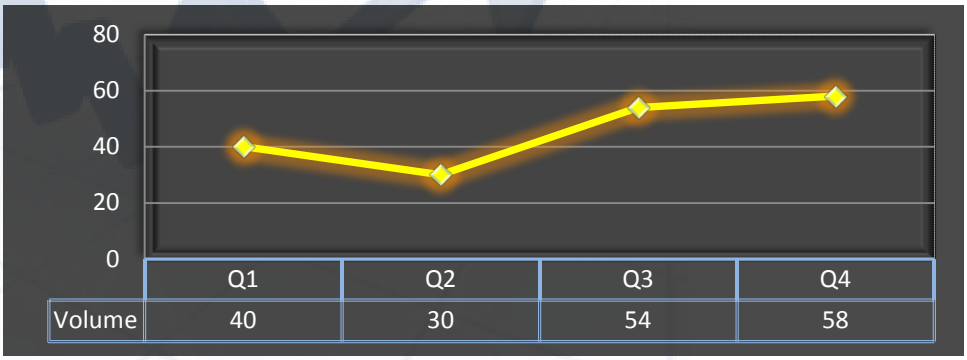
Annual Report *(2012– 2013 Fiscal Year)*

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

Volume

Number of complaints and convictions received.

The Committee had an annual total of 182 this fiscal year.

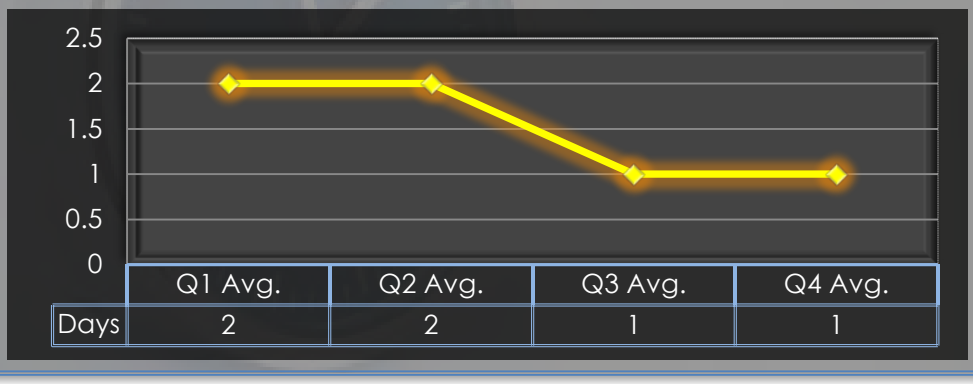


	Q1	Q2	Q3	Q4
Volume	40	30	54	58

Intake

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

The Committee has set a target of 30 days for this measure.

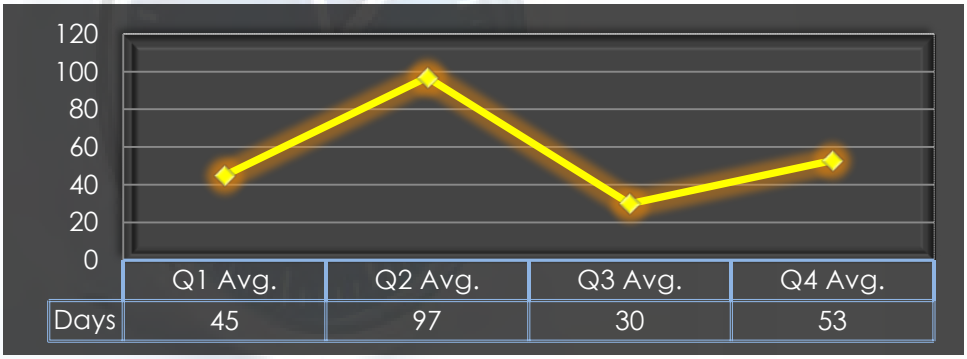


	Q1 Avg.	Q2 Avg.	Q3 Avg.	Q4 Avg.
Days	2	2	1	1

Intake & Investigation

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

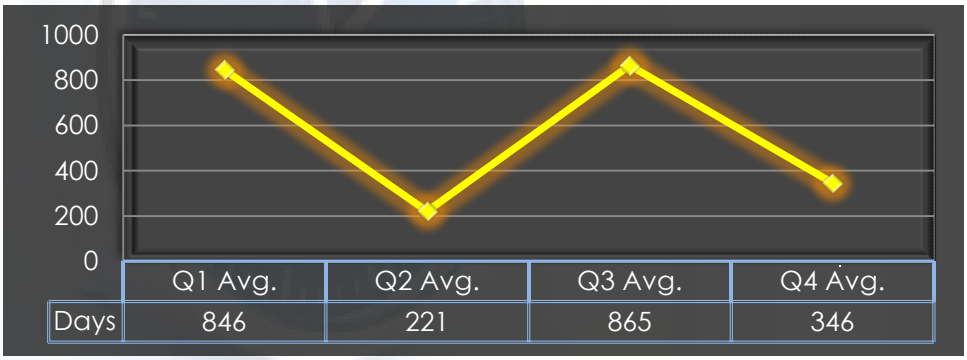
The Committee has set a target of 120 days for this measure.



Formal Discipline

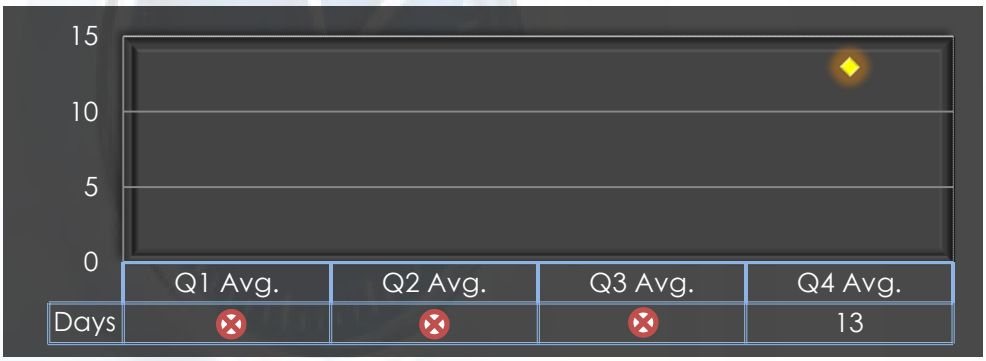
Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Committee, and prosecution by the AG)

The Committee has set a target of 540 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer. The Board has set a target of 10 days for this measure.



THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT F:

Joint Legislative Sunset Review Committee Background Paper for the Dental Board of California

(March 14, 2011)

BACKGROUND PAPER FOR THE DENTAL BOARD OF CALIFORNIA

(Oversight Hearing, March 14, 2011, Senate Committee on Business, Professions and Economic Development)

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE DENTAL BOARD OF CALIFORNIA

BRIEF OVERVIEW OF THE DENTAL BOARD OF CALIFORNIA

The Dental Board of California (DBC) was created by the California Legislature in 1885, and was originally established to regulate dentists. Today, DBC is responsible for regulating the practice of approximately 71,000 licensed dental health professionals in California, including 35,500 dentists, 34,300 registered dental assistants (RDAs), and 1,300 registered dental assistants in extended functions (RDAEFs). In addition, DBC is responsible for setting the duties and functions of approximately 50,000 unlicensed dental assistants. DBC, as a whole, generally meets at least four times throughout the year to address work completed by various committees of DBC and hear disciplinary cases.

The Dental Practice Act provides that the "[p]rotection of the public shall be the highest priority of the Dental Board of California in exercising its licensing, regulatory and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount." In concert with this statutory mandate, DBC formally adopted a mission statement in its 2010/2012 Strategic Plan, as follows: "The mission of the Dental Board of California is to protect and promote the health and safety of consumers of the State of California." The Strategic Plan also included a vision statement which indicated that DBC will be the leader in public protection, promotion of oral health, and access to quality care.

DBC implements regulatory programs and performs a variety of functions to protect consumers. These programs and activities include setting licensure requirements for dentists, and dental assistants, including examination requirements, issue and renew licenses, issue special permits, monitor probationer dentists and RDAs and manage a Diversion Program for dentists and RDAs whose practice may be impaired due to chemical dependency or mental illness.

DBC is composed of 14 members; 8 practicing dentists, 2 dental auxiliaries (RDH and RDA), and 4 public members. The 8 licensed dentists, the registered dental hygienist, the registered dental assistant, and 2 public members are appointed by the Governor. The Speaker of the Assembly and the Senate Rules Committee each get a public member appointment. According to DBC, public membership is 29% of the Board's composition. Of the 8 practicing dentists, 1 must be a member of a dental school faculty, and one shall be a dentist practicing in a nonprofit clinic.

Members of DBC are appointed for a term of 4 years, and each member may continue to hold office until the appointment and qualification of his or her successor or until 1 year has elapsed since the

expiration of the term, whichever occurs first. Each member may serve no more than 2 full terms. The following is a listing of the current members of the DBC with a brief biography of each member, their current status, appointment and term expiration dates and the appointing authority:

Board Members	Appointment Date	Term Expiration Date	Appointing Authority
John Bettinger, DDS, Board President Dr. Bettinger is a member of the American Dental Association, California Dental Association and Western Los Angeles Dental Society. He is a Life Member with Fellowship status in the Academy of General Dentistry. He served on the Western Los Angeles Dental Society Peer Review Committee for 10 years and on the Diversion Evaluation Committee of DBC for 2 years. Dr. Bettinger has been affiliated with Saint John's Hospital and the UCLA/Santa Monica Hospital and Health Care Center (formally the Santa Monica Hospital).	March 26, 2009	January 1, 2013	Governor
Bruce L. Whitcher, DDS, Board Vice President Dr. Whitcher has maintained a private practice of Oral and Maxillofacial Surgery in San Luis Obispo since 1987. Dr. Whitcher is a member of the Central Coast Dental Society, the California Dental Association, the California Association of Oral and Maxillofacial Surgeons, and the American Association of Oral and Maxillofacial Surgeons. He maintains hospital affiliations with French Hospital Medical Center, Sierra Vista Regional Medical Center, and Twin Cities Hospital Medical Center.	January 2, 2011	January 1, 2015	Governor
Luis Dominicis, DDS, Board Secretary Dr. Dominicis is a general dentist in private practice in the City of Downey, California since 1993. Dr. Dominicis is the President of Los Angeles Dental Society, Past President of the Latin American Dental Association; he has also served in various Councils in the California Dental Association such as Council on Legislative Affairs, Council on Community Health and in the Reference Committee for the House of Delegates. Dr. Dominicis is presently a member of the Dental Forum, which represents the ethnic dental societies in California.	March 26, 2009	January 1, 2012	Governor
Steven Afriat Mr. Afriat is President of the Los Angeles County Business License Commission. He was also the Los Angeles City Councilmember's Chief of Staff. Mr. Afriat has also served as President of the Los Angeles City Animal Services Commission, the LA City Council Redistricting Commission, and on the Boards of the Valley Community Clinic, Equality California, the West Hollywood Chamber of Commerce, and the Valley Industry and Commerce Association. Mr. Afriat owns his own Governmental Relations firm in Burbank.	July 2010	January 1, 2013	Speaker of the Assembly
Fran Burton Ms. Burton served twenty-one years in California in the Legislative and Executive branches of government. She currently consults on health policy issues. She holds a Master of Social Work degree from California State University, Sacramento.	June 2009	January 1, 2013	Senate Rules Committee
Stephen Casagrande, DDS Dr. Casagrande has been a dentist in private practice since 1974. He was previously the director of the Sacramento District Dental Society, a past member of the peer review committee, an advisor to the Sacramento City College Dental Hygiene Program Advisory Board Member to Hi-Tech Institute, a Proprietary School for Dental Assistants. Dr. Casagrande is a member of the American Dental Association, California Dental Association, and Sacramento District Dental Society.	March 27, 2009	January 1, 2012	Governor

Rebecca Downing Ms. Downing was appointed by Governor Schwarzenegger to the Dental Board in March of 2009. She is an attorney and the Chief Legal Officer for Western Health Advantage, a Sacramento-based health plan. Previously, she served as general counsel for Landmark Healthcare, Inc., a chiropractic / acupuncture health care company. In addition, Ms. Downing was the Executive Director of the California Chiropractic Association, and served in various capacities with the California Veterinary Medical Association and the California Dental Association. She received her Juris Doctorate degree from University of Southern California Gould School of Law and her Bachelor's degree from California State University, Sacramento.	March 26, 2009	January 1, 2012	Governor
Judith Forsythe, RDA Judith Forsythe, of Riverside, has been a Registered Dental Assistant in the State of California since 1994. She currently holds the position of director of back office development for Pacific Dental Services, where she has worked since 1998. She is a member of the American Dental Assistant Association.	March 26, 2009	January 1, 2013	Governor
Houng Le, DDS Dr. Le is a member of the American Dental Association, California Dental Association and Alameda County Dental Society. Dr. Le serves as a member on Board of Directors of National Network for Oral Health Access and Secretary for Western Clinicians Network. Additionally, she is President-Elect for Alameda County Dental Society. Dr. Le presently serves as Assistant Clinical Professor at UCSF School of Dentistry, A. T. Still School of Dental and Oral Health in Arizona and Dental Director of Lutheran Medical Center-affiliated AEGD program at Asian Health Services.	January 2, 2011	January 1, 2015	Governor
Suzanne McCormick, DDS Dr. McCormick is an Oral and Maxillofacial surgeon in private practice who is an active staff member at the Department of Oral and Maxillofacial Surgery at Tri-City Medical Center in Oceanside, California. She has been affiliated with many hospitals including, but not limited to, Health North Medical Center, Loma Linda University Medical Center, Riverside Medical Center, Metropolitan Medical Center, St. Vincent's Hospital and Medical Center, and New York University Medical Center. She has served as Trustee from District I, of the Board of Directors, International College of Oral and Maxillofacial Surgeons.	March 26, 2009	January 1, 2013	Governor
Steven Morrow, DDS After sixteen years of endodontic practice, Dr. Morrow returned to the field of dental education, completed a Master of Science Degree in Microbiology and accepted a faculty appointment in the Department of Endodontics at Loma Linda University School of Dentistry. Dr. Morrow is a Life Member of the American Dental Association and the American Association of Endodontists. He is a member of the California State Association of Endodontists, Tri-County Dental Society, Southern California Academy of Endodontics, and the American Dental Education Association. He is a Diplomate of the American Board of Endodontics and a member of the Scientific Advisory Board of the Journal of Endodontics. He is currently a Professor of Endodontics and Director of Patient Care Services and Clinical Quality Assurance at Loma Linda University School of Dentistry.	August 17, 2010	January 1, 2014	Governor
Thomas Olinger, DDS Since 1979, he has owned and operated his private practice. Dr. Olinger has also served as a dental officer in the U.S. Navy Reserve since 1976. He is a member of the California Dental Association, American Dental Association and San Diego County Dental Society. This position does not require Senate confirmation and the compensation is $100 per diem.	March 26, 2009	January 1, 2013	Governor

DBC currently has active committees dealing with dental assisting, enforcement, examinations, legislation and regulations, and licensing, certification, and permits. The Enforcement Committee reviews complaint and compliance case-aging statistics, citation and fine information, and investigation case-aging statistics in order to identify trends that might require changes in policies, procedures, and/or regulations. This Committee also receives updates on dentists participating in the Diversion Program. The Examination Committee reviews clinical/practical and written examination statistics and receives reports on all examinations conducted by staff. The Legislative/Regulatory Committee actively tracks legislation relating to the field of dentistry that might impact consumers and licensees and makes recommendations to the full Board whether or not to support, oppose, or watch a particular legislation. The Legislative/Regulatory Committee also develops legislative proposals, seeks authors, and attends Legislative hearings. The Licensing, Certification, and Permits Committee reviews dental and dental assistant licensure and permit statistics, and looks for trends that would indicate efficiency and effectiveness or might identify areas in the licensing units that need modifications. Additionally, the Dental Assisting Committee, made up of DBC members, evaluates all issues relating to dental assistants, RDAs, and RDAEFs.

DBC is a special fund agency, and its funding comes from the licensing of dentists and biennial renewal fees of dentists and RDAs. Currently, the license and renewal fee for dentists is $365 and the renewal fee for RDAs is $70. DBC also receives revenue through its cite and fine program. The total revenues anticipated by DBC for fiscal year 2010/2011 is $7,758,000, for FY 20111/2012, it is $8,929,000, and for FY 2012/2013 it is $10,021,000. DBC's anticipated expenditures for FY 2010/2011 is $11,159,000, for FY 2011/2012, it is $11,386,000, and for FY 2012/2013 it is $11,641,000. DBC spends approximately 68% of its budget on its enforcement program, with the major portion of these expenditures going to salary and wages followed by Attorney General and Evidence and Witness costs. DBC anticipates it would have approximately 4.7 months in reserve for FY 2010/2011, 2.1 months in reserve for FY 2011/2012, and 1.3 months reserve for 2012-2013.

In 2009, with the implementation of SB 853 (Perata), the State Dental Assistant Fund was established where all funds for the regulation of dental assistants is deposited. According to DBC, the total revenues anticipated for the dental assistant fund for FY 2010/2011, 2011/2012 and 2012/2013 is over $1.1 million. The total expenditures for each of the fiscal years is over $1.7million. DBC anticipates a 9.4 months reserve in 2010/2011, 5.1 months reserve in 2011/2012 and .7 months reserve in 2012/2013.

Currently, DBC has 72.8 authorized positions, of which 60.8 are filled and 12 are vacant. The Enforcement Unit is comprised of 35 staff, with 10.5 vacant positions. In 2010, the DCA launched the Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement process of healing arts boards. According to DCA, the CPEI is a systematic approach designed to address three specific areas: Legislative Changes, Staffing and Information Technology Resources, and Administrative Improvements. Once fully implemented, DCA expects the healing arts boards to reduce the average enforcement completion timeline to between 12 -18 months. As part of CPEI, DBC was authorized to hire 12.5 positions. However, because of a hiring freeze ordered by the Governor on August 31, 2010, as well as a 5% staff reduction directive from the Department of Finance on October 26, 2010, DBC has only hired 4 of the 12.5 positions allocated under CPEI.

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

DBC was last reviewed by the former Joint Legislative Sunset Review Committee (JLSRC) in 2002. At that time, the JLSRC issued five recommendations. Additionally, prior to this last review, SB 26 (Figueroa), Chapter 615, Statutes of 2001 required the Director of the DCA to appoint an Enforcement Monitor (Monitor) to evaluate DBC's disciplinary system and procedures with specific focus on the quality and consistency of complaint processing and investigation, timeframes needed for complaint handling and investigation, complaint backlogs, and other related managerial, organizational, and operational problems, issues, and concerns. The Monitor submitted his initial report to the Legislature in 2002, and made 40 specific recommendations for improvements. In this initial report, the Monitor indicated that there are numerous significant inconsistencies in the way complaints are processed and investigated, it was taking much too long to resolve or investigate complaints, and as a result of staff turnover and the state's hiring freeze, backlogs have begun to accumulate. The following are actions which DBC took to address the issues raised by the Monitor and the last sunset review. For those which were not addressed and which may still be of concern to the Committee, they are addressed and more fully discussed under "Current Sunset Review Issues."

On October 1, 2010, DBC submitted its required Sunset Report to this Committee. In this report, DBC described actions it has taken since its last sunset review and to address the recommendations of the Monitor. The following are some of the changes and enhancements that DBC had undertaken:

- Augmentation of enforcement unit staff and restructuring of its Complaint Unit has allowed DBC to respond to consumer complaints in a timely manner and has reduced the processing times of complaints.

- In response to concerns raised that DBC is unable to administer an adequate amount of examinations, DBC sponsored AB 1524 (Hayashi), Chapter 446, Statutes of 2010 which repeals the previous clinical and written examination administered by DBC and replaced it with a portfolio examination of an applicant's competence to practice dentistry to be administered while the applicant is enrolled in a dental school program.

- DBC converted limited term peace officer positions to permanent full time positions.

- New licensure, examination and permit requirements were established.

- To address issues raised by the Monitor on the lack of a case tracking system, DBC will be one of the Boards that will benefit from a new, integrated, enterprise-wide enforcement and licensing system, called BreEZe that will support applicant tracking, licensing, renewal, enforcement, monitoring, cashiering, and data management. According to DCA, BreEZe will replace the existing CAS, ATS, and multiple "workaround" systems with an integrated system for use by all DCA organizations. The BreEZe project was approved by the Office of the State Chief Information Officer (OCIO) in November 2009, and the Request For Proposal (RFP) for a solution vendor is currently under development.

- To address the need for tracking investigative case activity, in 2003, DBC tested a version of the Investigation Activity Reporting (IAR) program used by the Medical Board of California (MBC). According to DBC, although this demonstration version of MBC's database was intended to provide a method for managers to track casework on all cases, the system was not

established in protocol and was only used sporadically. DBC's enforcement program has partnered with the MBC to utilize MBC's newest version of the IAR to track casework. This format is intended to provide information for cost recovery purposes and allow managers to better track staff performance and productivity. Transition to the new IAR was anticipated to be completed by the end of 2010.

- The Expert Reviewer rate was increased from $75 to $100. However, DBC indicates it continues to struggle to recruit experts.

- Effective August 1, 2010, a new consumer survey procedure has been adopted.

- The Disciplinary Guidelines of DBC were revised and approved by the Office of Administrative Law on December 14, 2010. The regulations became effective January 13, 2011.

- DBC's regulatory authority and responsibility was extended to all dental assisting functions. The duties and functions of unlicensed dental assistants, RDAs, RDAEFs, Dental Sedation Assistants, and Orthodontic Assistants were revised in statute.

- The Board updated its dental assisting educational requirements relating to RDA programs, infection control courses, Orthodontic Assistant Permit Courses, Dental Sedation Assistant Courses, and RDAEF programs, and is moving forward with finalizing the rulemaking process.

- The DBC updated the regulations for the minimum standards for infection control applicable to all DBC licensees and is moving forward with finalizing the rulemaking process.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to DBC, or areas of concern for the Committee to consider, along with background information concerning the particular issue. There are also recommendations the Committee staff have made regarding particular issues or problem areas which need to be addressed. DBC and other interested parties, including the professions, have been provided with this Background Paper and can respond to the issues presented and the recommendations of staff.

BOARD ADMINISTRATION ISSUES

ISSUE #1: (CHANGE COMPOSITION OF DBC.) Should the composition of DBC be changed to include more public member representation?

Background: DBC's current composition of 8 professionals and 4 public members may not be in the best interest of consumer protection. DBC currently has 14 members: 8 dentists, 1 RDA, 1 RDH and 4 public members. The 8 licensed dentists, 1 RDH, 1 RDA, and 2 public members are appointed by the Governor. The Senate Rules Committee and the Speaker of the Assembly each get 1 public member appointment. According to DBC, public membership is 29% of DBC's composition.

Generally, a public member majority for occupational regulatory boards or greater representation of the public where current board membership is heavily weighted in favor of the profession is preferred for consumer protection. Since any regulatory program's (including DBC) primary purpose is to protect the public, increasing the public's representation on DBC assures the public that the professions' interests do not outweigh what is in the best interest of the public. Requiring closer parity between public and professional members is also consistent with both this Committee's and the DCA's recommendations regarding other boards that have undergone sunset review over the past 8 years. Additionally, almost all health related consumer boards have no more than a simple majority of professional members.

Staff Recommendation: ***To ensure the continued commitment of DBC to protect the public, the composition of DBC should be changed to include more public members. This could be accomplished by replacing one of the dentists appointed by the Governor with a public member and giving the Governor an additional public member appointment. This would bring the total of DBC to 15 members: 7 dentists, 1 RDA, 1 RDH and 6 public members.***

ISSUE #2: (STRATEGIC PLAN UPDATE NEEDED.) Should DBC's Strategic Plan include action items and realistic target dates for how its goals and objectives will be met?

Background: As part of the sunset report, DBC submitted its 2010-2012 Strategic Plan which laid out its mission, vision, values, goals and objectives. The Strategic Plan recognizes that the mission of DBC is to protect and promote the health and safety of consumers in California and lays out objectives in achieving this goal. However, the Strategic Plan lacks depth and specificity as to how the Board will achieve its specific objectives. For example, DBC specifies as goal 3: Ensure the Board's Enforcement and Diversion Programs provide timely and equitable consumer protection. For the objectives, DBC specifies that the Board will implement improved reporting and tracking of enforcement cases; implement short- and long-term IT improvements; maintain optimal staffing by continuing to fill vacant enforcement and diversion staff positions. However, there is no discussion on how the Board will achieve these objectives. The Strategic Plan is transparently lacking on the specifics of how DBC in concrete steps will achieve its objectives.

Staff Recommendation: ***DBC should develop and publish a detailed action plan with specific action items and realistic target dates for how each of the objectives will be met. Additionally, the Board should be given a written status report on the action plan at each board meeting.***

ISSUE #3: (LACK OF PERSONNEL EVALUATION.) Should DBC implement annual personnel performance evaluations or appraisals?

Background: According to the 2002 Enforcement Program Monitor's Initial Report, among other issues identified, there was no evidence of management or supervisory analysis of workload or work processes. At that time, the Monitor recommended that specific supervisory responsibilities and requirements should be defined, including conducting case reviews and annual performance appraisals. Additionally, the Monitor suggested that DBC identify all areas requiring documentation of policies and procedures, and schedule the completion of this activity over a phased period of time. The Monitor indicated that improved supervisory practices will be critical to achieving marked improvements in the aging of closed cases. However, the Monitor also recognized that previous

appraisal efforts were met with considerable employee resistance, and the appraisals were never completed.

Additionally, a 2009 Enforcement Process Assessment (Enforcement Assessment) of DBC indicated that the lack of personnel performance evaluations is evident in various areas of the enforcement program. Personnel appraisals, the Enforcement Assessment indicated are especially important in the case review and audit process to effectively track and manage investigations, and concluded that a consideration should be given to monthly reports, training participation and attendance to measure staff productivity and investigative progress, which will also help in conducting annual appraisals with staff.

Staff Recommendation: ***DBC should explain to the Committee its system of work performance evaluations and ensure that these evaluations or appraisals are completed by staff on a timely basis.***

ISSUE #4: (CLARIFICATION OF THE AUTHORITY OF DBC OVER THE DENTAL HYGIENE COMMITTEE AND DENTAL ASSISTANTS.) Is there some clarification needed regarding the authority which DBC has over the Dental Hygiene Committee and the Dental Assisting Forum?

Background: In 1974, the Legislature created the Committee on Dental Auxiliaries (COMDA) to provide advice on the functions of and work settings of dental auxiliaries, including dental assistants and dental hygienists. COMDA was vested with the authority to administer dental auxiliary license examinations, issue and renew dental auxiliary licenses, evaluate auxiliary educational programs, and recommend regulatory changes regarding dental auxiliaries. SB 853 (Perata) (Chapter 31, Statutes of 2008) abolished COMDA and transferred the regulation of dental hygienists to the Dental Hygiene Committee, and the regulation of RDAs and RDAEFs to DBC. SB 853 was the result of years of negotiations between stakeholders to create within the jurisdiction of DBC the Dental Hygiene Committee of California (DHCC). It removed dental hygienists from the more restrictive COMDA and provided it with a more autonomous regulatory direction. This was an action consistent with JLSRC's conclusion that the dental hygienists had reached the point where their responsibilities warranted a regulatory body separate from DBC. While the DHCC is proving successful, there have been issues raised regarding its autonomy. It has been argued that the autonomy that was designed and expected with the independent funding and governance of this new Committee has been sometimes limited by the suggestion that their actions, outside of changing the scope of practice for dental hygiene, requires special reporting or some kind of consent from DBC. Dental hygiene advocates claim that the adoption of the regulatory packet that will create the Dental Hygiene Practice Act remains stalled, and the DHCC is still acting under the old regulations that are found only in the Dental Practice Act that is controlled by DBC. However, according to DBC staff, it is unclear as to why the DBC is responsible for the failure to enact DHCC regulations. With new appointments due to occur in January 2012, it is imperative that the DHCC's ability to adopt regulations independent of DBC be clarified. Without clarification, the DHCC members are unclear as to what they can do as a Committee.

Additionally, SB 853 also stated legislative intent that DBC create and implement an effective forum where dental assistant services and regulatory oversight of dental assistants can be heard and discussed in full and where all matters relating to dental assistants can be discussed, including matters related to licensure and renewal, duties, standards or conduct and enforcement. In response to SB 853, in 2009, DBC established two groups to deal with dental assisting issues: The Dental Assisting Committee (DAC) composed of DBC members and chaired by the RDA appointee to DBC; and the Dental

Assisting Forum (DAF), composed of RDAs and RDAEFs. According to DBC, "the purpose of the DAF is to be a forum where dental assistants can be heard, and to discuss all matters relating to dental assistants in the State, including requirements for dental assistant licensure and renewal, duties, supervision, appropriate standards of conduct and enforcement for dental assistants." This purpose is essentially similar to the legislative intent specified in SB 853. The DAC meets at every board meeting and the DAF held short meetings in January and April 2010, and met again in January 2011. Advocates for dental assistants have indicated to Committee staff that many items that DAF members have requested be included on agendas but have been removed, requests that meetings be held in conjunction with DBC so that there can be open lines of communication and establish greater efficiency have been denied, and dental assisting issues are placed on the agenda for DBC's DAC, instead of on the DAF agenda. Additionally, Committee staff is unclear as to DBC's policy for referring issues to the DAF and DAC, how recommendations are referred from the DAF and DAC to DBC and what kind of discretion DBC has over deciding dental assisting issues; how often are issues referred to DAF and DAC and how often are they taken up by DBC, and how often are DAF and DAC recommendations accepted. Essentially, the establishment of two groups to deal with dental assisting issues has resulted in very inefficient and ineffective process. It is also unclear why DBC established a bifurcated process for hearing dental assisting issues.

Recommendation: ***It would appear as if the intent of the Legislature was that the Dental Hygiene Committee was created so that it could make independent decisions on issues related to the regulation of the hygienist profession unless it involved scope of practice changes which would need to be worked out between both the dentistry and hygienist professions. Clarification may be needed to assure that the Dental Hygiene Committee maintains its independence over that of DBC. Additionally, the Committee should ask DBC to explain the purpose for establishing two groups to deal with dental assisting issues, and consider merging the DAC and DAF into one entity.***

DENTAL WORKFORCE AND DIVERSITY ISSUES

ISSUE #5: (IMPACT OF FEDERAL HEALTH CARE REFORM ON THE DENTAL WORKFORCE?) Will California meet the increased demand for dental services with the enactment of the Federal Health Care Reform, and what can DBC do to assist in the implementation of the Federal Health Care Reform?

Background: A June 2009 Health Policy Fact Sheet (Health Policy Fact Sheet) by the University of California, Los Angeles Center for Health Policy Research indicated that California has about 14% of the total number of dentists nationwide (the largest percentage of any state). The dentist-to-population ratio in California is estimated as 3.5 dentists per 5,000 or a dentist for every 1,440 persons. This ratio is higher than the national estimate of three dentists per 5,000, or a dentist for every 1,660 persons. However, the Health Policy Fact Sheet revealed that although there is a large number of practicing dentists in California, many areas in the state continue to have a shortage of dentists, and these areas are mostly located in rural areas, including Yuba, Alpine, Colusa, Mariposa, Mono and San Benito Counties. The Health Policy Fact Sheet indicated that there are 233 dental health professional shortage areas statewide. These areas generally have a dentist-to-population ratio of one per 5,000 or lower; a high population need with a ratio of at least 1.25 dentists per 5,000 (or 1 per 4,000); and a public or non-profit health center that provides dental services to shortage areas or populations. Additionally, the Health Policy Fact Sheet indicated that the percentage of dentists who may be nearing retirement

age is greater than the percentage of newly licensed dentists. In some counties, far fewer are newly licensed and many more are nearing retirement age.

These shortages could potentially impact the implementation of the recently enacted federal health care reform measure, referred to as the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010. In California, implementation of the PPACA is under way with the enactment last year of AB 1602 (Perez), Chapter 655, Statutes of 2010, and SB 900 (Alquist, Steinberg), Chapter 659, Statutes of 2010, establishing the California Health Benefits Exchange within the California Health and Human Services Agency. According to advocates, an estimated 1.2 million California children will soon gain dental coverage due to the recent enactment of the PPACA. However, advocates argue that California will not be able to fulfill the promise of improving children's dental health if there are not enough dental providers to meet this growing demand. The following provisions are included in the PPACA and will impact dental workforce in California:

- Requires that insurance plans offered under the Exchange to include oral care for children.
- Expands school-based sealant programs.
- Authorizes $30 million for fiscal year 2010 to train oral health workforce.
- Establishes 5-year, $4 million demonstration projects to test alternative dental health care providers.
- Establishes a public health workforce track, including funding for scholarships and loan repayment programs for dental students and grants to dental schools.
- Establishes three-year, $500,000 grants to establish new primary care residency programs, including dental programs.
- Provides funding for new and expanded graduate medical education, including dental education.

Staff Recommendation: ***The Committee should ask DBC whether it has assessed the impact of, and planned for, implementation of the PPACA; how DBC is looking at the dental workforce capacity in light of implementation of the PPACA, given that millions of additional Californians, especially children, will gain dental coverage when the PPACA is implemented. Additionally, DBC should continue in its efforts to increase the dental workforce in California, explore approaches and work collaboratively with for-profit and non-profit organizations and other stakeholders to address the increased demand for oral healthcare as a result of the PPACA. Additionally, DBC should be proactive in finding ways to increase access to dental programs especially for socio-economic disadvantaged students.***

ISSUE #6: (IS THERE A LACK OF DIVERSITY IN THE DENTAL PROFESSION?) Should DBC enhance its efforts to increase diversity in the dental profession?

Background: As indicated by the Center for the Health Professions (Center), it has long been known that certain ethnic and racial groups are underrepresented in the health professions. "The subject of racial and ethnic underrepresentation in California's health professions training programs and workforce has come to occupy a central role in the effort to develop better models of health care practice and better systems for health care delivery," as stated by the Center. The reasons for this are varied, as explained by the Center as follows:

- The practice of linguistically and culturally competent health care of a diverse health professions workforce is critical to addressing health disparities.

- Student experiences in health professions training programs are enriched by the presence of fellow students with diverse social and cultural experiences.

- Economic development in communities is another reason to promote greater diversity in the health professions. The health industry is one of the few economic sectors in California that continues to create jobs and most jobs in health care are well paid, and many of them offer opportunities for professional development.

According to a 2008 report by the Center entitled "*Diversity in California's Health Professions: Dentistry*," a 2005/2006 gender and racial/ethnic composition of dentists shows that although White/Caucasians represent 44.5% of California's labor force, they make up 56.7% of active dentists, Asians account for 32.4% of active dentists while representing a 13.2% of the total labor force, and Latino dentists represent an estimated 7% of the state's active dentists, but roughly 34% of California's general labor workforce. African-American dentists represent an estimated 2.5% of California's dentists, which is roughly half the size of the state's African American general labor force. Native Americans, Native Hawaiians & Pacific Islanders, and multiracial dentists represent just 1.3% of active dentists in the state but almost 3% of California's general labor force. Available data indicates that active dentists are overwhelmingly male, but the gender composition may be expected to shift over time as more women graduates of DDS programs enter the labor force. Trended education data describing first-year enrollments indicate that women are more highly represented in California's five DDS programs by comparison with currently active dentists. In contrast, education data indicate that the racial/ethnic composition of students in California's DDS programs is similar to the active dental labor force. This suggests that the profession will remain largely White/Caucasian and Asian at least in the near term.

Furthermore, the report indicated that there are several factors that contribute to the successful recruitment of minority dental students, including the availability of dental programs that are committed to integrating community-based practice experience that highlight the role of cultural differences in treatment planning as part of the clinical education; the presence of minority clinical faculty; well-designed mentorship programs that foster relationships between students and practicing professionals in the community; increasing recruitment efforts for minorities (establishing dental pipeline programs); financial support and other career development programs.

Staff Recommendation: ***DBC should enhance its efforts on diversity issues, and increase its collaboration efforts with dental schools, dental associations, other state and local agencies, and for-profit and non-profit organizations.***

DENTAL PRACTICE ISSUES

ISSUE #7: (DIFFICULT TO DETERMINE SPECIALTY AREAS OF DENTAL PRACTICE.) Should DBC be responsible for determining and reviewing areas of specialty education and accreditation requirements for those specialized areas of Dentistry?

Background: In 2001, AB 1026 (Oropeza), Chapter 313, Statutes of 2001, enacted Section 651 (h)(5)(A) of the B&P Code which prohibits a dentist from holding himself or herself out as a specialist, or advertise in a specialty recognition by an accredited organization, unless the practitioner completed specialty education programs approved by the American Dental Association (ADA), as specified. Additionally, this section prohibits a dentist from representing or advertising himself or herself as accredited in a specialty area of practice unless the dentist is a member of, or credentialed by, an accredited organization recognized by DBC as a bona fide organization for an area of dental practice. This section also specified requirements to be considered a bona fide organization for purposes of credentialing. AB 1026 was sponsored by the California Dental Association (CDA) and was enacted in response to a DBC advertising regulations that were found to violate the First Amendment and were ruled unconstitutional by a federal court. In 2003, DBC was sued by Dr. Potts, a dentist, and a credentialing organization challenging the constitutionality of Section 651(h)(5)(A). See *Potts v. Hamilton*, 334 F.Supp.2d 1206. At issue was the statute's requirement that in order to advertise a post-dental school credential, a dentist must first complete a formal, full-time advanced education program that is affiliated with or sponsored by a university based dental school. A federal court ultimately ruled in favor of the dentist and held that the statute (Section 651(h)(5)(A)) was an unconstitutional restriction on commercial speech. Although DBC appealed this decision, it began negotiations with various stakeholder groups associated with or interested in the *Potts* litigation and worked out a dental advertising legislative proposal, but ultimately the proposed legislation did not push through and the appeal proceeded to the Ninth Circuit Court. In 2005, AB 1268 (Oropeza) was sponsored by CDA in an effort to amend Section 651(h)(5)(A) and provide that a disclaimer must be included on all advertising by any non-ADA recognized credential. However, AB 1268 did not move forward. In 2007, the Ninth Circuit Court remanded the case back to the Federal District Court and in 2010, the court reaffirmed its decision that the provision was unconstitutional. According to DBC, to prevent future litigation in this area and to mitigate costs associated with the *Potts* litigation (over $1.1 million), it is recommending that Section 651(h)(5)(A)(i) through 651(h)(5)(A)(iii) of the B&P Code be deleted from statute. They do not believe this is an area in which DBC needs to be involved.

Staff Recommendation: ***Adopt the recommendation of DBC to delete B & P Code Section 651(h)(5)(A)(i) through Section 651(h)(5)(A)(iii).***

EXAMINATION ISSUES

ISSUE #8: (LENGTHY PROCESSING TIME FOR EXAMINATION APPLICATIONS.) Currently DBC is averaging up to five months to process examination applications.

Background: The Dental Practice Act provides that each applicant for dentistry licensure must successfully complete Part I and Part II written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations, an examination in California Law and Ethics developed and administered by DBC, and one of the following: A portfolio examination conducted while the applicant is enrolled in a dental school program; or a clinical and written examination administered by the Western Regional Examining Board (WREB).

According to DBC's Sunset Report, the timeframe for processing examination application averages is from 45 to 150 days. In a follow-up discussion, DBC staff reported that statistics for the past 5 months show that dentist applications with no deficiencies are completed within an average of 32 days.

Applications that are deficient may be delayed depending upon how quickly the requirements are submitted by the applicant.

Staff Recommendation: ***DBC should explain further the reasons for the delays in processing examination application averages and whether these delays are attributable to DBC.***

ISSUE #9: (RANDOMIZATION OF DENTAL AND RDA LAW AND ETHICS EXAMINATIONS NEEDED.) Are there sufficient safeguards to avoid, if not limit, examination compromises and ensure that testing reflect current laws and regulations? Should the California Law and Ethics examination questions for dentists and RDAs be randomized and reflect current laws and regulations?

Background: As indicated above, as part of the licensure process, an applicant must also pass a California Law and Ethics examination that is developed and administered by DBC. DBC contracts with the DCA's Office of Professional Examination Services (OPES) for its examination development services. According to DBC, in FY 2006/2007 and 2007/2008, the pass rate for the Dental Law and Ethics examination was 96%, and for fiscal years 2008/2009 and 2009/2010, the pass rate increased to 98%. This pass rate is extremely high.

Aside from dentists, RDAs are also required to pass an RDA Law and Ethics Examination. On May 3, 2010, DBC was notified by OPES that information contained within the RDA Law and Ethics examination was posted on an Internet blog. Staff reviewed the information posted and stopped the examination from being administered beginning June 1, 2010. A special examination workshop was held on June 5 and 6, 2010, and the RDA Law and Ethics examination was modified and updated, and DBC resumed testing August 1, 2010. As part of the examination sign-in procedure, applicants are now required to certify that they will not release content information. Additionally, DBC did not grant licensure to the applicant who posted examination information on the blog.

Staff Recommendation: ***To avoid examination compromises and ensure that the examination questions reflect current law and regulations, DBC should require that OPES randomize (scramble) California law and ethics examinations for dentists and RDAs. Additionally, dentists should be required to certify that examination content will not be released.***

ISSUE #10: (RDA WRITTEN EXAMINATION PASS RATE IS LOW.) Should DBC explore pathways to improve the pass rates of RDAs taking the written examinations if the low pass rate trend continues?

Background: The pass rate in 2009/2010 (the first fiscal year that the RDA is under DBC) for the RDA written examination is 53%. There was no explanation given by DBC on why the pass rate was low.

Staff Recommendation: ***If in fiscal year 2010/2011, the RDA examination pass rate remains low, DBC should explore approaches to improve the passage rate of RDAs.***

CONTINUING COMPETENCY ISSUES

ISSUE #11: (LACK OF CONTINUING EDUCATION AUDITS.) DBC suspended audits of continuing education prior to 2009, and does not audit RDAs.

Background: The Dental Practice Act requires that each dentist and RDA fulfill continuing education (CE) requirements to renew their dental license. Currently, a dentist must fulfill 50 hours of continuing education for each renewal period, whereas RDAs are required to fulfill 25 hours of CE credits for each renewal period. Courses in basic life support, 2 hours of California Infection Control and 2 hours of California Dental Practice Act are required courses for both practitioners. DBC also approves continuing education courses and approves the CE provider. Effective January 1, 2010, all unlicensed dental assistants in California must complete an approved 8-hour infection control course, an approved 2-hour course in the California Dental Practice Act, and a course in basic life support.

There were no random CE audits since the last Sunset Review in 2002. According to DBC, random audits did not begin until the summer of 2009 when staff was redirected to perform the audits. DBC indicates that an average of 98% of dentists who were audited were found to be in compliance with continuing education requirements. Furthermore, DBC points out that when it inherited the dental assisting program and staff, there was no funding or staff to perform CE audits.

Staff Recommendation: ***DBC should explain to the Committee its current policy on continuing education audits for dentists and the reasons for suspension of the audits prior to 2009. DBC should also explain why it does not audit CE for RDAs and describe plans, if any, to implement audit for RDA CE.***

ENFORCEMENT ISSUES

ISSUE #12: (DISCIPLINARY CASE MANAGEMENT TIMEFRAME STILL TAKING ON AVERAGE 2 ½ YEARS OR MORE.) Will DBC be able to meet its goal of reducing the average disciplinary case timeframe from 2 ½ years or more, to 12 to 18 months?

Background: DBC is responsible for regulating the practice of approximately 35,000 dentists and 34,000 RDAs. DBC indicates that it receives between 3,000 and 3,800 complaints per year (See table below), and processes and closes about 3,900 complaints a year. Complaints are categorized into 4 distinct groups: complaints received from the public, other governmental agencies, licensee/professional groups and complaints labeled as "other." Complaints classified as "other" include mandatory reports from specific entities; including settlements and malpractice judgments pursuant to Business & Professions Code Section 801 et. seq., and Section 805 reports from peer review bodies, including health care service plans, dental societies, and committees that review quality of care cases if certain actions are taken by or imposed on dentists. The table below summarizes the sources and number of complaints received by DBC from 2006-2010. DBC states that the number of complaints referred to investigation has increased from 14% in 2000 to 25% in 2009. However, the percentage of complaints which ultimately result in the filing of accusations and disciplinary action averages about 3% which has remained stable over time, according to the Board.

Source of Complaint	2006-2007	2007-2008	2008-2009	2009-2010

Public	1858	2175	2528	2370
Governmental Agencies	454	286	87	67
Licensee/Professional Groups	633	1154	833	639
Other	137	94	79	96
TOTAL	**3,082**	**3,709**	**3,527**	**3,712**

According to DBC, the average number of days to process a claim from receipt of complaint to final disposition of a case ranged from 836 days in 2008/2009 to 857 days in 2009/2010. More recent statistics provided to the Committee shows that the average cycle time from the date the case was received as a complaint to when the Disciplinary Order was issued for 2010 is 951.7 days. This means that on average it is taking DBC 2 ½ years to pursue a disciplinary action against a problem dentist. It should be noted that DBC is not alone in its problems related to its lengthy disciplinary process; all other health boards under DCA are also affected. The table below shows the average case aging, and often the biggest bottleneck occurs at the investigation and prosecution stages of the process.

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECURE CASES				
	2006/2007	**2007/2008**	**2008/2009**	**2009/2010**
Complaint Processing	238	280	278	180
Investigations	247	211	302	351
Pre-Accusation*	208	283	182	187
Post-Accusation**	341	363	361	335
TOTAL AVERAGE DAYS *	**668**	**773**	**836**	**857**
*From Completed investigation to formal charges being filed ** From formal charges filed to conclusion of disciplinary case ***From date complaint received to date of final disciplinary of disciplinary case				

The cycle time is affected by several factors including the length of time it takes to process complaints, conduct investigations, file accusations by the AG's Office and schedule and hold hearings with the Administrative Law Judges. Lastly, the case goes back to DBC for a final decision. As the table above indicates, there has been a vast improvement in the case processing timeframe (from 278 days in 2008/2009 to 180 days in 2009/2010). According to DBC, the recent hiring of additional dental consultants has contributed to improved complaint processing. However, the 6 months average time to process complaints remains lengthy. It should be noted that since the release of the Sunset Report, the DBC has continued to reduce this timeframe, which is now 92 days.

A complaint that has merit is referred to investigation and assigned an investigator. DBC uses its own in-house investigators to conduct investigations. Assignment for investigation is based on a number of criteria including case complexity, investigator experience, companion cases on the same licensee, and caseload. An investigator then evaluates the case and sets priorities based on their own caseload. DBC indicates that over the past four years the average length of time required to complete investigation has risen from 247 in 2006/2007 to 351 days in 2009/2010. DBC points out that factors affecting the investigation timeframe include investigator vacancies, length of time to train new staff, increase in the number of complaints referred to investigation, and mandatory furloughs of last year.

At the conclusion of an investigation, if it is determined that there has been a violation of the Dental Practice Act, the case is referred by the investigator to the Office of Attorney General (AG's Office) for preparation and review of the administrative accusation. According to DBC, in 2009/2010, the average days from the date a case is received to the date a case is assigned to a Deputy Attorney General (DAG) is 44 days (96 days in 2007/2008 and 52 days in 2008/2009). As the table on the prior

page provides, it is taking the AG's Office over 6 months (187 days) in 2009/2010 from the time an investigation is completed to file an accusation. Additionally, the average number of days from when an accusation is served to a settlement is completed is 356 days for 2009/2010 (346 days in 2008/2009 and 379 days in 2007/2008). As such, it is taking the AG's office over 19 months to close cases that are not referred to the Administrative Law Judge for an administrative hearing. As noted above, these statistics were provided to Committee staff by DBC which is generated from DBC's database. The AG's office tracks its own cases with a different database, and was requested to provide the same information but was not made available for purposes of this Paper. Staff anticipates that the AG will provide their own statistics during the hearing. DBC indicates in the Sunset Report that the AG's Office is aware of these timeframes and recognizes that their staffing constraints have contributed to case aging.

On August 17, 2009, this Committee held an informational hearing entitled "*Creating a Seamless Enforcement Program for Consumer Boards*." This hearing revealed that Deputy AGs within the AG's Licensing Section handle both licensing and health care cases in a similar fashion without any expertise devoted to the prosecution of those cases involving serious health care quality issues. Moreover, the AG's staff often allows respondents to file a notice of defense long after the 15-day time limit has ended, which lengthens the time a case is processed by the AG's Office. The practice of the AG's Office of not requesting a hearing date when notice of defense is received is also contributing to the delays. The AG's Office often waits for settlement negotiations to break down before requesting a hearing date with Office of Administrative Hearings (OAH). It can then take one to two years to prosecute the case and for a disciplinary decision to be reached. Finally, OAH provides services to over 950 different governmental agencies. The DCA's cases are not given a higher priority and are calendared according to available hearing dates and Administrative Law Judges (ALJs) assigned. Cases on average can take up to 12 months or more months to be heard. Also, the DCA's boards and bureaus have over 40 different laws and regulations with which ALJs must be familiar. This lack of specialization and training for the cases referred by the other health care boards creates a situation in which judges are issuing inconsistent decisions. A board is then placed in a position of non-adopting the decision of the ALJ and providing for a hearing of its own to make a different determination regarding the disciplinary action which should be taken against the dentist.

As noted above, cases begin to age tremendously during the investigative phase. DBC points out that there are 10.5 positions currently vacant in the Enforcement Unit. Of these vacancies, 8.5 are CPEI positions. It should be noted that CPEI positions were created to expedite and maximize the efficiency of handling all pending disciplinary actions and are dedicated to tracking of AG cases. However, it is unclear if these positions will be filled and may be in jeopardy because of the recent hiring freeze ordered by the Governor.

The enforcement caseload is expected to rise as DBC implements new fingerprinting requirements for its licensees around April 2011. The new regulations would require a licensee to furnish a full set of fingerprints to the Department of Justice as a condition of renewal with DBC if the licensee was initially licensed prior to 1999 or if an electronic record of the fingerprint submission no longer exists. According to DBC, about 18,000 dentists, 23,500 RDA and RDAEFs will need to be fingerprinted and an additional 5,000 who were manually fingerprinted may need to update their prints. Additionally, licensees must disclose on the renewal form whether the licensee has been convicted of a crime, as defined, or had any disciplinary actions taken against any other license he or she holds.

Staff Recommendation: *In order to improve case processing and case aging, and to meet its goal of reducing the timeframe for the handling of its disciplinary cases, the following recommendations from the Monitor and Assessment Report should be considered by DBC:*

1) *Continue to reduce the amount of time to process and close complaints.*
2) *A Guideline for case assignments must be established, taking into consideration the skills or experience level of staff and other factors.*
3) *Making Case Processing and Aging a major focus of DBC's improvement planning.*
4) *Prioritize the review of aged cases.*
5) *Establish reasonable elapsed time objectives for each step of the case processing.*
6) *Monitor Performance by establishing regular oversight of case progress and staff productivity.*
7) *A policy or procedures for supervisory staff in performing case reviews should be established.*

Additionally, the Committee should give consideration to auditing both the Investigation Unit of DBC and the Licensing Section of the AG's Office to determine whether improvements could be made to the investigation and prosecution of disciplinary cases.

ISSUE #13: (DISCIPLINARY CASE TRACKING SYSTEM INADEQUATE.) Should DBC continue to monitor the quality of enforcement data and ensure that investigative activities are tracked? Additionally, should DBC adopt guidelines for the completion of specific investigative functions to establish objective expectations?

Background: One of the issues raised by the Monitor was the lack of reliable statistical data system to track disciplinary cases and investigative case activity. DBC currently uses the Consumer Affairs System (CAS) as its complaint, investigation, and discipline tracking database. However, because of constraints associated with the CAS, the DCA recently entered into the Request for Proposal process to identify a vendor and develop an updated applicant and licensing database to better meet the needs of all DCA users. This project is called "BreEZe." Boards and bureaus within DCA will transition into the BreEZe system, and for DBC, the target date is June 2013.

Furthermore, to track investigative activity, DBC transitioned into the Investigator Activity Report (IAR) program utilized by the Medical Board of California (MBC) in 2010. According to DBC, the Dot Net Sequel Server database provided a method for managers to track casework on all cases, provided information for cost recovery purposes and allowed them to better monitor staff performance and productivity. Although DBC had transitioned into the new IAR program used by the MBC, there has always been a resistance to complete the IAR and inconsistency in the use of this tracking tool. The Assessment Report highlighted the importance of the IAR indicating, "If a case is referred to the AG's Office for discipline, the IAR is the source document to recover investigative costs in any eventual settlement, probation terms, or penalty decision. In many cases, if staff had not completed the IAR and received a request for cost recovery, the information that was produced after the fact was based on rough estimates."

Staff Recommendation: *Although all the boards and bureaus within the DCA will transition into the BreEZe system, this process is several years out. In the meantime, DBC should continue to monitor the quality of enforcement data and tracking of investigative services. Moreover, although DBC had transitioned to the IAR utilized by the MBC, DBC should ensure that the IARs are*

consistent and completed. Additionally, as the Enforcement Assessment recommended, guidelines should be established for the completion of specific investigative functions to establish objective expectations. Lastly, DBC should continue in its role to work collaboratively with the DCA's Office of Information Services project staff, as well as with any vendor, to assist in creating an efficient and user-friendly integrated computer system.

ISSUE #14: (PROTRACTED PROCESS TO SUSPEND LICENSE OF A DENTIST.)

DBC must go through a cumbersome process to suspend the license of a licensee who may pose an immediate threat to patients or who have committed a serious crime and may even be incarcerated.

Background: Currently in California, even if a health care provider is thought to be a serious risk to the public, the boards must go through a cumbersome legal process to get permission to stop the provider from practicing, even temporarily. DBC had only obtained immediate suspension of dentists just seven times within five years. Under existing law, the Interim Suspension Order (ISO) process (Section 494 of the B&P Code) provides boards with an avenue for expedited suspension of a license when action must be taken swiftly to protect public health, safety, or welfare. However, the ISO process currently takes weeks to months to achieve, allowing licensees who pose a serious risk to the public to continue to practice for an unacceptable amount of time. Also the timeframes in which a future action against the licensee must be taken, where there is only 15 days to investigate and file an accusation, are unreasonable and prevents most boards from utilizing the ISO process to immediately suspend the license of a health care practitioner. Also, there are no uniform requirements for health care boards to automatically suspend the license of a practitioner who has been incarcerated after the conviction of a felony. Existing law allows for physicians and podiatrists to be suspended while incarcerated but not for other health care professionals, including dentists. Additionally, although existing law allows the DBC to revoke the license of an individual who is required to register as a sex offender, there is no similar requirement for when a licensee is convicted of acts of sexual exploitation of a patient.

Staff Recommendation: ***Extend the time constraints placed on the AG to file an accusation thus allowing the AG to utilize the ISO process without having to have their accusation prepared within a very limited time frame (15 days). Pursuant to Section 494 of the B&P Code, DBC does not have to always rely on an ALJ to conduct the ISO hearing, DBC also has authority to conduct the hearing and could do so more expeditiously where serious circumstances exist regarding the suspension of a dentist's license. Provide for automatic suspension of a dental license if the dentist is incarcerated and mandatory revocation of a license if a dentist is convicted of acts of sexual exploitation of a patient.***

ISSUE #15: (DIFFICULTY COLLECTING CITATIONS AND FINES FOR CERTAIN TYPES OF VIOLATIONS AND COST RECOVERY.) Should DBC contract with a collection agency to improve its cost recovery and cite and fine functions?

Background: Section 125.3 of the Business & Professions Code specifies that in any order issued in resolution of a disciplinary proceeding before any board with the DCA, the ALJ may direct the licensee, found to have committed a violation of the licensing act, to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General. DBC must make a cost recovery request to the ALJ who

presides over the hearing. The ALJ may award full or partial cost recovery to DBC or may reject the request for cost recovery. In cases where cost recovery has been ordered, licensees may be granted a payment schedule. As the table below indicates for FY 2008/2009, DBC collected approximately 60% of the costs ordered but for 2009/2010, it collected 45% of the costs ordered.

COST RECOVERY DATA	2006/2007	2007/2008	2008/2009	2009/2010
Total Enforcement Expenditures	$4,832,720	$5,310,717	$5,373,274	$5,351,113
# Potential Cases for Recovery*	86	100	75	132
# Cases Recovery Ordered	46	46	56	97
Amount of Cost Recovery Ordered	$125,216	$116,796	$229,195	$469,040
Amount Collected	**$90,376**	**$160,970**	**$148,905**	**$211,654**
* The "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation, or violations, of the Dental Practice Act.				

Moreover, Section 125.9 of the B & P Code authorizes DBC to issue citations and fines for certain types of violations. The majority of citations are issued for violations of unsafe and unsanitary conditions. Additionally, dentists who fail to produce requested patient records within the mandated 15 day time period are also subject to administrative citations. As is the case with cost recovery, the table below shows that DBC continues to struggle to collect citations and fines.

CITATIONS & FINES	FY 2006/2007	FY 2007/2008	FY 2008/2009	FY 2009/2010
Total Citations	25	16	11	48
Total Citations with Fines	21	16	10	42
Amount Assessed	$24,497	$14,300	$11,500	$75,100
Reduced, Withdrawn, Dismissed	3	3	2	6
Amount Collected	**$9,140**	**$5,000**	**$3,500**	**$6,700**

Staff Recommendation: ***In order to improve cost recovery and fine collection efforts, DBC should be allowed to procure a contract with a collection agency for the purpose of collecting outstanding fees, fines, or cost recovery amounts. According to the DCA, most of the boards within DCA are struggling to collect cost recovery amounts, outstanding fees, citations or fines. If this is the case, the DCA may wish to procure a contract with one collection agency for all its boards.***

ISSUE #16: (PROBLEMS WITH PROBATION MONITORING.) Should DBC adopt written guidelines on how to make probation assignments and ensure that probationary and evaluation reports are conducted consistently and regularly as recommended by the Enforcement Assessment?

Background: The Dental Practice Act authorizes DBC to discipline a licentiate by placing him or her on probation under various terms and conditions. The terms and conditions could include obtaining additional training or passing an examination upon completion of training; restricting or limiting the extent, scope or type of practice; requiring restitution of fees to patients; or community services. Additionally, dentists on probation are required to pay the monetary costs associated with monitoring the dentists' probation. Generally, DBC recommends five years of probation unless a longer or shorter term is warranted.

According to DBC, probation cases are assigned to inspectors or investigators after taking into consideration the variety of circumstances necessitating probation, combined with the known behavior

of certain licensees. RDAs are generally assigned to inspectors, and difficult or questionable probation subjects are assigned to sworn investigative staff. According to the Enforcement Assessment, there are no written guidelines on how to make probation assignments, and that probationary reports and evaluation reports have not been conducted with regularity. This observation was echoed by the Enforcement Monitor who indicated that probation monitoring practices differ between DBC's Tustin and Sacramento offices.

Staff Recommendation: ***As recommended in the Enforcement Assessment, DBC should adopt written guidelines on how to make probation assignments, and ensure that probationary and evaluation reports are conducted consistently and regularly.***

ISSUE #17: (NEED FOR ANNUAL REPORTING REQUIREMENTS.) Should DBC annually report specific licensing and enforcement information to its licensees and the Legislature?

Background: One of the issues raised by the Monitor was the need to improve DBC's statistical reporting capabilities. The Monitor indicated that DBC needs major enhancements to its complaint tracking system, including regular monthly, quarterly, and annual reporting of Enforcement Program workload and performance. The Monitor suggested that reports of this type also should be provided to DBC's governing Board and the Legislature on a periodic basis. Additionally, the Monitor indicated that DBC staff needs to comply with existing Section 806 reporting requirements (number and type of peer review reports received), which has been in effect since 1975.

According to DBC staff, during its quarterly board meetings, board members are given updated licensing and enforcement reports. However, these reports are not submitted to the Legislature. On the other hand, the Medical Board of California (MBC) is statutorily required to submit annual reports to the Legislature on specific information. The annual report is also included in MBC's newsletters that are distributed to physicians and surgeons and is also available on MBC's Website.

Staff Recommendation: ***The Dental Practice Act should be amended to require DBC to report annually to the Legislature information required under Business and Professions Code Section 2313 that applies to dentists, including malpractice settlements and judgments, Section 805 reports, the total number of temporary restraining orders or interim suspension orders sought by DBC, and other licensing and enforcement information as specified. Staff recommends that annual reports should also be published in DBC's newsletter and made available on its Website.***

ISSUE #18: (IMPLEMENT 2009 DBC ENFORCEMENT ASSESSMENT CORRECTIVE ACTION PLAN.) Should DBC implement the recommendations of a 2009 Enforcement Assessment of DBC's Enforcement Program?

Background: In the fall of 2009, DBC requested an outside assessment of its internal enforcement processes, to measure progress and determine if there were any new barriers to efficiency and productivity. The areas reviewed included: Complaint Intake & Assignment, Non-Sworn Enforcement Processes, Sworn Investigative Services, Enforcement Tools and Investigative Resources, Administrative Discipline Processes, Enforcement Program Data for Management Oversight, Personnel Resources, Peace Officer Training Requirements, Policies and Procedures, and Customer Satisfaction Surveys. Several of the recommendations contained in the Assessment are included in this background paper. However, there are other issues that need to be addressed, including evidence and

storage, tracking of criminal prosecutions, the need for procedures or policy directing supervisory staff to perform case reviews, and continued training of investigative staff.

Staff Recommendation: ***DBC should submit to this Committee a corrective action plan detailing how DBC intends to address and implement the recommendations contained in the 2009 Enforcement Assessment.***

ISSUE #19: (CONTINUED USE OF THE DENTAL LOAN REPAYMENT PROGRAM.) The California Dental Corps Loan Repayment Program still has funds available to provide to dental students.

Background: The California Dental Corps Loan Repayment Program, administered by DBC, was created in 2002 (AB 982, Chapter 1131, Statutes of 2002) to increase the number of dentists who practice in historically underserved areas by providing grants to help pay for the high cost of attending dental school. DBC selects participants to practice in underserved areas, in practice settings with a majority of underserved patients, and gives priority consideration to applicants who are best suited to the cultural and linguistic needs of those populations and meet other related criteria. After each consecutive year of service completed, participants will receive money for loan repayment ($25,000 for the 1st year, $35,000 for the 2nd year, and $45,000 for the 3rd year) for up to three years. The law states each participant may receive no more than $105,000 over three years. The program was extended until July 1, 2012 and authorized DBC to distribute funds remaining in the account. However, due to limited participation, DBC points out that the program should be extended until DBC distributes all the remaining money in the fund.

Staff Recommendation: ***The California Dental Corps Loan Repayment Program should be extended until DBC distributes all the funds in the account. DBC should indicate to the Committee its efforts to inform students about the availability of the loan repayment program.***

SUBSTANCE ABUSE AND DIVERSION PROGRAM ISSUES

ISSUE #20: (EFFECTIVENESS OF DIVERSION PROGRAM AND IMPLEMENTATION OF SB 1441 STANDARDS.) It is unknown how successful DBC's Diversion Program is in preventing recidivism of dentists who may abuse drugs or alcohol, and if the Diversion Program is effectively monitoring and testing those who participate in the program. Additionally, it is unclear when "Uniform Standards" for their Diversion Programs will be implemented.

Background: DBC administers a Diversion Program intended to identify and rehabilitate dentists whose competence may be impaired due to abuse of dangerous drugs or alcohol, so that licentiates may be treated and returned to the practice of dentistry in a manner that will not endanger the public health and safety. According to DBC's website, the diversion program offers a means of recovery without the loss of license by providing access to appropriate intervention programs and treatment services. DBC has established DECs for northern and southern California to assist it in evaluating licensees who may be impaired due to the abuse of alcohol or drugs. DECs are composed of three dentists, one dental auxiliary, one physician or psychologist, and one public member who all have experience or knowledge in the field of chemical dependency. Entry into the diversion program may be through self-referral but most participants enter the diversion program because they are under

investigation by DBC and were referred by a program manager. Since 1983, the clinical management of the diversion program has been done by MAXIMUS, Inc. After an initial evaluation, individuals accept a participation agreement (diversion program recovery terms and conditions contract) and are regularly monitored in various ways, including random drug testing, to ensure compliance. According to the DBC, a Clinical Assessment (initial evaluation) is conducted in accordance with acceptable practice standards for chemical dependency and mental health assessments. It includes a complete psychosocial and drug history. The intent of the evaluation is to determine whether the licensee has a substance abuse problem, is a threat to himself/herself or others, and will provide recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice. Each chemically impaired professional entering the program is responsible for meeting the requirements of the Diversion program. A Diversion Program Recovery Terms and Conditions Agreement serves to clearly define the monitoring requirements and reports of the Program and obtain the participant's written statement of acceptance. MAXIMUS provides the following services: medical advisors, compliance monitors, case managers, urine testing system, reporting, and record maintenance. The table below summarizes the number of participants and the costs of administering the program.

DIVERSION PROGRAM STATISTICS	2006/2007	2007/2008	2008/2009	2009/2010
Total Program Costs	$141,060	$113,026	$137,452	$133,471
Total Participants	58	52	61	59
Successful Completions	9	5	4	4
Unsuccessful Completions	2	7	4	1

In 2007 and 2008, this Committee held informational hearings on the Physician Diversion Program (PDP) after an audit of MBC's diversion program revealed that the MBC's program was not sufficiently protecting the public. Although the MBC voted unanimously to end the PDP on June 30, 2008, this Committee recognized the need to strengthen the diversion programs of boards that continue to administer them. As such, in 2008, SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) became law and required the DCA to establish a Substance Abuse Coordination Committee (SACC) to adopt uniform guidelines on sixteen specific standards that would apply to substance abusing health care licensees, regardless of whether a board has a diversion program. The intent of SB 1441 was to establish common and uniform standards to govern the different health care licensing boards' diversion programs so as to maintain public confidence that these programs are truly monitoring and rehabilitating substance abusing licensees. These sixteen standards, at a minimum, include: requirements for clinical diagnostic evaluation of licensees; requirements for the temporary removal of the licensee from practice for clinical diagnostic evaluation and any treatment, and criteria before being permitted to return to practice on a full-time or part-time basis; all aspects of drug testing; whether inpatient, outpatient, or other type of treatment is necessary; worksite monitoring requirements and standards; consequences for major and minor violations; and criteria for a licensee to return to practice and petition for reinstatement of a full and unrestricted license.

On March 3, 2009, the SACC conducted its first public hearing and the discussion included an overview of diversion programs, the importance of addressing substance abuse issues for health care professionals and the impact of allowing health care professionals who are impaired to continue to practice. During this meeting, the SACC members agreed to draft uniform guidelines for each of the standards. During subsequent meetings, roundtable discussions were held on the draft uniform standards, including public comments. In December 2009, the DCA adopted the uniform guidelines for each of the standards required by SB 1441. Last year, SB 1172 (Negrete McLeod) Chapter 517,

Statutes of 2010, was passed to give boards the statutory authority to implement certain standards that needed statutory authority. Moreover, the DCA had instructed health care boards to begin the process of implementing the SB 1441 standards, including amending disciplinary guidelines through the regulatory process to be consistent with SB 1441.

In 2010, MAXIMUS was audited by the DCA and it was indicated that they were complying with all of the requirements of their contract; however, Committee staff had serious concerns about the completeness of this audit and the serious deficiencies which may still exist with this program. This came to light when it was found that MAXIMUS was recently testing those participants in the health boards' Diversion Programs and using inexact standards (i.e., participants were tested at a higher standard and tested negative when they should have been tested at a lower standard and may have potentially tested positive). The DCA took immediate steps to rectify this problem, but it still raises questions about the effectiveness and efficiency of MAXIMUS and those diversion programs which rely on this contractor.

Staff Recommendation: ***The Committee should consider requiring an audit of DBC's Diversion Program in 2012, along with the other health boards which have Diversion Programs to assure that these programs are appropriately monitoring and treating participants and to determine whether these programs are effective in preventing further substance abuse. Additionally, the audit should also determine the value of utilizing DECS in a diversion program. DBC should also indicate to the Committee how the Uniform Standards are being implemented and if all Uniform Standards are being followed, and if not, why not; give a definite timeframe when disciplinary guidelines will be amended to include SB 1441 standards, whether formal training for DECS is necessary to ensure that standards are applied consistently, and the necessity of revising the Maximus diversion program recovery contract signed by a dentist who enters the diversion program to incorporate certain aspects of SB 1441 including the requirement that a dentist must undergo a clinical diagnostic evaluation to participate in the program; the practice restrictions that apply while undergoing a diagnostic evaluation; the requirement to provide the names and contacts of employers or supervisors for participants who continue to work; the frequency of drug testing; that collection of specimens shall be observed; that certain requirements exist for facilitators; what constitutes major or minor violations; and the consequences for major or minor violations.***

ISSUE #21: (DBC CANNOT ACCESS RECORDS OF THE DIVERSION PROGRAM WHEN A DENTIST IS TERMINATED FOR NON-COMPLIANCE.) Should DBC be authorized to access diversion records for dentists who are terminated from the diversion program for non-compliance, which usually involves relapse?

Background: Section 1698 of the B&P Code specifies that except where the licentiate presents a threat to the public's health and safety, all DBC and DEC records and records of proceedings pertaining to the treatment of a licentiate in a diversion program is kept confidential and are not subject to discovery or subpoena. In 2009, AB 456 (Emmerson) was sponsored by DBC to make changes to the current confidentiality of diversion records, and would have allowed for the sharing of diversion information with DBC's enforcement program when a licensee participating in the diversion program is terminated for non-compliance while on probation by DBC. DBC further indicated at that time that the exception when a licensee presents a threat to the public's health and safety, does not allow DBC's diversion program to notify its own enforcement program when a licensee participating in diversion is not in substantial compliance. The diversion program can only provide the name of the terminated licensee and not any specifics as to why the individual was terminated from the program. This

notification, DBC argues, is necessary as the information obtained in the diversion program could be used for subsequent disciplinary action by DBC. At that time, Committee staff, among other issues and recommendations, suggested that AB 456 should be amended to indicate that rules and regulations required by AB 456 shall, at a minimum, be consistent with the uniform standards adopted pursuant to SB 1441. The Author and Sponsor eventually decided not to pursue the bill. However, the confidentiality of diversion records remain a priority for DBC and staff recognizes the need for the enforcement unit to have all available records if a licensee is terminated from the program for non-compliance and disciplinary action ensues.

Staff Recommendation: ***Amend the Dental Practice Act to authorize DBC to access any diversion records of a licensee who participates in a diversion program and is terminated for non-compliance, for purposes of investigation and imposition of a disciplinary action.***

CONSUMER NOTICE ISSUE

ISSUE #22: (NOTICE TO CONSUMERS THAT DENTISTS ARE REGULATED BY DBC.) Should DBC promulgate regulations pursuant to a statute enacted in 1999 to require dentists to inform patients that they are licensed by DBC?

Background: Section 138 of the Business & Professions Code requires that DCA board and bureaus, including healing arts boards such as DBC, initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, to provide notice to their clients or customers that the practitioner is licensed by this state. A board is exempt from the requirement to adopt regulations if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state. The purpose of this statute is to inform consumers the appropriate regulatory body that regulates a particular licensee or practitioner.

Recently, the MBC promulgated regulations pursuant to Section 138 to require physicians and surgeons to inform their patients that they are licensed by the MBC, and includes the board's contact information. In the same manner, DBC should implement Section 138 and adopt regulations to require dentists to inform their patients that they are licensed by the Board.

Staff Recommendation: ***Pursuant to Section 138 of the B & P Code, DBC should adopt regulations to require dentists to inform their patients that they are licensed by the DBC.***

BOARD, CONSUMER AND LICENSEE USE OF THE INTERNET ISSUES

ISSUE #23: (NEED FOR CONTINUED ENHANCEMENT OF DBC's INTERNET SERVICES.) Should DBC continue to explore ways to enhance its Internet Services and Website to licensees and members of the public?

Background: DBC points out that one of the major changes since its last sunset review has been its increased utilization of the Internet and computer technology to provide services and information to the public and its licensees on its Website. These include:

- A DBC Website, www.dbc.ca.gov, which receives an average of 966 visitors per day.

- Full texts of final enforcement decisions, including accusations are now available on the Website. A consumer may look up a licensee by name and/or license number, and is provided with all information relevant to the final decision.

- An online complaint form is available for filing a complaint, a "Frequently Asked Questions" section, a pamphlet on "Problems with Your Dentist," and general information about DBC's complaint process.

- Licensees may review continuing education requirements, disciplinary guidelines, and access various forms.

- E-News subscription service sign-up is available online to be notified of DBC's activities.

The Board indicated that it has begun modifying its Website to allow for the posting of meeting materials, and allow consumers, stakeholders, and interested parties to download these documents at no charge. Furthermore, DBC plans on publishing an online newsletter beginning 2011, and is exploring the feasibility of providing live webcasts of its board meetings. Additionally, all reports submitted to the Legislature should be posted on DBC Website

Staff Recommendation: ***DBC should continue to explore ways to enhance its Internet Services to licensees and members of the public, including posting meeting materials, board policies, and legislative reports on the Internet and webcasting Board meetings.***

BUDGETARY ISSUES

ISSUE #24: (ARE RECENT LICENSING FEES SUFFICENT TO COVER DBC COSTS?) Is DBC adequately funded to cover its administrative, licensing and enforcement costs and to make major improvements to its enforcement program?

Background: DBC is a self-supporting, special fund agency that obtains its revenues from licensing fees of dentists and RDAs. The collection of fees supports DBC's ability to operate its Enforcement, Licensure, Examination, Renewal/Continuing Competency, Permit Programs and Dental Assisting Programs. DBC's primary source of revenue is the biennial renewal for dentists and RDAs. DBC currently charges dentists a $365 renewal fee. The statutory maximum is $450. There have been no fee increases from dental license or renewal since 1998. As DBC explains, it anticipates a significant increase in enforcement costs starting FY 2010/2011 due to the implementation of CPEI. Increased productivity and a higher rate of case closures, in addition to reduction in processing timeframes, is expected to justify the costs. Additionally, the Board will be implementing its new portfolio examination to replace the current dental licensure examination. In FY 2002/2003 and 2003/2004 loans were made from the State Dentistry Fund to the State General Fund in the amount of $5 million for each fiscal year. Of the $10 million total loan, $0.6 million was repaid in FY 2004/2005, $2.5million was repaid in FY 2005/2006, and another $2.5 million was repaid in FY 2006/2007. There is an outstanding loan balance of $4.4 million. In the 2011/2012 Budget Act, the Governor proposed a reimbursement of $2.5 million but the Legislature recently reduced this to $1.2 million. The table

below illustrates the fund condition of the Dental Fund if CPEI positions are filled and the remaining $3.2 million loan to the General Fund is reimbursed by FY 2012/2013. DBC points out that assuming all the loans to the General Fund are reimbursed, it may be looking at fee increases for dentists as soon as FY 2012/2013, because the fund reserve at that time would be at 1.3 months. According to DBC, its objective is to maintain a three-month reserve of funds for economic uncertainties and to operate with a prudent reserve. However, if the CPEI positions are not filled, all the loans to DBC are repaid and the Governor's hiring freeze directive continues, then the fund reserve will be much higher and fee increases may be delayed to a later time.

Dental Board Updated Fund Condition Table

ANALYSIS OF FUND CONDITION	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/2011 (Projected)	FY 2011/2012 (Projected)	FY 2012/2013 (Projected)
Total Reserves, July 1	$7,053,000	$7,394,000	$7,320,000	$7,865,000	$4,464,000	$2,007,000
Total Rev. & Transfers	$8,037,000	$7,985,000	$7,920,000	$7,758,000	$8,929,000	$10,921,000*
Total Resources	$15,345,000	$15,548,000	$15,424,000	$15,623,000	$13,393,000	$12,928,000
Total Expenditures	$7,948,000	$8,230,000	$7,559,000	$11,159,000	$11,386,000	$11,641,000
Unreimbursed Loans to General Fund	$4,400,000	$4,400,000	$4,400,000	$4,400,000	$3,200,000	$0
Accrued Interest	$0	$0	$0	$0	$0	$0
Loans to General Fund	$0	$0	$0	$0	$0	$0
Reserve, June 30	**$7,394,000**	**$7,318,000**	**$7,865,000**	**$4,464,000**	**$2,007,000**	**$1,287,000**
MONTHS IN RESERVE	**10.8**	**11.6**	**8.5**	**4.7**	**2.1**	**1.3**
NOTES:*This table assumes the repayment of the $1.9 million balance of GF loan, in FY 12/13. GF loan must be fully reimbursed before a fee increase can be implemented. (Item 1250-011-0741, BAs 2002/2003 and 2003/2004)						

For RDAs, DBC currently charges $70 for license renewal, with an $80 statutory maximum. The table below shows that the Dental Assisting Fund will be in a deficit spending situation in FY 2012/2013. DBC points out that it will need to increase, via Board Resolution pursuant to Section 1725 of the B & P Code, the renewal fees for RDA's to the $80 statutory maximum.

Dental Assisting Fund Condition Table

ANALYSIS OF FUND CONDITION	2007/08	2008/09	2009/10	2010/11 (Projected)	2011/12 (Projected)	2012/13 (Projected)
Total Reserves, July 1	N/A	N/A	$0	$1,925,000	$1,354,000	$760,000
Total Rev. & Transfers			$3,183,000	$1,146,000	$1,141,000	$1,134,000
Total Resources			$3,183,000	$3,071,000	$2,495,000	$1,894,000
Total Expenditures			$1,258,000	$1,715,000	$1,735,000	$1,787,000
Unreimbursed Loans to General Fund			$0	$0	$0	$0

Accrued Interest			$0	$0	$0	$0
Loans to General Fund			$0	$0	$0	$0
Reserve, June 30			$1,925,000	$1,354,000	$760,000	$107,000
Months in Reserve			**13.5**	**9.4**	**5.1**	**0.7**

Staff Recommendation: DBC should assure the Committee that it will have sufficient resources to cover its administrative, licensing and enforcement costs and to provide for adequate staffing levels for critical program areas if appropriate staffing and funding is provided. Additionally, the Committee may consider amending Section 1725 of the B & P Code to instead require that any changes in licensing and permitting fees of dental assistants be established by regulations, instead of Board Resolutions as currently required.

ISSUE #25: (LACK OF STAFF CONTINUES TO HAMPER DBC'S ENFORCEMENT PROCESS.) DBC should explain to the Committee the negative impact of enforcement program vacancies to its overall functions.

Background: There are currently 72.8 authorized positions for DBC, wherein 60.8 positions are filled and 12 positions are vacant. The CPEI authorized 12.5 positions for DBC, of which 4 positions are filled and 8.5 remain vacant. The Enforcement Unit is comprised of 35 staff, including peace officers, inspectors and staff managers. The Enforcement Unit currently has 10.5 vacant positions. DBC points out that the enforcement program is allocated 16 peace officer positions to perform criminal and complex quality of care investigations. However, due in part to vacancies within enforcement, up to five positions have been vacant for 6 months or more since July 2006.

Contributing to these lengthy vacancies are required background processes which can take six to nine months, training academies (four months), and the establishment of a new hiring list. More recently, mandatory furloughs have reduced the number of hours staff can legally work by three days per month. As a consequence, case age has increased as less staff hours were available to perform the necessary work.

DBC indicates that during previous reviews, a number of efforts (case reviews, approved overtime) were initiated to focus on closing the oldest cases and reducing the overall number of cases pending investigation. Case reviews have been ongoing with field investigative staff and continue to focus on case progress and closing older cases. Despite these challenges, DBC indicates, the additional positions from the CPEI offer the potential for the enforcement program to show marked improvements in its case statistics. DBC points out that it is still under order to continue with a former Governor's Directive for a hiring freeze that began on August 31, 2010, as well as to continue with a 5% staff reduction. The hiring freeze allows state departments to transfer existing employees within the department, and for DBC, it was able to hire employees away from other DCA boards or bureaus. DBC states that it needs to fill its vacant positions, including the sworn and non-sworn investigative staff it was authorized to hire under CPEI in order to critically improve its enforcement process.

Staff Recommendation: ***DBC should express to the Committee its frustration in being unable to meet the staffing needs of its various critical programs, especially that of its enforcement program,***

and the impact that it will have on its ability to address the problems identified by this Committee, especially as it concerns its goal to reduce the timeframe for the investigation and prosecution of disciplinary cases.

ISSUE #26: (IMPACT ON DBC OF THE UNPAID LOANS MADE TO THE GENERAL FUND.) Will the unpaid loan to the General Fund have an impact on the ability of DBC to deal with its case aging and case processing?

Background: In FY 2002/2003 and 2003/2004 loans were made from the State Dentistry Fund to the State General Fund in the amount of $5 million for each fiscal year. Of the $10 million total loan, $0.6 million was repaid in FY 2004/2005, $2.5million was repaid in FY 2005/2006, and another $2.5 million was repaid in FY 2006/2007. There is an outstanding loan balance of $4.4 million. In the 2011/2012 Budget Act, the Governor proposed a reimbursement of $2.5 million but the Legislature recently reduced this to $1.2 million, and with this reduction the loan balance is $3.2 million. It is unclear when DBC should anticipate these payments. If the loan balance remains unpaid in FY 2012/2013, DBC will be in deficit spending.

This has been a constant problem for the Committee and the Legislature in regards to the boards and bureaus under the DCA. This Committee along with the Assembly Business and Professions Committee has over the years reviewed all boards (through the process of sunset review) and any anticipated problems in the appropriate funding of their programs has been considered and efforts have been made to either reduce their budget or program requirements, or increase their level of funding through license fee increases. The boards over the years have been placed in a position of not being able to spend the revenue which has been made available to them for purposes of properly running their enforcement programs. They have either been denied spending authority for their increased revenue by denial of BCPs or by other directives, which has had the effect of increasing their reserve funds, and then find that rather than having any chance of using these funds in the future to deal with increased enforcement costs, the money reverts back to the General Fund by way of a "loan." Unless there is a strong mandate that licensing fees should only be used for purposes of properly operating the boards this vicious cycle will continue. One of the outcomes of budget changes and cutbacks to boards has been the slow-down of cases or actual holding off on pursuing cases by the AG's Office because the board(s) ran out of money at some point later in the fiscal year.

Staff Recommendation: ***No more loans from the reserve funds of the DBC to the General Fund. DBC should explain to the Committee what the impact will be to its overall Budget and its enforcement process if the outstanding loan is not repaid as soon as possible. This of course is if DBC is granted an exemption from the hiring freeze, otherwise new expenditures will not be necessary.***

CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT MEMBERS OF THE DENTAL BOARD OF CALIFORNIA

ISSUE #27: (CONSUMER SATISFACTION WITH DBC IS LOW.) A 2010/2011 Consumer Satisfaction Survey of DBC shows only about 30% of complainants are satisfied with the service provided by the Board. Additionally, DBC failed to disseminate a consumer satisfaction survey prior to 2010.

Background: In 2002, the Monitor recommended that DBC implement a survey tool to establish measurements of customer satisfaction with the Enforcement Program. Although a document was developed, according to the 2009 Enforcement Assessment, the survey was not used. In its sunset report, DBC indicated that in August 1, 2010, it joined in DCA's effort to develop ongoing performance measures. DBC indicates that consumers are provided with a web address at the bottom of complaint and case closure letters and encouraged to visit the site and provide feedback on their satisfaction with the Board's complaint process. The questions used in the survey and the identifying five-rankings for evaluating the consumers' responses are consistent with the Joint Legislative Sunset Review Committee's recommendations back in 1996 for all DCA boards to conduct a consumer satisfaction survey. DBC indicates that on a monthly basis consumer responses will be compiled and analysis will be provided. Committee staff requested a sample of consumer surveys, and at its early stages, it appears that only about 30% of complainants were satisfied with the way in which DBC handled their complaints. This is a shortcoming of many of the boards under the DCA; most have low satisfaction rates around 50%. The most prominent reason for dissatisfaction with boards is that consumers do not feel as if they are being kept updated about the status of their complaint and case, and the outcome takes so long that they see the board as not really having any real interest in their case as it moves slowly through the process. And the only satisfaction the complainant gets is usually to either see the licensee placed on probation (with conditions) or to have their license revoked. Waiting 2 ½ years or more for some resolution to their case is extremely frustrating for consumers and is probably something they don't clearly understand, and while the final result may be taking the practitioners license or placing them on probation, one wonders whether there could be a better result for the original complainant. The Contractor's Board seems to enjoy a better satisfaction rate in resolving a complaint because it tries under certain circumstances to try and mediate disputes first to hopefully bring quicker resolution to the matter and possibly provide some form of restitution to the consumer who has been harmed by the licensee. If there is an issue of competency or violation of law(s) then the Contractor's Board will still proceed with licensing action against the contractor even though the complainants issue has been settled. This Committee should begin to explore the use of mediation or what is called alternative dispute resolution (ADR) for health boards and whether they could utilize those trained in ADR or current ADR programs to resolve complaints. Consideration could be made of possibly expanding on the current "Complaint Mediation Program" (CMP) of DCA to also include consumers who have problems with health professionals. The CMP under DCA now only deals with difficulties by consumers in purchasing products or services, but there are certainly instances where ADR could be utilized when disputes arise (in the form of a complaint to the board) regarding services provided by health professionals.

Staff Recommendation: ***DBC should explain to the Committee why a Consumer Satisfaction Survey was not implemented as recommended by the Monitor, and explain why it believes consumer satisfaction regarding its service is so low, and what other efforts DBC could take to improve its general service to the consumer. Does DBC believe that mediation could be used in certain circumstances to help resolve complaints from the general public regarding health care practitioners?***

ISSUE #28. (CONTINUED REGULATION OF DENTISTS BY DBC.) Should the licensing and regulation of the dental profession be continued, and be regulated by the current board membership?

Background: The health and safety of consumers are protected by a well-regulated dental profession. DBC should be continued with a four-year extension of its sunset date so that the Committee may review it once again if the issues and recommendations in this Paper and others of the Committee have been addressed.

Staff Recommendation: ***Recommend that the dental profession should continue to be regulated by the current DBC members in order to protect the interests of consumers and be reviewed once again in four years.***

THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT G:

Letter of DHCC Support from

President Pro Tempore Don Perata

(July 23, 2010)

Former President Pro Tempore, Senator Don Perata

July 23, 2010

Ms. Rhona Lee, President
Dental Hygiene Committee of California
2005 Evergreen Street, Suite 1050
Sacramento, CA 95815

Ms. Lori Hubble, Executive Officer
RDH Examinations, Licensure by Credential, and RDHAP Licensure
2005 Evergreen Street, Suite 1050
Sacramento, CA 95815

Dear President Lee and Executive Officer Hubble:

I spent a considerable amount of time in both the Assembly and Senate and specifically as President pro Tempore of the Senate, working on dental care issues. Most importantly, I am the author of the legislation that created the Dental Hygiene Committee of California (DHCC) (SB 853, 2008).

I am writing this letter to clarify the intent of the legislation. It was agreed by all parties involved in the negotiations surrounding this bill, that the bill would create an autonomous committee. The medical model was used, a model which has the medical board with autonomous committees such as the Physician's Assistance Committee, that function as a "board."

The legislation clearly delineates the responsibilities of the DHCC. In terms of recommendations, the DHCC will only make recommendations to the Board regarding scope of practice issues as they relate to the practice of dental hygiene.

Section 1905.01, I have been told, is being interpreted to mean that the DHCC is "under" the DBC and therefore the DHCC should be consulting with or working under the direction of the DBC. As I have stated above, this was not the intent of the bill-nor is it what the bill stipulates.

I have been made aware that Section 1905.02 is also causing some confusion. In my investigation of this section I realized that, inadvertently, this language, which represents old committee on Dental Auxiliaries language, was left in, SB 853.

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It is my recommendation that it be removed, as the sections immediately preceding Section 1905.2, as well as the sections after 1905.2, clearly delineate the charge of the DHCC, which includes setting regulations, licensure and enforcement for dental hygienists. The DHCC is to carry out these functions autonomously.

The DHCC is the first self-regulating dental hygiene committee in the country. So, I understand that there may be some confusion as to how the committee is to function. However, the DHCC should continue to fulfill its charge without being hindered by the DBC's perception that the DHCC is under the DBC's rule.

A great deal of work went into the process of creating the DHCC. I appreciated very much the dental community and the hygiene community coming together. Please allow the DHCC to act autonomously, except on scope of practice, as it was agreed upon. No one wants to go back to old battles when there is so much good that can be done.

Sincerely,

DON PERATA

cc: Dr. John Bettinger, President
Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815

Terry McHale
Aaron Read & Associates, LLC
1415 L Street, Suite 1100
Sacramento, CA 95814

THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT H:

Crossing the Quality Chasm:

A New Health System for the 21st Century

Chapter 9 – Preparing the Workforce (p. 217)

9

Preparing the Workforce

Health care is not just another service industry. Its fundamental nature is characterized by people taking care of other people in times of need and stress. Patients are ill, families are worried, and the ultimate outcome may be uncertain. Stable, trusting relationships between a patient and the people providing care can be critical to healing or managing an illness. The people who deliver care are the health system's most important resource.

All of the issues raised in the previous chapters of this report have important implications for the health care workforce, potentially requiring different work in new types of organizations that may use fewer people. Accountabilities and standards of care may change; relationships between patients and health professionals are certain to do so.

The health care workforce is large, having employed almost 6 million people in 1998 (Occupational Employment Statistics, 2000) with a wide variety of educational backgrounds, specialization, and skills. Professional hierarchies are well established and reinforced by training, laws, and regulations, as well as culture and history. In general, health professionals are also conservative, stressing the application of precedent and risk avoidance in clinical practice, particularly relative to changes that may affect the quality of care for patients. As a result, any change can be exceedingly slow and difficult to accomplish, especially if there is not a clear understanding of why the change may be needed or of its impact on current practices.

The importance of appropriately preparing the workforce for the changes in health care delivery that will be necessitated by the recommendations in this report cannot be underestimated. There are many serious challenges facing the

health care workforce, including difficulties in retention of personnel, the impending crisis in nursing supply, and the need for strong leadership within the health care system to guide and support what will be a very difficult transition. When clinicians are under stress themselves, it is difficult to take care of patients who are ill and stressed. Indeed, this was one of the key transitional issues identified during the committee's deliberations. It is a broad topic that can only be introduced here, but the committee emphasizes the need for additional study to understand the effects of the changes recommended herein on how the workforce is prepared for practice, how it is deployed, and how it is held accountable.

Recommendation 12: A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for (1) restructuring clinical education to be consistent with the principles of the 21st-century health system throughout the continuum of undergraduate, graduate, and continuing education for medical, nursing, and other professional training programs; and (2) assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals.

Recommendation 13: The Agency for Healthcare Research and Quality should fund research to evaluate how the current regulatory and legal systems (1) facilitate or inhibit the changes needed for the 21st-century health care delivery system, and (2) can be modified to support health care professionals and organizations that seek to accomplish the six aims set forth in Chapter 2.

This chapter briefly examines three specific issues: clinical training and education, regulation of the health professions, and legal liability issues. Clinical training and education is seen as particularly important for changing the culture of health care practice to support achievement of the aims set forth in Chapter 2. Greater understanding is needed of why prior efforts at modifying clinical education have not had the desired impact and of the supportive strategies needed to overcome such barriers.

CLINICAL EDUCATION AND TRAINING

To achieve the six aims proposed in Chapter 2, additional skills may be required of health professionals—not just physicians, but all clinicians who care for patients. Prior chapters have identified a number of changes affecting health care delivery, including a shift from acute to chronic care, the need to manage a continually expanding evidence base and technological innovations, more clinical practice occurring in teams and complex delivery arrangements, and changing patient–clinician relationships. The need to balance cost, quality, and access in

health care will put pressures on clinical education programs, particularly given the outlay of public dollars for clinical education.

The types of new or enhanced skills required by health professionals might include, for example, the ability to:

- Use a variety of approaches to deliver care, including the provision of care without face-to-face visits (e.g., using electronic communications to provide follow-up care and routine monitoring) (see Chapter 3).
- Synthesize the evidence base and communicate it to patients (see Chapter 6).
- Combine the evidence base, knowledge about population outcomes, and patient preferences to tailor care for an individual patient (Weed and Weed, 1999a) (see Chapter 6).
- Communicate with patients in a shared and fully open manner to support their decision making and self-management (to the extent they so desire), including the potential for unfettered access to the information contained in their medical records (see Chapter 3).
- Use decision support systems and other tools to aid clinical decision making in order to minimize problems of overuse and underuse and reduce waste (Weed and Weed, 1999a) (see Chapter 6).
- Identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification (Institute of Medicine, 2000) (see Chapter 5).
- Understand the course of illness and a patient's experience outside of the hospital (where most training is conducted).
- Continually measure quality of care in terms of both process and outcomes; develop and implement best practices (Berwick et al., 1992) (see Chapter 5).
- Work collaboratively in teams with shared responsibility (Chassin, 1998) (see Chapter 5).
- Design processes of care and measure their effectiveness, even when the members of the team that cares for a patient are not in the same physical locale (Berwick et al., 1992).
- Understand how to find new knowledge as it continually expands, evaluate its significance and claims of effectiveness, and decide how to incorporate it into practice (Chassin, 1998) (see Chapter 6).
- Understand determinants of health, the link between medical care and healthy populations, and professional responsibilities.

Teaching these skills will likely require changes in curriculum. Although some schools have added courses that are consistent with the desired skills, the needed content is likely to evolve over time. For example, many schools now have courses in patient communications, information systems, and biostatistics.

However, communicating with patients to improve adherence to a recommended treatment is different from communicating with patients who are key decision makers and full partners in their care. Using information technology to do a MEDLINE search is important, but not the same as using the technology as a central component in delivering care and using decision support as an aid to clinical decision making. Knowing biostatistics aids in understanding the published literature, but is not the same as using statistics to design processes of care to reduce variations in practice. Likewise, care provided by multidisciplinary teams involves more than knowing the responsibilities of people in a clinical department; it should involve knowing how to form and use teams to customize care across settings and over time, even when the members of the team are in entirely different physical locations.

Although curriculum changes are essential in providing new skills to health professionals, they are not sufficient by themselves. It is also necessary to address how health professional education is approached, organized, and funded to better prepare students for real practice in an information rich environment. Two examples are teaching evidence-based practice and training in multidisciplinary teams.

The traditional emphasis in clinical education, particularly medical education, is on teaching a core of knowledge, much of it focused on the basic mechanisms of disease and pathophysiological principles. Given the expansiveness and dynamic nature of the science base in health care, this approach should be expanded to teach how to manage knowledge and use effective tools that can support clinical decision making (Evidence-Based Medicine Working Group, 1992; Weed and Weed, 1999c). Effective teaching of evidence-based practice requires faculty role models, an emphasis on teaching the application of critical appraisal skills in actual patient care settings, and experience in conducting literature searches and applying methodological rules to the evaluation and understanding of evidence (Evidence-Based Medicine Working Group, 1992). In a survey of 269 internal medicine residency programs, it was found that only 99 offered a freestanding program in evidence-based medicine (Green, 2000). The curricula for these 99 programs varied greatly: 77 included critical appraisal of the literature; 52 provided information on how to search for evidence; 44 covered issues related to the articulation of a focused clinical question; 35 covered the application of evidence to individual decision making; and 23 included integration of the evidence into decision making in actual practice. Nearly all programs provided access to MEDLINE, while only about one-third provided access to the Cochrane Library (see Chapter 6).

Similarly, as more care is provided by teams, more opportunities for multidisciplinary training should be offered (Institute of Medicine, 1996a). People should be trained in the kinds of teams in which they will provide care, starting with initial professional training and continuing through graduate training and ongoing professional development. Multidisciplinary training is difficult

to implement because of professional boundaries, the traditional hierarchical structure of health care, clinical specialization, faculty experience, and educational isolation. Changing the situation will require an examination of clinical curricula, funding for education, and faculty preparation. Although there was great interest and innovation in multidisciplinary training during the 1960s, little lasting change resulted (Pew Health Professions Commission, 1993). The ability to plan care and practice effectively using multidisciplinary teams takes on increasing importance as the proportion of the population with chronic conditions grows, requiring the provision of a mix of services over time and across settings.

A changing relationship between clinicians and their patients also calls for new skills in communication and support for patient self-management, especially for patients with chronic conditions. Collaborative management requires collaboration between clinicians and patients in defining problems, setting goals, and planning care; training and support in self-management; and continuous follow-up (Von Korff et al., 1997). Patients with chronic conditions who are provided with knowledge and skills for self-management have been shown to experience improvements in health status and reduced hospitalizations (Lorig et al., 1999). Clinicians need to have skills to train patients in techniques of good self-management.

Teaching a different set of skills also has implications for the capabilities of health care organizations that conduct training programs if these skills and behaviors are to be reinforced in training beyond basic coursework. For example, training can emphasize the importance of information technology in clinical care, but that message is not reinforced if students continue their training in health care organizations that are not equipped with such systems or where the faculty are not prepared to use the skills themselves. This is a particular challenge for training in ambulatory settings and physician offices. Although many would agree that more training needs to be offered in such settings, additional support may be required for this purpose.

Although improved methods of training the next generation of clinicians are important, efforts must also be made to retool practicing clinicians. Traditional methods of continuing education for health professionals, such as formal conferences and dissemination of educational materials, have been shown to have little effect by themselves on changing clinician behaviors or health outcomes (Davis et al., 1995). Continuing education needs to emphasize a variety of interventions, particularly reminder systems, academic detailing, and patient-mediated methods, and use a mix of approaches, including Web-based technologies. Reorientation of credentialing processes to assess a clinician's proficiency in evidence-based practice and the use of decision support tools may be necessary to provide strong incentives for clinicians to undertake this important learning process. The development of clinical leadership is another area that needs attention. Clinical leadership will be required to direct the changes discussed, but there will also be

a need for new leaders who are able to function effectively in and lead complex delivery systems.

Finally, there are implications for the training and development of nonclinical administrative and management personnel, as well as governance. By making budgetary and resource decisions for health care organizations, these groups, with input from and in collaboration with the clinical community, influence priorities and the pace at which they are implemented. For example, the administration of a hospital can provide sufficient resources to support the implementation of medication order/entry systems that help clinicians provide safer care, or they can slow the pace at which such systems are implemented by not ensuring sufficient resources or training. Training and development for both management and governance should recognize the important role these groups play in collaborating with clinicians to make possible the types of changes needed for the health system of the 21st century.

There have been many prior examinations of clinical education, particularly medical education. The structure and form of medical education were set through the Flexner report of 1910. That report called for a 4-year curriculum comprising 2 years of basic sciences and 2 years of clinical teaching, university affiliation (instead of proprietary schools), entrance requirements, encouragement of active learning and limited use of lectures and learning by memorization, and emphasis on the importance of problem solving and critical thinking (Ludmerer, 1999; Regan-Smith, 1998).

More than 20 different reports followed Flexner's, each calling for the reform of medical and clinical education. The striking feature of these reports is their similarity in the problems identified and proposed solutions. Christakis (1995) reviewed 19 reports and found eight objectives of reform among them: serve changing public interest, address physician workforce needs, cope with burgeoning knowledge, foster generalism and decrease fragmentation, apply new educational methods, address the changing nature of illness, address the changing nature of practice, and improve the quality and standards of education. Enarson and Burg (1992) reviewed 13 studies of medical education and summarized the recommended changes under the categories of (1) methods of instruction and curriculum content (including the need for a broad general education, definition of educational objectives, acquisition of lifelong learning skills, and expansion of training sites); (2) internal structure of medical school (including integration of medical education across the continuum of preparation, control of education programs in multidisciplinary and interdepartmental groups, and definition of budget for teaching); and (3) the relationship between medical schools and external organizations (including integration of accreditation processes, assessment of readiness for graduate training, and use of licensing exams).

Many believe that changes in medical education are needed. In their survey of medical school deans, Cantor et al. (1991) found that 68 percent believed

fundamental change in medical education was needed. This was true for their own institutions as well as medical education overall. Petersdorf and Turner (1995) report that the education given to students is "dated and arcane" and not in tune with societal needs. In interpreting their survey of young physicians, Cantor et al. (1993) found that "while medical training has remained largely unchanged, the demands placed on practicing physicians have changed dramatically."

Some believe that the premises of the current apprenticeship model of medical education are so faulty in today's complex health care environment that they need drastic overhaul (Chassin, 1998). Others have suggested that "research's stranglehold on medical education reform needs to be broken by separating researchers from medical student teaching and from curriculum decision making" (Regan-Smith, 1998). Teaching should be an explicit and compensated part of one's job. Still others have called for new relationships between medical schools and academic health centers that would permit the latter to focus on making the best decisions for patient care and allow medical schools to control education and its location (Thier, 1994). In such a circumstance, academic health centers might be affiliated with several medical schools and medical schools might be affiliated with multiple health centers to allow for greater flexibility by the partners.

Medical curriculum has not been static over the years, but has undergone extensive changes (Anderson, 2000; Milbank Memorial Fund and Association of American Medical Colleges, 2000). However, many believe that in general, the current curriculum is overcrowded and relies too much on memorizing facts, and that the changes implemented have not altered the underlying experience of educators and student (Ludmerer, 1999; Regan-Smith, 1998). Despite the changes that have been made, the fundamental approach to clinical education has not changed since 1910. A number of reasons have been cited for so little response to so many calls for reform:

- Lack of funding to review curriculum and teaching methods and of resources to make changes in them (Griner and Danoff, 2000; Meyer et al., 1997)
- Emphasis on research and patient care, with little reward for teaching (Cantor et al., 1991; Griner and Danoff, 2000; Ludmerer, 1999; Petersdorf and Turner, 1995; Regan-Smith, 1998)
- Need for faculty development to ensure that faculty are available at training sites and able to teach students effectively (Griner and Danoff, 2000; Weed, 1981)
- Decentralized structure in medical schools, with powerful department chairs (Cantor et al., 1991; Marston, 1992; Petersdorf and Turner, 1995; Regan-Smith, 1998)
- No coordinated oversight across the continuum of education, and fragmented responsibilities for undergraduate and graduate education, licensing, certification, etc. (Enarson and Burg, 1992; Ludmerer, 1999)

• Difficulty in assessing the impact of changes in teaching methods or curriculum (Ludmerer, 1999)

Although much has been written on medical education, future work on the clinical preparation of the workforce should include examining issues related to the education of all health professionals individually and the way they interact with each other. Separation of clinical training programs and dispersed oversight of training programs, especially across the continuum of initial training, graduate training, and continuing development, inhibit the types and magnitude of change in clinical education. For example, various aspects of medical education are affected by the policies of the Liaison Committee on Medical Education, the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, 27 residency review committees, the American Board of Medical Specialties and its 24 certifying boards, the Bureau of Health Professions at the Department of Health and Human Services, the American Medical Association, the American Osteopathic Association and its 18 certifying boards, the American Association of Colleges of Osteopathic Medicine, and various professional societies involved in continuing medical education. Similarly, nursing education is influenced by the policies of the American Association of Colleges of Nursing, the National League for Nursing, the American Nurses Credentialing Center, the National Council of State Boards of Nursing, the American Nurses Association, and various specialty nursing societies. Academic health centers and faculty also play a strong role in shaping the education experience of their students. Such diffusion of responsibilities for clinical education makes it difficult to create a vision for health professional education in the 21st century.

REGULATION OF THE PROFESSIONS

If innovative programs are to flourish, they will require regulatory environments that foster innovation in organizational arrangements, staffing and work relationships, and use of technology. The 21st-century health care system described in this report cannot be achieved without substantial change in the current environment of regulation and oversight.

In general, regulation in this country can be characterized as a dense patchwork that is slow to adapt to change. It is dense because there is a forest of laws, regulations, agencies, and accreditation processes through which each care delivery system must navigate at the local, state, and federal levels. It is a patchwork system because the regulatory and accreditation frameworks at the state level are often inconsistent, contradictory, and duplicative, in part because the needs, priorities, and available resources of the states are not equal. And the regulating process is slow in that it is unable to keep pace with changes in health care. The health care delivery system is under great pressure to innovate and change to

incorporate new knowledge and technologies. Regulatory and accreditation requirements can, at times, be at odds with needed innovations (Pew Health Professions Commission, 1993). Statutes and regulations, while not the only factors that influence the practices of nonphysician clinicians, are powerful determinants of their authority and independence (Cooper et al., 1998).

A key regulatory issue that affects the health care workforce and the way it is used is scope-of-practice acts, implemented at the state level. The general public does not have adequate information to judge provider qualifications or competence, so professional licensure laws are enacted to assure the public that practitioners have met the qualifications and minimum competencies required for practice (Pew Health Professions Commission, 1993; Safriet, 1994). Along with licensure, such state laws that define the scope of practice for specific types of caregivers serve as an important component of the overall system of health care quality oversight.

One effect of licensure and scope-of-practice acts is to define how the health care workforce is deployed. In general, medical practice acts are defined broadly so that individual practitioners are licensed for medicine (not a specific specialty), and are thereby permitted to perform all activities that fall within medicine's broad scope of practice. Although a dermatologist would not likely perform open-heart surgery, doing so is not restricted by licensure. However, patients often seek out information about a physician's reputation and credentials, and professional societies also monitor the activities of their members. Other health professions have more narrowly defined scopes of practice, having to carve out their responsibilities from the medical practice act in each state (Safriet, 1994).

Although scope-of-practice acts are motivated by the desire to establish minimum standards to ensure the safety of patients, they also have implications for the changes to the health care system recommended in this report. Since, any change can potentially affect scope-of-practice acts, it can be difficult to use alternative approaches to care, such as telemedicine, e-visits, nonphysician providers, and multidisciplinary teams, all of which can help in caring for patients across settings and over time (see Chapter 3).

Current systems of licensure raise both jurisdictional and liability issues for some clinical applications of telemedicine, such as centralized consultation services to support primary care (Institute of Medicine, 1996b) or the provision of online, continuous, 24-hour monitoring and clinical management of patients in intensive care units for hospitals that have no or too few critical care intensivists on staff to provide this coverage (Janofsky, 1999; Rosenfeld et al., 2000). Integrated delivery systems that cross state lines and telemedicine have rendered geographic boundaries obsolete (Finocchio et al., 1998), making it more difficult for those charged by statute to protect the public.

Scope-of-practice acts can include provisions that inhibit the use of nonphysician practitioners, such as advanced practice nurses and physician assistants, for primary care (Pew Health Professions Commission, 1993; Safriet, 1994).

In some states, advanced practice nurses can diagnose, treat, and prescribe; in others they work only under the direction of a physician (Cooper et al., 1998). Inconsistencies are exacerbated by variation in the scope of practice by setting of care. For example, advanced practice nurses may be permitted a broader scope of practice in rural areas or community health clinics than in other settings (Safriet, 1994). Such policies are enacted to address problems of underservice that exist in certain areas. Although patient needs do not necessarily differ in rural versus urban areas of a state, the available resources of talent, capital, and personnel often vary considerably.

Scope-of-practice acts can also affect the ability to form cohesive care teams that draw on individuals from different disciplines to complement one another in patient care. The skills of some nonphysician providers may overlap with a subset of physician services, often creating tensions among clinicians (Cooper et al., 1998). For example, although there is a difference in their knowledge and training for practice, certified registered nurse anesthetists and anesthesiologists have a subset of skills that overlap (Cromwell, 1999). Separate governance structures and standards are maintained for different types of health professionals even though they may perform a subset of overlapping functions, practice together in the same state and at the same health care institutions, and serve the same population of patients (Finocchio et al., 1998). The complexity of rules across disciplines and settings makes it a challenge to form multidisciplinary teams and establish best practices, especially those that draw on caregivers based in different settings (e.g., hospital, physician's office, and home). Scope-of-practice laws are not the only barrier to greater use of multidisciplinary teams (Sage and Aiken, 1997), but are an important one.

Because licensure and scope-of-practice acts are implemented at the state level, there is a great deal of variation among the states in who is licensed and what standards for licensure and practice are applied. State licensure is not constitutionally based, but rather founded in tradition (Safriet, 1994). On the one hand, state licensure permits regulations to be tailored to meet local needs, resources, and patient expectations. On the other hand, the resulting state-by-state variation is not always logical given the growth of the Internet and the formation of large, multistate provider groups that cut across geographic boundaries. Even with new technologies and organizational arrangements, however, public protections must still be ensured. In response, some have proposed nationally uniform scopes of practice (O'Neil and the Pew Health Professions Commission, 1998) or, at least, more coordinated, publicly accountable policies (Grumbach and Coffman, 1998). The National Council of State Boards of Nursing has endorsed a mutual recognition model for interstate nursing practice that retains state licensure authority, but provides a mechanism for practice across state lines (similar to a driver's license that is granted by one state and recognized in other states) (Finocchio et al., 1998). Still others have argued the relative merits of state-based versus national licensing systems (Federation of State Medical Boards, 1998).

The committee does not recommend one approach over another, but does call for greater coordination and communication among professional boards both within and across states as this issue is resolved over time.

Although the preceding examples suggest that some regulations may be duplicative or outdated for today's clinical practice, gaps exist in other areas as well. For example, current licensure and scope-of-practice laws offer no assurance of continuing competency. In a field with a continually expanding knowledge base, there is no mechanism for ensuring that practitioners remain up to date with current best practices. Responsibility for assessing competence is dispersed among multiple authorities. For example, a licensing board may question competence only if it receives a complaint, but does not routinely assess competency after initial licensure. A health care organization may assess competence when an individual applies for privileges or employment. Professional societies and organizations may require examination for certification, but are just beginning to assess competence in addition to knowledge for those health professionals who voluntarily seek certification. There are no consistent methods for ensuring the continued competence of health professionals within current state licensing functions or other processes.

At least two approaches have been suggested to address this gap. First, some researchers have suggested that licensure be based on a professional's demonstrated ability to perform certain functions or on a certain level of practice (Cooper et al., 1998; Weed and Weed, 1999b). In aviation, for example, pilots are granted a private, commercial, or air transport license by the Federal Aviation Administration. Generally, pilots first obtain a private, single-engine license and then progressively add multi-engine and instrument qualifications to obtain a commercial license. They can then accumulate flying hours and experience to qualify for an air transport license, subsequently obtaining particular types of ratings for specific aircraft (Bisgard, 2000). In addition, professional pilots are recertified at regular intervals throughout their flying career. Taking such an approach in health care would represent a profound paradigm shift, with a gradation of licensure being based on the services in which a health professional has demonstrated competence to serve patients.

A second approach has been suggested, involving an additional level of oversight in which teams of practitioners, in addition to individuals, would be licensed or certified to perform certain tasks (Pew Health Professions Commission, 1993). For example, an individual receiving care for diabetes could go to a "certified" diabetes team that would ensure specific competencies and resources within the delivery team. The team could be collocated or comprise a dispersed network of individual providers practicing and communicating with each other as a team. The certification requirements could be used as a measure of quality by consumers and as a tool for quality improvement by teams seeking to obtain such certification.

It would be premature for the committee to offer a recommendation related to licensure, scope-of-practice, or other regulations. In raising these issues, however, we recognize their importance in supporting or hindering the types of changes recommended in this report. Thus we call for additional, in-depth study aimed at understanding the areas and forms of regulation that are most beneficial for patients and in which modification may be needed to achieve the 21st-century health care system envisioned in this report. Properly conceived and executed, regulation can both protect the public's interest and support the ability of health care professionals and organizations to innovate and change to meet the needs of their patients.

LEGAL LIABILITY ISSUES

The recommendations in this report represent, in many instances, a very different way of delivering services to patients. Achieving the aims set forth in Chapter 2 will require significant innovations in the delivery of care, innovations that may also raise concerns associated with traditional forms of accountability, especially liability issues. Delivering care that is patient-centered, evidence-based, and systems-minded has implications for traditional methods of accountability, particularly with regard to patients' participation in their care, efforts to define standards of care consistent with the evidence base rather than local traditions, and the responsibilities of individual practitioners who deliver care within larger systems that have the capacity for improvement.

Innovations in care can contribute to increased threats of litigation because, by definition, innovation implies a change from previous practice, and medical advances are often imperfect when first applied in clinical practice. Mohr (2000) cites an early example of compound fractures. Through a change in treatment, patients may have avoided an amputation, but they did not always regain full functioning of the limb and pursued litigation against the physician. Significant innovation in health care will occur in many areas with the use of new processes of care and new technologies that will alter how and by whom services are delivered to patients. It is not yet clear how these new processes and technologies, such as e-mail, will affect the liability of health professionals in the future.

Although less studied, changes in organizational approaches raise similar issues. For example, patients may receive care from members of a care team other than a physician or be counseled by e-mail rather than in a face-to-face visit. Such changes can be disorienting to patients if not well understood and in the short run, and create new hazards and new risks of litigation. Thus there is a need for good educational efforts and communication with patients about the changes taking place. It is also necessary, however, to examine the extent to which current liability approaches inhibit the kinds of changes needed to improve the quality and safety of care. For example, liability concerns can affect the

willingness of physicians and other clinicians to share information about areas in which quality improvement is needed if they believe the information may subsequently be used against them (Institute of Medicine, 2000). The committee's previous report on patient safety calls for peer review protection of data that are used inside health care organizations or shared with others solely for purposes of improving safety and quality, as well as an improved climate for identifying areas needing improvement (Institute of Medicine, 2000).

Legal issues are also likely to influence the development of evidence-based practice. The legal system influences health care through two types of decisions—medical malpractice and benefits coverage—both of which involve judgments about the quality of care (Rosoff, 2001). Should the legal system fail to incorporate evidence-based thinking into its decision-making processes (whether related to medical malpractice or other decisions), clinicians and health care organizations will be subject to confusing and conflicting incentives and demands.

Legal decisions that involve determining whether care provided was consistent with the "standard practice in the relevant medical community" (Rosoff, 2001) often rely on expert testimony. It is unclear how courts will incorporate clinical evidence and clinical practice guidelines into legal decision making. To date, clinical practice guidelines have had little effect on litigation. In a legal search covering the period January 1980 to May 1994, Hyams et al. (1996) found only 37 cases involving clinical practice guidelines. But clinical practice guidelines probably have had some effect on prelitigation decisions, since surveys show that medical malpractice attorneys consider guidelines in making decisions about whether to take on malpractice cases and conducting settlement negotiations (Hyams et al., 1996).

Alternative approaches to liability, such as enterprise liability or no-fault compensation, could produce a legal environment more conducive to uncovering and resolving quality problems. Enterprise liability shifts liability from individual practitioners to responsible organizations (Abraham and Weiler, 1994; Sage et al., 1994). For example, workplace injuries to employees are handled through a form of no-fault, enterprise liability. Although analysis of such approaches is beyond the scope of the present study, the committee believes they merit a focused, in-depth analysis.

RESEARCH AGENDA FOR THE FUTURE HEALTH CARE WORKFORCE

Modifying training, regulatory, and legal environments is not a quick strategy for changing practice. These environments are closely interrelated with the delivery setting. Training programs are not likely to change unless the delivery setting does so, but the setting cannot change if people are not trained to practice differently. Similarly, the delivery setting cannot change without modifications

in regulation and legislation, but adjustments in practice often prompt additional regulation to protect against unwanted consequences.

A comprehensive approach is needed for the many aspects of health care workforce planning. Many prior efforts in such planning have focused on attempting to determine an appropriate supply of clinicians. Previous studies have examined the adequacy of supply for selected disciplines (e.g., physicians) or the mix of providers within a discipline (e.g., primary care and specialty mix of physicians), or have assumed a specific organizational model (e.g., supply of physicians needed given extensive enrollment in HMOs). Although a comprehensive workforce agenda should address issues of supply, it would be difficult to conduct any such studies meaningfully without first addressing how clinicians might be deployed given different approaches to training, regulation, and liability. It is not sufficient to ask how many health professionals are needed; one must also ask what types are needed (Pew Health Professions Commission, 1993). Ultimate assessments of supply depend on how responsibility for patients is divided among licensed clinicians, as well as on society's expectations (Cromwell, 1999). Workforce planning should shift from determining the supply of clinicians in specific disciplines who continue to perform the same tasks using the same methods toward assessing the adequacy of supply given that care is provided through processes that rely on multidisciplinary approaches, modern technological support, and continuous care. The starting point for addressing workforce issues should not be the present environment of licensure, reimbursement, and organization of care, but a vision of how care ought to be delivered in the 21st century. A comprehensive agenda on workforce planning should cover the following key issues:

- Training and Education Issues

  – What is the vision for the education and training of health professionals for the 21st century? What is the relationship between the education of health care providers and quality of care?

  – How is the vision relayed throughout the continuum of education? How can new health professionals learn most effectively the basic skills related to patient-centeredness, evidence-based practice, and systems thinking? How can such skills be reinforced in graduate training programs? How can they be meaningfully relayed to professionals already in practice?

  – What are the implications of changes in clinical education for the health care organizations that serve as training sites? What is the potential effect on the role and mission of academic health centers?

  – What are the implications of changes in clinical education for licensing and accreditation processes? For funding approaches to support clinical education?

- Legal and Regulatory Issues

  – How can regulatory and other oversight processes be coordinated to reinforce the principles of patient-centeredness, evidence-based practice, and systems thinking? What specific legal and regulatory constraints inhibit changes in processes of care? Where are different types of regulations needed? In what areas can existing regulations be streamlined or reduced?

  – How can greater coordination among licensing boards within an individual state and across states be facilitated? How can the continuing competence of health professionals be assessed and ensured?

  – Can liability reform support the principles of patient-centeredness, evidence-based practice, and systems thinking? Are alternative models, such as enterprise liability, desirable?

  – What is the link between regulation of health professions and quality of care?

  – What are the appropriate links among licensure, accountability, and liability?

- Workforce Supply

  – Given a greater understanding of the previous issues (e.g., what training is provided, the need for greater flexibility in deploying human resources, and alternative approaches to accountability), what are the implications for the needed supply and mix of health professionals?

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THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT I:

Health Profession Education:

A Bridge to Quality

Executive Summary (p. 8)

Executive Summary

ABSTRACT

The 2001 Institute of Medicine report *Crossing the Quality Chasm: A New Health System for the 21st Century* recommended that an interdisciplinary summit be held to develop next steps for reform of health professions education in order to enhance patient care quality and safety. In June 2002, the IOM convened this summit, which included 150 participants across disciplines and occupations. This follow-up report focuses on integrating a core set of competencies—patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement and informatics—into health professions education.

The report's recommendations include a mix of approaches related to oversight processes, the training environment, research, public reporting, and leadership. The recommendations targeting oversight organizations include integrating core competencies into accreditation, and credentialing processes across the professions. The goal is an outcome-based education system that better prepares clinicians to meet both the needs of patients and the requirements of a changing health system.

Education for the health professions is in need of a major overhaul. Clinical education simply has not kept pace with or been responsive enough to shifting patient demographics and desires, changing health system expectations, evolving practice requirements and staffing arrangements, new information, a focus on improving quality, or new technologies (Institute of Medicine, 2001):

- Health professionals are not adequately prepared—in either academic or continuing education venues—to address shifts in the nation's patient population (Cantillon and Jones, 1999; Council on Graduate Medical Education, 1999; Davis et al., 1999; Grantmakers in Health, 2001; Halpern et al., 2001; Health Resources and Services Administration, 1999; Pew Health Professions Commission, 1995). Patients in America are becoming more diverse, are aging, and are increasingly afflicted by one or more chronic illnesses, while at the same time being more likely to seek out health information (Calabretta, 2002; Frosch and Kaplan, 1999; Gerteis et al., 1993; Mansell et al., 2000; Mazur and Hickam, 1997; Wu and Green, 2000). This changing landscape requires that clinicians be skilled in responding to varying patient expectations and values; provide ongoing patient management; deliver and coordinate care across teams, settings, and time frames; and support patients' endeavors to change behavior and lifestyle—training for which is in short supply in today's clinical education settings (Calabretta, 2002).
- Once in practice, health professionals are asked to work in interdisciplinary teams, often to support those with chronic conditions, yet they are not educated together or trained in team-based skills.
- These same clinicians are confronted with a rapidly expanding evidence base—upon which health care decisions should ideally be made—but are not consistently schooled in how to search and evaluate this evidence base and apply it to practice (American Association of Medical Colleges, 1999; Detmer, 1997; Green, 2000; Shell, 2001).
- Although there is a spotlight on the serious mismatch between what we know to be good quality care and the care that is actually delivered, students and health professionals have few opportunities to avail themselves of coursework and other educational interventions that would aid them in analyzing the root causes of errors and other quality problems and in designing systemwide fixes (Baker et al., 1998; Buerhaus and Norman, 2001).
- While clinicians are trained to use an array of cutting-edge technologies related to care delivery, they often are not provided a basic foundation in informatics (Gorman et al., 2000; Hovenga, 2000). Training in this area would, for example, enable clinicians to easily access the latest literature on a baffling illness faced by one of their patients or to use computerized order entry systems that automatically flag pharmaceutical contraindications and errors.

While there are notable pockets of innovation—settings in which clinicians are being trained for a 21st-century health care system—these are by and large exceptions to the rule.

Building a Bridge to Cross the Quality Chasm

Numerous recent studies have led to the conclusion that "the burden of harm conveyed by the collective impact of all of our health care quality problems is staggering" (Chassin et al., 1998:1005). Errors lead to tens of thousands of Americans dying each year, and hundreds of thousands suffering or becoming sick as a result of nonfatal injuries. Other studies have documented pervasive overuse, misuse, and underuse of services (Chassin et al., 1998; Institute of Medicine, 2000; President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998a; Schuster et al., 1998).

Crossing the Quality Chasm: A New Health System for the 21st Century (Institute of Medicine, 2001) emphasizes that safety and quality problems exist largely because of system problems, and that browbeating health professionals to just try harder is not the answer to addressing the system's flaws and future challenges. Quality problems are occurring in the hands of health professionals highly dedicated to doing a good job, but working within a system that does not adequately

prepare them, or support them once they are in practice, to achieve the best for their patients.

The *Quality Chasm* report concludes that reform around the edges will not solve the quality problem, and sets forth an ambitious agenda for redesign of the broken health care system to achieve six national quality aims: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Implementing such an agenda has important implications for current and future health professionals. The *Quality Chasm* report provides initial guidance on what kinds of competencies clinicians would need to carry out this agenda, and emphasizes further study to better understand how the workforce should be educated for practice, how it should be deployed, and how it should be held accountable.

Health Professions Education Summit

The *Quality Chasm* report recommends that a multidisciplinary summit of leaders within the health professions be held to discuss and develop strategies for restructuring clinical education across the full continuum of education. The Committee on the Health Professions Education Summit was convened to plan and hold this summit—which was held on June 17–18, 2002—and to produce this follow-up report.

The committee organized a multidisciplinary summit involving allied health, nursing, medical, and pharmacological educators and students; health professional and industry association representatives; regulators and representatives of certifying organizations; providers; consumers; innovators in education and practice settings; and influential policy makers. Participants were asked to develop proposed strategies and actions for addressing the five competency areas recommended by the committee (described below) in health professions education: patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics.

Summit participants worked in small interdisciplinary groups using the Hoshin method (Counsell et al., 1999; Hyde and Vermillion, 1996; Platt and Laird, 1995), a structured facilitation process for gathering expert opinion and identifying, prioritizing, and implementing strategies. The ideas generated at the summit are included in this report in Appendix B. The committee conducted a literature review related to the core competencies and various recommendations that were considered. The committee also reviewed the over 200 ideas proposed by summit participants as part of its deliberations.

A New Vision for Health Professions Education

With the ideal 21st-century health care system described in the *Quality Chasm* report as a backdrop, the committee developed a new vision for clinical education in the health professions that is centered on a commitment to, first and foremost, meeting patients' needs. The committee believes that the following should serve as an overarching vision for all programs and institutions engaged in the clinical education of health professionals, and further that such organizations should develop operating principals that will allow this vision to be achieved.

> *All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.*

The committee's vision is apparent in selected institutions—both academic and practice settings—around the country, but is not incorporated into the basic fabric of health professions education, nor is it supported by oversight processes or financing arrangements. Accordingly, the committee proposes a set of five core competencies that all clinicians should possess, regardless of their discipline, to meet the needs of the 21st-century health system. Competencies are defined here as the habitual and judicious use of communication,

knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice (Hundert et al., 1996).

- ***Provide patient-centered care***—identify, respect, and care about patients' differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health.
- ***Work in interdisciplinary teams***—cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable.
- ***Employ evidence-based practice***—integrate best research with clinical expertise and patient values for optimum care, and participate in learning and research activities to the extent feasible.
- ***Apply quality improvement***—identify errors and hazards in care; understand and implement basic safety design principles, such as standardization and simplification; continually understand and measure quality of care in terms of structure, process, and outcomes in relation to patient and community needs; and design and test interventions to change processes and systems of care, with the objective of improving quality.
- ***Utilize informatics***—communicate, manage knowledge, mitigate error, and support decision making using information technology.

Many efforts have arisen in response to the need to prepare clinicians for a changing practice environment (ABIM Foundation, 2002; Accreditation Council for Graduate Medical Education, 1999; American Association of Medical Colleges, 2001; Brady et al., 2001; Center for the Advancement of Pharmaceutical Education [CAPE] Advisory Panel on Educational Outcomes, 1998; Halpern et al., 2001; O'Neil and the Pew Health Professions Commission, 1998). To formulate the above core competencies, the committee examined the skills outlined in the *Quality Chasm* report, reviewed other efforts to define core competencies within and across the health professions, and reviewed the relevant literature.

The five competencies are meant to be core, but should not be viewed as an exhaustive list. The committee recognizes that there are many other competencies that health professionals should possess, such as a commitment to lifelong learning, but believes those listed above are the most relevant across the clinical disciplines; advance the vision in the *Quality Chasm* report; and overlap with recent, existing efforts to define competencies (Accreditation Council for Graduate Medical Education, 1999; Accreditation Council on Pharmaceutical Education, 2000). The committee also acknowledges that the core competencies will differ in application across the disciplines.

Next Steps

With some notable exceptions (O'Neil and the Pew Health Professions Commission, 1998; Pew Health Professions Commission, 1995), most current and past reform efforts have focused within a particular profession (Bellack and O'Neil, 2000; Christakis, 1995; Harmening, 1999; Jablonover et al., 2000). The committee believes the time has come for leaders across the professions to work together on the cross-cutting changes that must occur to effect reform in clinical education and related training environments, and that they should carefully consider the cultural changes necessary to support such reform efforts.

The committee believes that integrating a core set of competencies—one that is shared across the professions—into the health professions oversight spectrum would provide the most leverage in terms of reform of health professions education. A recent article synthesizing nine major reports on physician

competencies, focused on the important role oversight organizations can play, concluded that "without data about medical-education quality, accreditation is the most potent lever for curricula reform in our decentralized medical education system" (Halpern et al., 2001). Many participants at the IOM summit concurred with this conclusion. The two levers for change most often cited by the 150 participants were oversight approaches and changes to financing.

The committee also recommends pursing other leverage points—such as the use of report cards that incorporate education-related measures and innovations in financial incentives—but the preponderance of its recommendations are directed at oversight organizations. This is the case in part because of the lack of education measures and the charge to this committee, which is focused on clinical education.[1] Also, health professions oversight processes, such as accreditation and certification, function at the national level, thereby affording a leverage point for systemwide change. The committee believes that such an approach will stimulate efforts on the part of educational institutions and professional associations.

The committee would like to highlight its definition of "oversight processes" and underscore that it includes the efforts of both private – and public – sector organizations:

> *Oversight processes include accreditation, certification, and licensure. Educational accreditation serves as a leverage point for the inclusion of particular educational content in a curriculum. Licensure assesses that a student has understood and mastered formal curricula. Certification seeks to ensure that a practitioner maintains competence in a given area over time. Organizational accreditation also may influence practitioners' ongoing competency.*

The call for accrediting and certifying organizations to move toward a competency-based approach to education is in response to growing concerns about patient safety (Institute of Medicine, 2000), the persistent and substantial variation in patient care across geographic settings that does not relate to patient characteristics (O'Connor et al., 1996; Wennberg, 1998), and the related desire on the part of public payers and consumers for increased accountability (Leach, 2002; Lenburg et al., 1999). Competency-based education focuses on making the learning outcomes for courses explicit and on evaluating how well students have mastered these outcomes or competencies (Harden, 2002). The evidence base on the efficacy of various educational approaches is slim. However, the limited evidence that does exist points to improvements, such as better performance on licensing exams, associated with the use of competency– or outcome-based educational approaches (Carraccio et al., 2002).

A competency-based approach to education could result in better quality because educators would begin to have information on outcomes, which could ultimately lead to better patient care. Defining a core set of competencies across educational oversight processes could also reduce costs as a result of better communication and coordination, with processes being streamlined and redundancies reduced. Integrating core competencies into oversight processes would likely provide the impetus for faculty development, curricular reform, and leadership activities.

Common Language and Adoption of Core Competencies

Before steps can be taken to integrate a core set of competencies into oversight processes, an interdisciplinary group that includes leaders from the professions, educational institutions, and oversight organizations will need to define common terms. A number of studies have shown that any collective movement to reform education must begin by defining a shared

[1] A current Institute of Medicine study addressing academic health centers is considering financing questions.

language (Halpern et al., 2001; Harden, 2002). Such an effort can help set in motion a process focused on achieving a threshold level of consensus across the disciplines around a core set of competencies.

The lack of consensus across the professions around language and terms related to the core competencies may be undermining their integration into oversight processes. For example, with respect to evidence-based practice, leaders in the field have worked to expand the definition of evidence so it includes qualitative research and to dispel the myth that such practice ignores clinical experience and expertise (Guyatt, 1992). Despite these efforts, a review of the literature suggests that misconceptions regarding the definition of evidence persist (Ingersoll, 2000; Marwick, 2000; Mazurek, 2002; Mitchell, 1999; Satya-Murti, 2000; Woolf, 2000). A review of the literature related to teaching interdisciplinary team skills reveals differing terminologies as an obstacle: faculty struggle to understand other professions' core concepts and content, which leads to conflict when they teach interdisciplinary courses (Lavin et al., 2001; Pomeroy and Philp, 1994). The committee believes that an interdisciplinary group, created under the auspices of the Department of Health and Human Services (DHHS), should be charged with developing a common language across the health disciplines and achieving consensus around a core set of competencies.

Recommendation 1: DHHS and leading foundations should support an interdisciplinary effort focused on developing a common language, with the ultimate aim of achieving consensus across the health professions on a core set of competencies that includes patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics.

Integrating competencies into oversight processes

The extent of integration of competencies into existing oversight processes varies. Any effort at further integration would be strengthened if predicated on a core a set of competencies—competencies with universal definitions shared across the professions. The committee recognizes that these competencies are by no means exhaustive, but represent an important core of what health professionals need to know to practice in a 21st-century health system.

During the last decade, competencies have begun to redefine accreditation, particularly in pharmacy and medicine. The competencies that these disciplines have defined overlap with the core competencies recommended by the committee. In 1997, the American Council on Pharmaceutical Education (ACPE) adopted accreditation standards focused on 18 professional competencies (American Council on Pharmaceutical Education, 2002). In 1999, the Accreditation Council for Graduate Medical Education (ACGME) and the organization of certifying boards, the American Board of Medical Specialties (ABMS), endorsed six general competencies as the foundation for all graduate medical education, and these competencies are currently being phased in (Accreditation Council for Graduate Medical Education, 2002). Until they are fully incorporated and evaluated, it remains to be seen what effect these competencies will have on pharmacological and medical education. In nursing, the two accrediting organizations also have defined competencies—which do not fully overlap with the core competencies defined here—but differ in whether they require demonstration of such competencies (Commission on Collegiate Nursing Education, 2002; National League for Nursing Accrediting Commission, 2002). Finally, the curricula for the selected allied health professions examined in this report vary in the extent to which they incorporate the five competencies outlined above (Collier, 2002).

The competency movement, however, does

not have as much of a foothold in licensure and certification processes. Requirements for maintaining a license vary considerably, as do requirements for those who pursue recognition of clinical excellence. Further, research has raised questions about the efficacy of continuing education courses, the most common way to demonstrate ongoing competency (Cantillon and Jones, 1999; Davis et al., 1999).

Efforts to incorporate a core set of competencies across the professions into the full oversight framework—accreditation, licensing, and certification—would need to occur on the national, state, and local levels; coordinate both public- and private-sector oversight organizations; and solicit broad input. Again, the involvement of DHHS, and specifically the Health Resources and Services Administration, would be important in getting this effort off the ground, in helping to establish a process for soliciting input from professional associations and the education community, and in identifying linkages and synergies across the various oversight groups within and across professions.

It is imperative to have such linkages among accreditation, certification, and licensure; it would mean very little, for example, if accreditation standards set requirements for educational programs, and these requirements were not then reinforced through testing on the licensing exam. All processes must be linked so they are focused on the same outcome—the ability of professionals to provide the highest quality of care.

Recommendation 2: DHHS should provide a forum and support for a series of meetings involving the spectrum of oversight organizations across and within the disciplines. Participants in these meetings would be charged with developing strategies for incorporating a core set of competencies into oversight activities, based on definitions shared across the professions. These meetings would actively solicit the input of health professions associations and the education community.

Strategies for incorporating the competencies into oversight processes would necessarily differ across the oversight framework based on history, regulatory approach, and structure. In all cases, the oversight bodies should proceed with deliberation, with efforts made to solicit comments on draft language, and initial testing of new requirements, such as through the use of provisional standards. Processes should also be established to monitor and evaluate new requirements to ensure that they are useful and not overly burdensome.

The experiences of ACPE and ACGME provide some guidance on how accrediting bodies could incorporate competencies into their processes. Both ACPE and ACGME undertook an intensive, decade-long process of rethinking how they were preparing professionals for practice. They concluded that fundamental change was necessary, and that they needed to move away from approaches that had become increasingly precise, prescriptive, and burdensome (Byrd, 2002; Batalden et al., 2002, Leach, 2002).

What has not yet occurred is coordination across accrediting bodies of the various professions in defining a core set of competencies and related standards and measures. Such coordination would obviate the need for each accrediting body to reinvent the wheel, promote synergies, and enable better communication and working relationships, as well as more consistent integration of the core competencies across schools. This sort of coordinated effort would also help ensure that educational innovators would not be stifled by outdated accreditation requirements. Organizational accreditors—such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA)—should likewise consider more fully how clinicians maintain competency in the core set of competencies outlined above.

Recommendation 3: Building upon previous efforts, accreditation bodies should move forward expeditiously to revise their standards so that programs are required to demonstrate—through process and outcome measures—that they educate students in both academic and continuing education programs in how to deliver patient care using a core set of competencies. In so doing, these bodies should coordinate their efforts.

With the exception of patient-centered care, which is consistently included in examinations across the professions, licensing exams for health professionals vary considerably in whether they test for competency in the core areas (National Association of Boards of Pharmacy, 2002; National Council of State Boards of Nursing, 2001; United States Medical Licensing Exam, 2002). This situation also needs to be addressed and could be the focus of a subset of the oversight organizations described in recommendation 2.

In addition, geographic restrictions on licensure and separate and sometimes conflicting scope-of-practice acts need to be examined to determine whether they are a serious barrier to the full integration of the core competencies into practice, and if so, how to modify them so that all clinicians can practice to the fullest extent of their technical training and ability. Although beyond the scope of this report, the committee believes that this matter deserves further examination because licensure and scope of practice influence how clinicians are deployed, which in turn affects decisions about education. For example, licensure restrictions might hamper a rural hospital's ability to consult a specialist because she happened to be located in another state and licensed to practice only there (Phillips et al., 2002). Similarly, scope-of-practice restrictions in one state might prohibit a nurse practitioner who was part of an interdisciplinary diabetes care management team from prescribing medications, while another state might allow such activity—even though both practitioners worked for the same national health plan (Phillips et al., 2002). These restrictions make less and less sense as health care organizations and health professionals cross state lines.

Finally, the committee believes that there should be a focused effort to integrate a core set of competencies into oversight processes focused on practicing clinicians. Such an effort would require coordination among an array of public- and private-sector licensing and certification organizations, within which there is currently little uniformity in approach across the professions or within a given profession across the states. At present, many boards require only a fee for license renewal (Swankin, 2002b; Yoder-Wise, 2002), and many others view continuing education courses as evidence of competence, even though, as noted above, this has not been shown to be a reliable measure of such ability (Davis et al., 2000; O'Brien et al., 2001).

To begin with, state legislatures would need to require state licensing boards to insist that their licensees demonstrate competence, not just pay a license renewal fee, to maintain their authority to practice. To date, state legislators have not insisted upon such a requirement, in part because there is disagreement about what constitutes evidence of competency, how often it should be demonstrated, and who should judge. Licensing boards also would need to consider clinician competency at varying career stages. For example, a veteran intensive care nurse or physician subspecialist should be expected to have a higher level of competence than a new graduate in either profession.

The committee believes that all health professions boards need to require demonstration of continued competency, and that they should move toward adopting rigorous tests for this purpose. Beyond licensure examinations, there is evidence to suggest that structured direct observation using standardized patients, peer assessments, and case– and essay-based questions are reliable ways to assess competency (Epstein and Hundert, 2002; Murray et al., 2000).

Recommendation 4: All health professions boards should move toward requiring licensed health professionals to demonstrate periodically their ability to deliver patient care—as defined by the five competencies identified by the committee—through direct measures of technical competence, patient assessment, evaluation of patient outcomes, and other evidence-based assessment methods. These boards should simultaneously evaluate the different assessment methods.

There is more uniformity among certifying organizations as compared with professional boards, in that nearly all require some means of demonstrating continuing competence. The vast majority allow for two or more approaches, and many also consider competency at various career stages. Moreover, in response to the paucity of evidence that taking continuing education courses improves practice outcomes, some certifying organizations are beginning to emphasize alternative measures that are more evidence based (American Board of Medical Specialties, 2000; American Nurses Association/NursingWorld.Org, 2001; Bashook et al., 2000; Board of Pharmaceutical Specialties, 2002; Federation of State Medical Boards, 2002; Finocchio et al., 1998; National Council of State Boards of Nursing, 1997-2000; Swankin, 2002a). Although such efforts are challenging to implement and often costly, certification bodies should only recognize continuing education courses as a valid method of maintaining competence if there is an evidence-based assessment of such courses; if clinicians select courses based on an assessment of their individual skills and knowledge; and if clinicians then demonstrate, through testing or other methods, that they have learned the course content.

The committee recognizes that there is a monetary and human resource cost to moving to evidence-based assessment, whether it is related to licensure or certification. Consequently, such assessments may need to be phased in, or less costly assessment methods identified. The committee also recognizes that increased investment in computer-based clinical records would provide the kind of rich clinical data necessary to fully realize this approach.

Recommendation 5: Certification bodies should require their certificate holders to maintain their competence throughout the course of their careers by periodically demonstrating their ability to deliver patient care that reflects the five competencies, among other requirements.

Training Environments

Education does not occur in a vacuum; indeed, much of what is learned lies outside of formal academic coursework. A "hidden curriculum" of observed behavior, interactions, and the overall norms and culture of a student's training environments are extremely powerful in shaping the values and attitudes of future health professionals. Often, this hidden curriculum contradicts what is taught in the classroom (Ferrill et al., 1999; Hafferty, 1998; Maudsley, 2001).

Consequently, the committee believes that initial support should be provided for existing exemplary practice organizations that partner with educational institutions, and are already providing the interdisciplinary education and training necessary for staff to consistently deliver care that incorporates the core competencies. Further, the committee believes that these leading organizations should be identified as training models for other organizations, and should be given the resources necessary to open their doors to students, clinicians, and faculty from other organizations, as well as support for testing alternative approaches to providing curricula that integrate the core competencies. Given that faculty shortages and lack of preparedness are a barrier to implementing some of the core competencies (Griner and Danoff, 2000; Halpern, 1996; Weed

and Weed, 1999) attention should be given to faculty development as well as instruction of students.

These learning centers could test various approaches for incorporating the core competencies into education for students, clinicians, and faculty, and provide guidance to practice and educational organizations about key operational issues. Is problem-based learning the best approach to teaching these competencies? Should the teaching of these competencies be infused into other courses, or should they be stand-alone? In terms of staging, when should these competencies be taught? These learning centers should also consider how, after an initial investment, they could become self–sustaining in 3–5 years. Such a model might include provision of health care services or require outside clinicians and faculty to pay for training.

There is precedence for focusing on learning centers that span occupations. For example, in health care there are selected examples of area health education centers (AHECs) training a broad range of professionals with support from the HRSA, while in other sectors, such as the airline industry, there are more comprehensive interdisciplinary training efforts (O'Neil and the Pew Health Professions Commission, 1998). Such organizations could provide centralized locations for information technology infrastructure, which would be an efficient way of aggregating costs across many organizations.

Recommendation 6: Foundations, with support from education and practice organizations, should take the lead in developing and funding regional demonstration learning centers, representing partnerships between practice and education. These centers should leverage existing innovative organizations and be state-of-the art training settings focused on teaching and assessing the five core competencies.

There are many barriers to incorporating the five competencies into the practice environment, where medical residents and new graduates in allied health, nursing, and pharmacology obtain initial training that leaves an important imprint on their future practice (Partnership for Solutions, 2002). In addition to the barriers of time constraints, oversight restrictions, resistance from the professions, and absence of political will, the overall health care financing system is a large impediment to integrating the core competencies into practice settings. Therefore, the committee believes steps must be taken to explore alternative ways of paying clinicians so as to foster such integration.

The lack of a supportive financial incentives structure becomes abundantly clear when one considers, for example, the kinds of services from which the chronically ill elderly would benefit and what Medicare fee-for-service pays for. Currently, Medicare fee-for-service does not generally pay for clinician time spent providing education that enables, for example, patients with diabetes and heart disease to make necessary lifestyle and behavioral changes, or for time spent helping such patients by teaching them how to actively manage their condition with the support of technology. Medicare fee-for-service also does not pay for the work involved in coordinating and integrating the various services such patients need across teams and settings (Institute of Medicine, 2002). Consequently, the financing system often undermines integration of the five competencies into practice, despite evidence that patients who are actively involved in managing and making decisions about their care have better quality and functional status outcomes at lower cost (Gifford et al., 1998; Superio-Cabuslay et al., 1996; Von Korff et al., 1998; Wagner et al., 2001).

As the largest payer, Medicare has a major effect on the system when it innovates (Institute of Medicine, 2002). Moreover, the committee believes that patients with chronic conditions—a sizable proportion of whom are covered by Medicare—would benefit greatly from

integration of the five competencies into practice. There are a number of different options that could serve as models for these payment experiments, including capitation, bundled payments, bonuses, withholds, and various ways to share risk and responsibility between clinicians and payers (Bailit Health Purchasing, 2002; Guyatt et al., 2000). The committee encourages other payers to follow suit.

Recommendation 7: Through Medicare demonstration projects, the Centers for Medicare and Medicaid Services (CMS) should take the lead in funding experiments that will enable and create incentives for health professionals to integrate interdisciplinary approaches into educational or practice settings, with the goal of providing a training ground for students and clinicians that incorporates the five core competencies.

Research and Information

Along with oversight changes and supportive training environments, the committee believes that evidence of the efficacy of an educational intervention can be a catalyst for change. To this end, evidence related to the link between clinical education and health care quality needs to be better developed, as does evidence about various teaching approaches.

In a review of 117 trials in continuing education, fewer than 20 percent were found to use health care outcomes as their measure of effectiveness (Davis et al., 2000), and a review of 2,000 papers on continuing education showed that only about 5 percent assessed the relationship between course content and clinical outcomes (Jordan, 2000). Teaching itself is dominated by intuition and tradition, which do not always hold up when submitted to empirical verification (Tanenbaum, 1994; van der Vleuten et al., 2000). For example, studies have shown that lecture-based teaching of isolated components, the most common means of imparting information in both academic and continuing education settings, fails in that it does not provide a way for students to integrate or apply the information provided (Wass et al., 2001).

Although there is significant public funding of health professions education, limited public and private resources are available for research that could help in determining whether the dollars are being well spent. In addition, much of the research that does exist is discipline-specific and therefore does not reflect the current practice environment.

The committee believes the time has come to focus energy and resources on developing a more robust and compelling evidence base about what educational content matters for patient care and what works in teaching clinicians so that educators, payers, and regulators can assess objectively what needs to be emphasized in the health professions curricula and what should be eliminated. The research should also span disciplines.

Recommendation 8: The Agency for Healthcare Research and Quality (AHRQ) and private foundations should support ongoing research projects addressing the five core competencies and their association with individual and population health, as well as research related to the link between the competencies and evidence-based education. Such projects should involve researchers across two or more disciplines.

The committee believes that incorporation of education-related measures into quality-reporting efforts and ongoing monitoring will be required to realize the vision articulated in this report. The lack of standardized information about the quality of clinical education makes the job of leaders seeking to reform such education more difficult. The lack of standardized measures also sets clinical education apart from

the broader health care quality movement. A ranking—by NCQA regarding health plan quality or by *U.S. News and World Report* regarding hospitals, for example—forces leaders to focus their attention on improving performance on a given set of comparable metrics (National Committee for Quality Assurance, 2002; U.S. News and World Report, 2002). The National Healthcare Quality Report Card, anticipated for release by AHRQ in 2003 and annually thereafter, will likely further standardize quality measurement and focus attention on the strengths and weaknesses of the current system. Yet no education-related measures are anticipated for inclusion in this first annual report (Agency for Health Care Research Quality, 2002).

A focused effort to develop education-related measures must begin now, given the amount of time required to develop and test prospective measures before they can be incorporated into report cards. The committee recognizes that initially there will be a small number of measures ready for public reporting.

Recommendation 9: AHRQ should work with a representative group of health care leaders to develop measures reflecting the core set of competencies, set national goals for improvement, and issue a report to the public evaluating progress toward these goals. AHRQ should issue the first report, focused on clinical educational institutions, in 2005 and produce annual reports thereafter.

Providing Leadership

Significant reform in health professions education is a challenge to say the least. The oversight framework is a morass of different organizations with differing requirements and philosophies, now under considerable pressure to demonstrate greater accountability (Batalden et al., 2002; Finocchio et al., 1998; Leach, 2002; O'Neil and the Pew Health Professions Commission, 1998). In academia, deans, department chairs, residency directors, and other leaders face a stream of requests for adding new elements to a curriculum that is already overcrowded. Shortages of key professionals, such as nurses and pharmacists, are another significant challenge. Moreover, funding for some academic health centers has been under pressure, and states are facing budget shortfalls that are causing them to trim education budgets, including funding for universities and community colleges (Griner and Danoff, 2000).

When change happens in health professions education, it does not happen overnight. Multiyear processes are required to develop, review, and achieve consensus on new requirements or methods before they can be implemented. Given this environment, the committee believes that reform of clinical education will be possible only with the skill and commitment of a broad range of health care leaders. A recent analysis and synthesis of 44 curriculum reform efforts revealed that leadership is the factor most often cited as affecting curriculum change (Bland et al., 2000).

Consequently, the committee believes that to maintain momentum for reform in clinical education, there will need to be biennial summits at which leaders who have demonstrated a real commitment to implementing the committee's overarching vision can gather. These summits should serve as a forum for leaders to take stock—including review of education-related performance measures and, over time, related trends against goals—and to define future plans. There should be a written report issued from the summit that captures such information and communicates it more broadly to the field.

Recommendation 10: Beginning in 2004, a biennial interdisciplinary summit should be held involving health care leaders in education, oversight processes, practice, and other areas. This summit

should focus on both reviewing progress against explicit targets and setting goals for the next phase with regard to the five competencies and other areas necessary to prepare professionals for the 21st-century health system.

Conclusion

The committee has set forth 10 major recommendations for reforming health professions education to enhance quality and meet the evolving needs of patients. Each of these recommendations focuses on ways of integrating a core set of competencies into health professions education. Taken together, they represent a mix of approaches related to oversight processes, the practice environment, research, public reporting, and leadership.

The staging of these recommendations is important. The first step is to articulate common terms so that shared definitions can inform interdisciplinary discussions about core competencies. Once the disciplines have agreed on a core set of competencies, public and private oversight bodies can consider how to incorporate such competencies into their processes—providing a catalyst for many educational institutions and professional associations, as well as support for those who have already moved toward adopting a competency-based approach. The committee believes that the development of common language and definition of core competencies should happen as rapidly as possible and by no later than 2004, given that the integration of core competencies into oversight processes will take considerable time, perhaps a decade or more if the efforts of ACGME and ACPE are any guide.

As the work of integrating core competencies into oversight processes proceeds, the efforts of leading practice organizations to integrate the core competencies into care delivery should be fostered through regional demonstration learning centers and Medicare demonstration projects. Simultaneously with these efforts, AHRQ and private foundations should provide support for research focused on the efficacy of the competencies and competency education and, most important, develop a set of measures reflecting the core set of competencies, along with national goals for improvement. Given that the committee calls upon AHRQ to issue a first report on health professions educational institutions by 2005, albeit with a limited number of initial measures, efforts related to reporting must begin immediately. Finally, the committee believes that biennial summits of health care leaders who control and shape education—starting in 2004—will be an important mechanism for integrating and furthering the efforts of those developing measures, practice and education innovators, researchers, and leaders from oversight organizations.

The committee is confident that its recommendations are both sound and feasible to implement because they are supported by a literature review, and informed by a broad range of leaders who shape education both directly and indirectly (see appendix C). Building a bridge to cross the quality chasm in health care cannot be done in isolation. The committee hopes that this report will jump start other efforts to reform clinical education, both individually and collectively, so that it focuses on continually reducing the burden of illness, injury, and disability, with the ultimate aim of improving the health status, functioning, and satisfaction of the American people (President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998b). The public deserves nothing less.

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THE DHCC 2013/14 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT J:

Registered Dental Hygienists in Alternative Practice (RDHAP): Increasing Access to Dental Care in California

Elizabeth Mertz, MA

(May 2008)

Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California

Elizabeth Mertz, MA

Center for the Health Professions

University of California, San Francisco

May 2008

THE CENTER
FOR THE HEALTH PROFESSIONS
University of California, San Francisco

The mission of the Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities.
The Center is committed to the idea that the nation's health will be improved if the public is better informed about the work of health professionals.

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Acknowledgements

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Introduction

Lack of access to dental care is a persistent problem for vulnerable populations in California resulting in extensive untreated dental disease.[1-3] The State has invested in multiple programs and policies aimed at improving access to dental treatment. These efforts include provider targeted incentives such as loan repayment and scholarship programs, residency training programs, and licensure by credential, as well as public targeted incentives such as funding dental benefits and public clinics.[4] Most efforts seek to expand access to the existing care delivery model, which consists primarily of private dental offices and community dental clinics. Relatively recent additional State efforts promote disease prevention in non-dental office settings.

Registered Dental Hygienists (RDH) are dental disease prevention specialists. They are not well-positioned to significantly improve access for underserved populations because only 2.5% of RDHs practice in non-private practice settings.[5] A key problem of the existing system is that many Californians cannot access care in dental offices as they either do not have the financial means to pay for dental care (i.e. uninsured or low income), or face physical impediments to getting to a dental office, (i.e. not in geographic proximity, institutionalized).[6]

In 1998, California officially recognized a new dental health profession: the Registered Dental Hygienist in Alternative Practice (RDHAP). To become an RDHAP, candidates must have a baccalaureate degree (or equivalent), hold an RDH license, have 2000 hours of clinical practice in the past 36 months, complete a 150-hour accredited educational program and pass an examination on California Law and Ethics administered by the Committee on Dental Auxiliaries (COMDA), a subcommittee of the California Dental Board (CDB). RDHAPs may practice *unsupervised* in homes, schools, residential facilities and other institutions, and in Dental Health Professional Shortage Areas.[7]

Recent RDHAP licensees (over two hundred in the last few years) have been able to set up practices successfully, however they do report difficulties with providing services in underserved areas for a variety of reasons. These obstacles could be removed through policy adjustments.[5] This study explores the ways in which reasonable policy modifications may

improve utilization of the RDHAP workforce. Accordingly, we examine the evolution of RDHAP practices and their progress in creating and expanding access to care for vulnerable populations. The specific aims of this research project are to:

- Profile the RDHAP workforce and compare it to the RDH workforce to understand the unique practice settings, patient demographics and services of RDHAPs.
- Explore the practice realities of RDHAPs as they enter underserved communities and devise new models of care delivery outside of the traditional dental office.
- Discuss laws specific to the RDHAP profession and develop policy recommendations to further enable RDHAPs to expand access to preventive dental care for underserved Californians.

Historical Development of the RDHAP

The dental care system consists of a variety of organizations that strive to meet the dental needs of diverse populations in the U.S. The expansion of private practice dental services in combination with public health interventions such as water fluoridation and the expanded use of personal dental hygiene products have resulted in improvements in oral health status over the past 50 years. However, there is a growing segment of the population which increasingly can not access services and is shouldering a disproportionate burden of dental disease.[6, 8] To address the widening disparities in oral health status, in 2000, the Surgeon General issued a National Call to Action, to which many organizations responded.[2] Proposed solutions ranged from more traditional ways to increase the health workforce through state planning and expansion of educational programs to small pilot projects testing multiple pathways to addressing access issues locally.[4, 9, 10]

The dental workforce is a critical component of health care delivery. Views differ on how providers may best reach underserved people. There have been multiple proposals recommending new categories of providers, more ethnically diverse providers or simply more of the same in greater numbers. Some of these proposed models have been tried, but have not significantly advanced against the dominant delivery system of private practice dentistry. Only in the last decade have alternative models of independent and public health dental hygiene begun to attain legal recognition across the U.S [11]

Figure 1: Historical Overview of the Dental Hygienist Profession in the U.S.

Early 1900's
Dentists generally oppose the utilization of dental assistants and hygienists.

1950s & Post WWII
Unexpected consumer demand for dental care arises from the baby boom. In response, the dental hygienist workforce, comprising mostly of women, emerges to help meet this demand. The dental profession regulates the training and practice of hygienists from the beginning.

1965
Medicaid and Medicare laws are enacted without provisions for dental care, setting Medicine on a new trajectory but leaving dentistry untouched.

1970's
Predominantly female dental hygiene workforce continues to expand, coinciding with a continued overall expansion of women in the workforce and rising feminist projects regarding equality in working conditions and pay. Efforts toward professional independence originate.

1980s and 1990s
Market solutions to health care crises are explored. The increasing popularity of cosmetic procedures makes private practice dentistry more lucrative. Access to dental care becomes a major policy issue. Dental hygiene continues to push professional independence. States begin to consider using different delivery models, including independent or expanded dental hygiene scopes of practice.

1990s -2000's
Turmoil in health care increases. The Surgeon General's report on Oral Health and Call to Action address health care access, disparities and market failures. States begin to adopt new delivery models, including public health, independent and expanded dental hygiene scopes of practice. California legally recognizes the RDHAP profession, and establishes two educational programs. As of late 2007, the State has 202 RDHAPs.

Several studies have been conducted to examine these new practice models.[11-14] Most have focused on the safety and efficacy of pilot programs, not the actual process of implementation or impact on access of alternative dental hygiene practice. For example, economic and practice studies have been conducted in Colorado where RDHs may now practice independently.[15, 16] In Alaska, preliminary results of the Dental Health Aide Therapist program have shown safe and effective outcomes of the few providers in practice.[14] In California, studies conducted by researchers as a component of the Health Manpower Pilot Projects Program (HMPP) (now, Health Workforce Pilot Projects Program (HWPP))

examined the RDHAP pilot in terms of practice settings, quality of service and patient satisfaction and demographics. These studies provided the positive evidence needed for the establishment of the RDHAP profession.[17-20] Still, few alternative dental workforce models have been implemented, given the opposition from the mainstream dental community. In spite of this past opposition, however, initiatives to develop new workforce models have finally emerged as a legitimate undertaking, as evidenced by new workforce models being developed by the American Dental Association, the American Dental Hygienists' Association, and others.[14] The RDHAPs' experiences provide the best evidence as to *how new models already in practice actually are working*.

This study does not evaluate the "outcomes" of the RDHAP practices in the traditional way through counts of utilization or services delivered, quality of care, or economics of practice. These areas may be ripe for study in the future; however, they provide no understanding of the change process, only its outcomes. Rather, I examined the qualitative experiences and backgrounds of RDHAPs to understand their motivations, experiences and aspirations that greatly impact what they do, how they do it, and why they do it. Unveiling such data is an important first step in allowing more stakeholders to understand and consider the utilization of alternative dental providers. Accordingly, this paper discusses the context surrounding RDHAP practices, including strategies to develop practices, successes and shortcomings. It then presents policy recommendations to increase the capacity of RDHAPs to treat underserved people.

Research Task and Methods

This study utilized a mixed methods approach, which was approved by the UCSF Committee on Human Research. First, I conducted a standard statistical analysis of the 2005-2006 California Survey of Registered Dental Hygienists.[5] The survey sample represented the State's dental hygiene workforce as of September 2005. The response rate was 74%.

Second, I examined legislative histories, current regulations and commentaries from the 2005-2006 California Survey of Registered Dental Hygienists. I also interviewed practicing RDHAPs and experts from educational institutions and professional associations involved in

the development and regulation of the RDHAP profession. The legislative review includes an overview of RDHAP licensure requirements and scope of practice. Sources for the literature review include OSHPD archives.

The open-ended portion of our statewide sample survey of RDHAPs was invaluable to the study. Fifty-two percent of the respondents provided comments on their practices and experiences. These comments were used in combination with other background research to create our final interview protocol. The protocol was used to interview: 1) one focus group, which consisted of seven RDHAPs (five in practice, one graduate currently developing her practice and one student) and 2) five additional practicing RDHAPs, individually. I also interviewed representatives of several key organizations and institutions regarding their roles in the professional development of RDHAPs: the California Dental Hygienists' Association (CDHA), the California Dental Association (CDA), the Committee on Dental Auxiliaries (COMDA), the California Dental Board (CDB), the University of the Pacific (UOP) and West Los Angeles College (WLAC).

Legislative Review[i]

Historical Development of Alternative Providers

In 1972 the California Legislature enacted AB1503 (Duffy), The Health Manpower Pilots Act, setting the stage for efforts to bring the RDHAP into existence. Today, this program is the Health Workforce Pilot Projects Program (HWPP). It "allows organizations to test, demonstrate, and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes in licensing laws are made by the Legislature." [22] Organizations may use HWPPs to study the potential expansion of a profession's scope of practice to a) facilitate better access to healthcare, b) expand and encourage workforce development, c) demonstrate, test and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives, or d) help inform the legislature when considering changes to existing legislation in the Business and Professions code.[22]

[i] A review of the history of legislative policies conducted by the California Dental Hygienists' Association formed the basis of much of the following analysis.(21. Hurlbutt, M. and K. Menage-Bernie, RDHAP: Past, Present, Future. 2007, California Dental Hygienists' Association: Glendale.)

In 1980, California State University at Northridge in collaboration with the Southern California Dental Hygienists' Association[ii] submitted an application (HMPP #139) to "teach new skills to existing categories of health care personnel and expand the role of dental auxiliaries, specifically dental hygienists."[23] The approved application was underway in 1985 when Maxine Waters introduced companion bills AB844 and AB845, which would have allowed RDHs to practice without supervision in selected sites.[21] These bills were defeated, and in 1987, a lawsuit against the HMPP project host and participants was initiated by the California Dental Association (CDA). This lawsuit was dismissed. A second class of HMPP participants then entered independent practice, only to be followed by a second lawsuit in 1990 that focused on a technicality of the HMPP process. This lawsuit terminated HMPP#139; however, a subsequent application for HMPP#155 to continue the project was approved. During this time, a payment mechanism had been authorized by Denti-Cal to pay the hygienists enrolled and active in the employment phase of the project.[23]

The second HMPP stated as its purpose to "expand the role of dental auxiliaries to allow the independent practice of dental hygienists."[24] As the safety and efficacy of independent practice had been established by this time, the project objectives of the second HMPP were more specific to examining the metrics of the project, including the economic viability and sustainability of independent hygiene practice, as well as patient flows and outcomes. Two bills sponsored by Areias (AB2353 in 1992 & AB221 in 1993) sought to codify a series of changes in the law regarding licensure and regulation of dental hygienists and establish the independent hygiene category; however they were both defeated.

In 1995 AB560 (Rosenthal/Perata) was introduced to again try to establish the category of independent practice. After becoming a two year bill it was signed into law in 1997. It amended the Business and Professions code to extend the scope of practice for dental hygienists, and added a new category of provider, the RDHAP, who could provide

[ii] In 1980, Dental Hygiene had two separate associations for Northern and Southern California. Today these are combined into the California Dental Hygienists' Association. The initiative was spearheaded by a group of hygienists in the Southern California Association who raised approximately $500,000 to fund the pilot.

independent services *with the prescription of a dentist or physician and surgeon*[iii]. The passing of this legislation also terminated the HMPP project #155. The participants in the original HMPPs were considered as having satisfied licensing requirements and were allowed to continue their practices.[24]

Figure 2: Summary of RDHAP Scope of Practice

COMDA Regulations:

Once licensed, an RDHAP may practice as (1) an employee of a dentist; (2) an employee of another registered dental hygienist in alternative practice; (3) an independent contractor; (4) a sole proprietor of an alternative dental hygiene practice; (5) an employee of a primary care clinic or specialty clinic that is licensed pursuant to Section 1204 of the Health and Safety Code; (6) an employee of a primary care clinic that is licensed pursuant to Section 1204 of the Health and Safety Code; (7) an employee of a clinic owned or operated by a public hospital or health system; or, (8) an employee of a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions code

They may perform the duties established by Board regulation in the following settings:
(1) Residences of the homebound.
(2) Schools.
(3) Residential facilities and other institutions.
(4) Dental health professional shortage areas, as certified by the Office of Statewide Health Planning and Development in accordance with existing office guidelines.

Prior to the establishment of an independent practice, an RDHAP must provide to the board documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services. The dentist's license must be current, active and not under discipline by the Board. Any changes must be reported to the Board in writing, within 30 days following such change.

Existing Practitioners under the HMPP

Persons who completed the required coursework under the HMPP (Health Manpower Pilot Project) and established an independent practice by June 30, 1997, do not need to comply with the above requirements. They may apply for a license by obtaining an application from COMDA. Applicants must provide proof of having established a practice by June 30, 1997, complete the application, and pay a $20 application fee and a $56 fingerprint fee. A license will be issued once the person's criminal history background investigation has been completed.

The original participants of the pilot project have been practicing independently since the completion of the HMPP; however a formal education program for RDHAPs did not become available until 2003.[25] Although the curriculum was already developed, it took several years

[iii] The original HMPP pilot did not require a prescription requirement for independent hygiene services.

to find a new host for the program. The first RDHAP class graduated from West Los Angeles College in 2003 and, following a Request for Proposals from the CDHA for a distance education program, a second program opened at the University of the Pacific, which has been graduating RDHAPs since 2004.

The enactment of the RDHAP category and state institutional support through education, licensure and billing status of these providers were the critical first steps toward enabling the implementation of RDHAP practices around the state. Since that time, additional legislation has modified the conditions and restrictions on RDHAP practices.

Current RDHAP Legislation (2002-present)

AB1589 (Perata) allowed RDHAPs to be employees of specified clinics in addition to the other areas of practice they are allowed in their licensure category. SB2022 (Figuroa) specified in detail the parameters of practice of dental hygiene and set new limitations on any other profession (besides the RDH or DDS) performing these procedures. Additionally, the bill allowed dental hygienists to provide education and preventive services without supervision in public health programs. Finally, it specified that a dental hygienist may use any material or device approved for use in the performance of a service or procedure within his or her scope of practice if they have the appropriate level of education and training required. This provision essentially allowed hygienists to use new technology as it becomes available without having to revisit the legal requirements of their scope of practice.

AB1334 (Salinas) changed the prescription requirement so that rather than needing a prescription prior to providing care, RDHAPs must *obtain written verification that a patient has been examined by a dentist or physician if the hygienist provides services to the patient 18 months or more after the first date the hygienist provides service… valid for a period not to exceed two years*. Finally, SB238 (Aanestad) was enacted in 2007 allowing a Federally Qualified Health Center (FQHC) to bill directly for an RDH or RDHAP encounter. This allows a clinic to employ an RDH or RDHAP regardless of whether they employ a dentist.

Dental Hygiene Practice - Related Legislation

The practice of RDHAPs may be affected by legislation pertaining to the practice of dental hygiene. For example, California now allows for RDH licensure by credential. RDHs from other states may thus be re-licensed in California through an expedited application process.[iv] However, the State cannot grant similar reciprocity to RDHAPs because the profession is not recognized outside of California.

In 2006, a California bill proposed to establish a Dental Hygiene Bureau in the Department of Consumer Affairs. The bill would have shifted the licensure and consumer protection duties over the state's RDHs and RDHAPs from COMDA to the self-regulating bureau. However, the bill was vetoed by the Governor.[v] In 2007 another bill proposed to create the Dental Hygiene Committee of California within the jurisdiction of the Dental Board. The new committee would have been responsible for the licensure of the state's RDHs and RDHAPs. However, the Governor likewise vetoed this bill.[vi] Both bills primarily sought to shift the professional oversight responsibilities from one entity to another, along with reconstituting the oversight committee. If implemented, these changes would not immediately affect RDHAP practice, but might have unknown long-term effects on RDHAP practice.

In 2007, two bills were introduced which would have improved access to oral health care. The bills would have permitted FQHCs to bill for services for FQHC patients when the services are delivered at locations other than FQHC sites. If passed, the bills would have allowed FQHCs to contract with providers in designated offsite locations, such as migrant camps and homeless shelters. However, one bill has been suspended in the Senate Appropriations Committee since summer 2007, while the other has been inactive since January 2008.[vii]

Also in 2007, a bill passed which will require COMDA licensees, including RDHs and RDHAPs, to report information regarding their specialty board certification and practice

[iv] Cal. Business & Professions Code §1766 (AB 2818 (2002, Aanestad)); "RDH Licensure by Credential," COMDA (2007), http://www.comda.ca.gov/rdhlbc.html.
[v] SB 1472 (2006, Figueroa).
[vi] SB 534 (2007, Perata).
[vii] AB 363 (2007, Berg); SB 400 (2007, Corbett).

status upon initial licensure and subsequent applications for renewal. The information will be posted on either COMDA's or the Dental Board of California's Internet Web site. Moreover, licensees will be permitted to report their cultural background and foreign language proficiency upon licensure renewal.[viii] The new law will not directly impact RDHAP practices. However, the tracking of the dental workforce may assist the State in pinpointing dentally underserved populations.

Examination of Legal Requirements for RDHAP Practice

RDHAP practice is bound by a set of requirements. The first is a condition of practice (see form in Appendix 1). Under the California Code of Regulations, prior to the establishment of independent practice, an RDHAP must provide the Dental Board of California with *documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services*.[ix] However, the Code of Regulations does not define "existing relationship." The minimum standard for the relationship is therefore ambiguous. The standard for the circumstances that warrant "referral, consultation, and emergency services" is similarly vague.

Thus, to provide a frame of reference, we examined the nature of other legally-mandated relationships in the medical community, specifically, between physicians and 1) nurse practitioners (NPs);[x] 2) certified nurse midwives (CNMs); 3) physician assistants (PAs);[xi] 4) direct entry midwives;[xii] and 5) public health nurses.[26] We also found similar legally-mandated agreements between hygienists and dentists in other states, particularly in public health settings where the hygienists may work without dentist supervision if "a stipulated standing order and protocol" is in place.[26]

[viii] Cal. Business & Professions Code §1715.5 (AB 269 (2007, Eng)).
[ix] Cal. Code of Regulations §1090.1.
[x] For an example of an NP agreement see http://www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf
[xi] For physician assistants, the relationship requires a delegation of services agreement, which explicitly sets out the type of procedures delegated, consultation requirements, practice setting/sites, and emergency specifications. (see Sjoberg 2002)
[xii] For the legal code outlining direct entry midwife requirement http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2505-2521

The mandated relationship between an RDHAP and a dentist is unique in many ways. First, the relationship is required even for procedures that are already within RDHAP scope of practice. Second, other non-physician professions are not required to maintain such relationships as a condition of licensure. Rather, mandated relationships between physicians and non-physicians generally must be maintained only where the non-physician intends to provide services beyond his legal scope of practice.

Table 1: Comparison of Professional Practice Agreements in California

	Supervision Requirement	Expanded Duties	Agreement Type	Institutional Role in Agreement
RDHAP	No	No	Documented DDS Relationship	No
Public Health Hygienists	Yes-General	No	Standing Orders	Yes
Direct Entry Midwife	No	No	Referral Agreement with MD	No
Nurse Practitioner	No	Yes	Standardized Procedure	Yes
Certified Nurse Midwife	No	Yes	Standardized Procedure	Yes
Physician Assistant	Yes - Direct	Yes	Delegation of Services Agreement	Yes
Public Health Nurse	No	No	Standardized Procedure	Yes
Registered Nurse	No	No	Standardized Procedure	Yes

For example, the "Standardized Procedure" legally permits NPs and CNMs to *perform functions which are considered the practice of medicine*. These procedures must be *developed collaboratively by nursing, medicine and administration in the organized health care system in which they practice*.[xiii] They do not need any agreement with a physician to perform duties within their nursing scope of practice.

The PA-physician agreement constitutes a formal delegation of medical duties from the supervising physician to the PA. The supervising physician must be available in person or by electronic communication whenever the PA is treating patients. Therefore, the physician need not be onsite at all times.[26] The mandated relationship between direct-entry/lay midwives and

[xiii] Regulations can be found at http://www.rn.ca.gov

physicians is more analogous to that between RDHAPs and dentists. Both groups must maintain a relationship with a medical provider in the event of unforeseen circumstances. However, the two groups differ with regard to education and training. Midwives are trained "on the job" to provide services entirely outside of the medical model. The sole purpose of the mandated midwife-physician relationship is therefore to provide pregnant patients with emergency medical care in case a life-threatening need arises. RDHAPs, on the other hand, must maintain relationships with dentists for referral and consultation in addition to emergency situations.

The mandated relationship for RDHAPs is also unique because such agreements between physicians and other non-physician providers are typically overseen by the medical institution in which they practice, such as a hospital or a clinic. Since there are few major "dental institutions" or hospitals with dental departments, the mandated RDHAP-dentist relationship is, in practice, really an agreement between two individual providers, with no organizational support to ensure standardization, good-faith and fairness.

While unique in many ways, the RDHAP is similar to other providers in that it has *Standards for Clinical Dental Hygiene Practice.* These standards guide professional practice both in the "provider-patient relationship" as well as the facilitation of "implementation of collaborative, patient-centered care in multi-disciplinary teams of health professionals."(p3) These standards hold providers accountable to all local, state and federal statutes and regulations over their scope of practice.[27]

The prescription requirement is a separate provision that limits RDHAPs ability to freely practice under their scope. As discussed, a patient must obtain a dentist or physician prescription for dental hygiene services if the patient seeks treatment from an RDHAP 18 months or more after the first RDHAP visit. This is unique in that most restrictions requiring a prescription of one provider to another are for specialty care, not for primary preventive health care services.

Finally, many RDHAP practices are with the elderly so federal and state laws regarding dental care in nursing homes affect them. Under federal law, nursing homes and skilled nursing

facilities are required to "assist residents in obtaining routine and 24-hour emergency dental care."[xiv] Under California law, "arrangements shall be made for an advisory dentist to participate at least annually in the staff development program for all patient care personnel and to approve oral hygiene policies and practices for the care of patients."[xv] Further, "[i]f [a] service cannot be brought into the facility, the facility shall assist the patient in arranging for transportation to and from the service location."[xvi]

Significant confusion has arisen among nursing home administrators, RDHAPs and dentists over the interpretation of these laws. For example, most facilities comply with the regulations by contracting with a dental provider (usually a Denti-Cal provider) to meet patients' dental needs. Because these contracts are not specifically required by law, their scope and reach are often unclear. For instance, a large percentage of RDHAPs are developing their practices in nursing homes, providing on-site preventive care and education, and referring restorative treatment needs to a dentist. However, many dentists with whom the nursing homes have a contractual relationship *assume* that the relationship grants them exclusive authority to provide dental care to the nursing home patients (which the law does not require), and have sought to have the RDHAPs removed from the homes. This is causing much frustration for nursing home administrators who want to both provide on-site preventive care as well as have a dentist available for treatment needs but who are told they may only have the latter if they deny the former.

Legislative Summary: Impacts on Access to Care

In summary, any legislation regarding dental hygiene education, training, licensure, scope of practice, or reimbursement mechanisms may impact the practice landscape of RDHAPs, and consequently, their ability to improve access to care. Neutrally-worded legal provisions can, in effect, constrict the profession's practices. Policy-makers should thus consider potential impediments to access that may follow from seemingly innocuous proposals, such as proposals to "restructure" reimbursement schemes.

[xiv] 42 CFR Ch. IV (10-1-01 Edition) p. 528-29, section 483.55 Dental Services
[xv] Cal. Code of Regulations §72301.
[xvi] Id.

The restrictions placed on the RDHAP profession are the result of a political compromise that allows for independent hygiene practice in exchange for improving access to dental care for underserved populations in California. Legislators understood that permitting RDHAPs to practice independently was imperative to meeting this goal because RDHAPs often practice in communities where few dentists practice and few dentists accept Denti-Cal. Logically, therefore, the more ties RDHAPs are required to maintain with dentists, the more constrained RDHAPs will be from reaching the underserved.

Contrary to original legislative intent, many recent proposals have sought to restrict RDHAPs from full independent practice, inevitably creating barriers to access. Policy-makers should instead focus on the purpose of RDHAP profession – to improve access to dental care. The profession's capacity to improve access is inherently tied to reimbursement policies for treating the underserved, including the elderly and developmentally disabled. Legislators may therefore want to consider expanding public financial support structures for RDHAPs.

Profile of the RDHAP Workforce

The results from the 2005-2006 UCSF Statewide Survey of Dental Hygienists in California provide a baseline understanding of who is choosing to enter this licensure category and what kind of work they are doing. [5] The RDHAP workforce, while still small in numbers[xvii], is distinct in many important ways. First of course is its very existence. Dental hygienists have been working to expand their scope of practice and reduce their supervision requirements for over twenty years. California was one of the first states to allow a pilot of independent practice and subsequently legislatively enact this new category of provider.[19] The following section describes the overall profile and practice characteristics of the 119 RDHAPs in comparison to the 11,083 RDHs in the workforce as of 2005-2006.

[xvii] The survey included 119 RDHAPs as of September 2005. As of September 20, 2007, there were 202 individuals ever licensed as an RDHAP in California, and 196 active licenses (Personal Email Communication, Elizabeth Ware, Executive Officer, Committee on Dental Auxiliaries, September 20, 2007).

Demographics

In many ways, the RDH and RDHAP workforce are alike given that RDHAPs are a subset of the RDH workforce. The age distribution of the two groups is similar, as are the marital status and gender distributions.

Table 2: Comparison of Workforce Demographics

	RDHAP	**RDH**
Age Distribution		
18-30	5%	7%
31-40	22%	26%
41-50	31%	33%
51-65	41%	32%
65+	2%	2%
Marital Status		
Single	15.0%	13.6%
Married/Partner	64.5%	72.5%
Divorced / Separated / Widow	20.6%	13.9%
Gender		
Male	3.7%	2.5%
Female	96.3%	97.5%
Underrepresented Minority**		
African-American, Hispanic, Native American*	21%	9%

**Statistically significant differences*
*** Reported together due to small sample size*

There are some significant demographic differences, with RDHAPs more likely than RDHs to be from an underrepresented minority group (African American, Hispanic, Native American), more likely to speak a foreign language (35% vs. 27%), and less likely to have children living at home (41% vs. 55%).

Education

The RDHAP workforce is required to have a baccalaureate (or equivalent) education as a pre-requisite for licensure. Hence, RDHAPs are more likely than RDHs to have a bachelor's degree or above (70% vs. 48%). RDHAPs who participated in the original Manpower Pilot Projects (HMPP #139 & #155) were not required to be baccalaureate educated. RDHAPs are equally likely as RDHs to have been educated in-state (78% vs. 77%).

Clinical practice

Many RDHAPs reported that they are maintaining a traditional RDH job in addition to developing their RDHAP practice. Therefore, the clinical practice data we collected cannot be used to specifically distinguish the clinical work of an RDH vs. an RDHAP. In spite of this, we can make some general observations about practice differences between the two groups. First, RDHAPs work a half day more per week on average (3.8 days) than the average RDH (3.4 days). They reported significantly greater difficulty finding an acceptable salary range (18% vs. 11%) and/or benefit package (23% vs. 14%) when last looking for work.[xviii] RDHAPs did not report a significant difference from RDHs in difficulty finding work, opinion of the supply of RDHs in the state, or years they intended to work.

Table 3: Comparison of Clinical Practice Experience

	RDHAP	**RDH**
Difficulty Finding Work		
None	77.5%	78.3%
Some Difficulty	13.5%	16.8%
Difficult	7.9%	3.5%
Extremely Difficult	1.1%	1.4%
Opinion of RDH Supply		
Too Many	18.4%	12.1%
Adequate Number	62.1%	67.5%
Not Enough	19.5%	20.4%
Years Intending to Practice		
<2	6.6%	4.1%
2-5	11.0%	16.7%
6-10	36.3%	30.4%
10+	46.1%	48.5%

**no statistically significant differences in these categories*

Patient Populations

RDHAPs and RDHs reported similar numbers of patients per day (8.5 and 8.4 respectively) and similar racial, ethnic and age breakdowns of their patient populations. The only category showing a statistically significant difference is the 0-1 year olds, however the percentages were extremely low. RDHAPs reported a slightly higher percent of patients (3.5%) they had difficulty communicating with due to language barriers than did RDHs (1.9%), however the

[xviii] Respondents did not differentiate whether this was when last looking for a traditional RDH job or when looking for work as an RDHAP. Therefore, it may reflect a difficulty with traditional practice that would have been an impetus to become and RDHAP, or could reflect difficulty establishing RDHAP practice.

differences were not statistically significant. The largest differences in patient populations between the RDHAPs and RDHs were those considered medically compromised, developmentally disabled, mentally ill and having a behavioral management problem[xix].

Table 4: Comparison of Patient Characteristics

	RDHAP	RDH
Age of Patients		
0-1*	0.6%	0.1%
2-5	5.0%	4.2%
6-17	12.3%	12.3%
18-64	61.2%	61.8%
65+	21.3%	21.3%
Race/Ethnicity of Patients		
African-American	5.6%	5.8%
American Indian	0.9%	1.4%
Asian/Pacific Islander	6.9%	8.4%
Hispanic/Latino	18.0%	15.0%
White	67.2%	67.3%
Other	2.4%	2.4%
Special Needs Patients		
Medically Compromised*	25.8%	16.8%
Developmentally Disabled	4.7%	2.9%
Mentally Ill*	5.6%	2.6%
Behavior Management	2.6%	1.4%

**Statistically significant difference*

Practice Characteristics

There are quite a few differences in the practice characteristics of RDHAPs and RDHs. RDHAPs are more likely to work at multiple sites but for fewer clinical hours on average, across all sites than an RDH (31.8 hours vs. 34.6 hours per week).[xx]

Work settings of RDHAPs are much more diverse than for RDHs, with 24.5% of their reported practice sites being something other than a private dental practice, compared to 2.5% of RDHs.

Figure 3: Work Settings of Clinically Active RDHs in California

[xix] These data are reported for all their patients across all their practice sites. They do not distinguish which patients are in their "RDHAP" practices versus those in a traditional RDH practice.

[xx] These data differ from the total hours worked data reported above in that the question was how many hours you work at each individual site. RDHAPs are working many hours either in independent practice or doing other activities, so while their weekly practice site hours are fewer, their total weekly hours are greater.

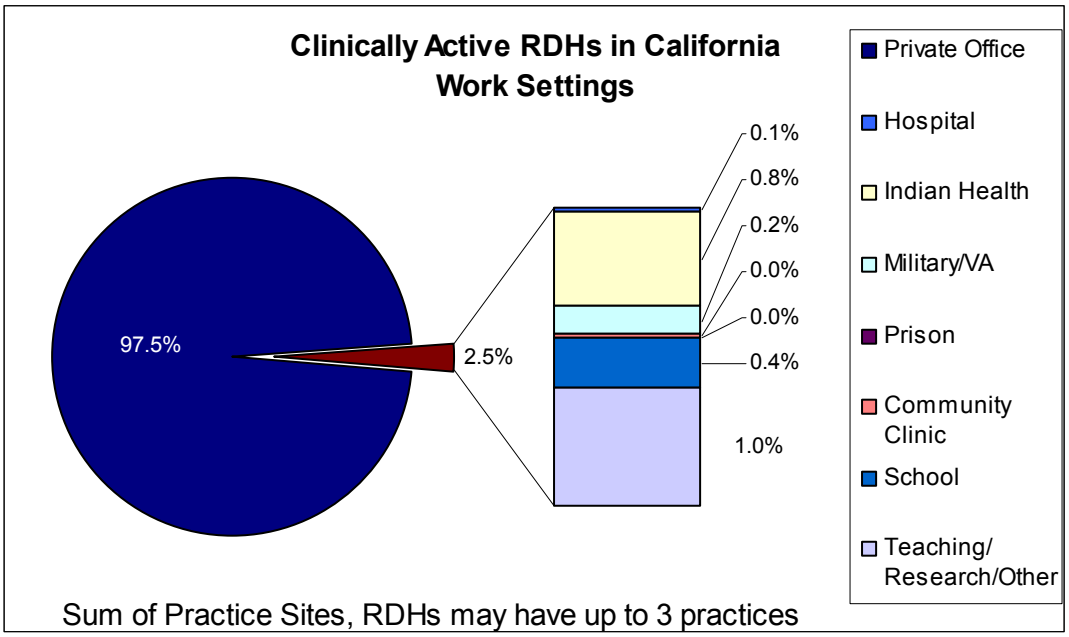
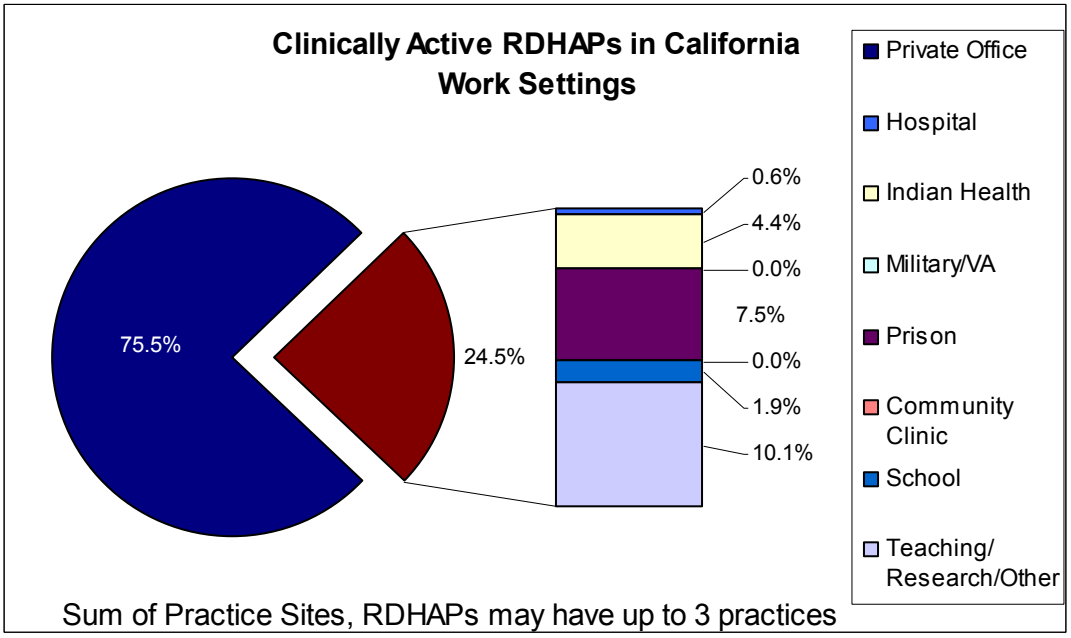


Figure 4: Work Settings of Clinically Active RDHAPs in California



The practice type (general practice, pediatrics, endodonics, etc) of the practices they are in do not vary significantly, except for among "other" types of practices, indicating that for those that continue to work as an RDH, they continue to mirror their peers in work patterns, but as an RDHAP they are in alternative settings. This pattern is further elaborated as RDHAPs

report being employed for one or two practice sites, but self-employed for a second or third. No RDHs reported being self-employed. Significantly more RDHAPs reported they had a contract for their second (40.0% v. 19.4%) and third (62.5% vs.12.0%) practice settings than did RDHs.

Table 5: Comparison of wages, benefits and health care consultations

	RDHAP	**RDH**
Benefits		
Continuing Education	45.7%	52.4%
Dental Care/Coverage*	51.1%	64.8%
Disability Insurance	10.9%	7.3%
Medical Insurance	25.0%	26.7%
Paid Liability/Malpractice	9.8%	5.9%
Paid Sick Leave*	12.0%	20.4%
Paid Vacation	45.7%	48.8%
Production Bonus	25.0%	29.0%
Paid Professional Dues	5.4%	2.8%
Retirement/Pension Plan	35.9%	35.4%
Hourly Wage		
Practice 1	$46.47	$45.63
Practice 2*	$48.22	$45.52
Practice 3*	$52.19	$45.06
Average Wage - All Practices*	$50.73	$45.28
Consultations		
Dental Specialist	46.7%	52.6%
Physician*	57.6%	47.4%
Physician Assistant*	14.1%	4.5%
Nurse Practitioner*	14.1%	5.1%
Registered Nurse*	18.5%	6.0%
Nutritionist*	8.7%	2.1%
Other*	12.0%	3.7%
None	26.1%	28.2%

**Statistically significant difference*

RDHAPs reported higher hourly wages across practice sites than RDHs did ($50.73 vs. $45.28)[xxi]. The benefits reported by RDHAPs and RDHs varied significantly in two categories. RDHAPs reported less coverage for dental benefits and paid sick leave. A significantly greater number of RDHAPs reported consultations with non-dental professionals in the care of their patients. Finally, there were no differences between the two groups in the number of years worked at each practice site.

[xxi] This is not the wage reported for their AP practice, rather the average of the wage they reported at each practice site, one or more of which may have been a private practice.

Scope of work

An RDHAP may perform any preventive or therapeutic duty that an RDH is allowed to perform under general supervision. We found differences in the distribution of work done within this shared scope of practice between the two groups. Table 6 reports the average percent of procedures in each category done by group. Each category encompasses multiple procedures. On average, RDHAPs were performing a greater mix of procedures in each category than were RDHs. As well, RDHAPs, while working an equivalent number of patient care hours per week, were spending significantly more hours in administration, public health and other categories of work than were RDHs.

Table 6: Comparison of Scope and Hours of Work

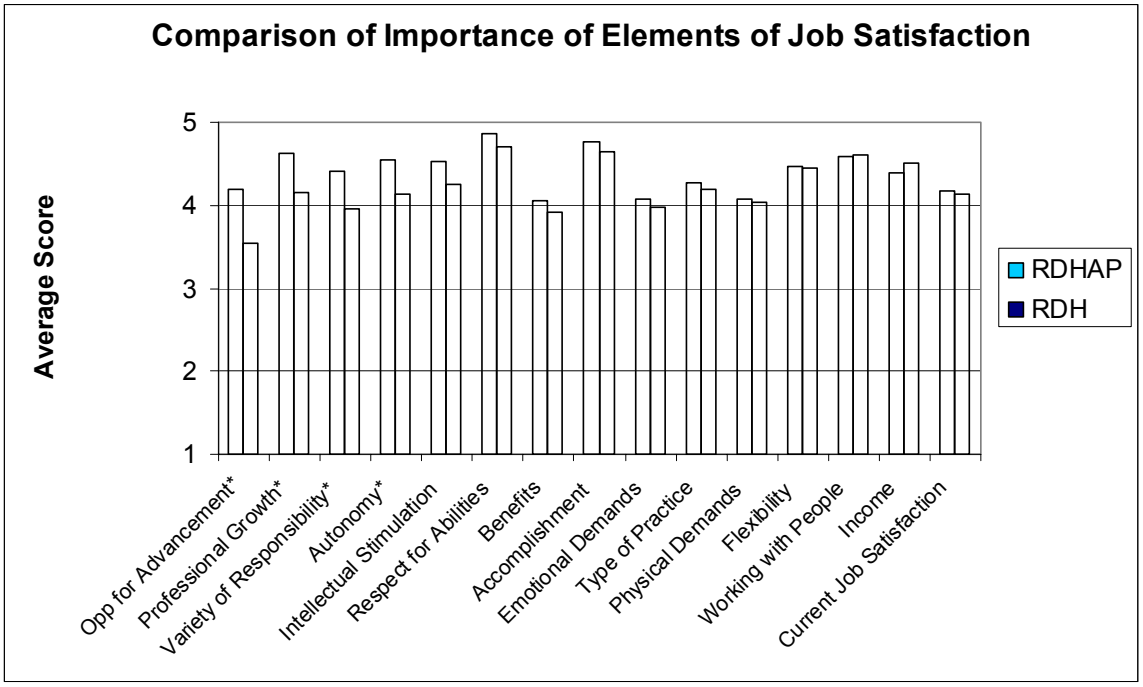
	RDHAP	**RDH**
Scope of Work	Average Percent of Procedures in Category Reportedly Done in Practice	Average Percent of Procedures in Category Reportedly Done in Practice
Diagnostic	73%	68%
Preventive	87%	82%
Therapeutic	94%	92%
Restorative*	16%	8%
Surgical	41%	37%
Cosmetic	23%	13%
Weekly Hours Worked		
Patient Care	22.91	23.33
Administration*	2.20	0.77
Public Health*	1.88	0.11
Teaching	1.38	0.35
Research	0.01	0.02
Other*	1.26	0.20

**Statistically significant difference*

Job Satisfaction

Both RDHAPs and RDHs report high levels of job satisfaction (4.16 and 4.12 respectively on a 1-5 scale, 5 being greatest). However, they differ in what factors contribute to their job satisfaction. The top items contributing to RDHAP satisfaction are “Respect for Abilities”, “Sense of Accomplishment” and “Professional Growth”. The top items contributing to RDH job satisfaction are “Respect for Abilities”, “Sense of Accomplishment”, and “Working with People”. The items where there was significant difference between the groups, with RDHAPs

rating the factor higher than RDHs, were "Opportunity for Advancement", "Professional Growth", "Variety of Responsibility", and "Autonomy".



Opinions on Professional Issues

Survey respondents were asked to personally agree or disagree with a set of statements about professional issues. There was a statistically significant difference on answers to all questions between RDHs and RDHAPs. A much greater percentage of RDHAPs think access to care is an important issue and express a personal desire to work with underserved patients and communities. In addition to significant differences in opinion on the major issues facing the profession, 78.8% of RDHAPs report being a member of their professional association, vs. 36.1% of RDHs.

Table 7: Comparison of Professional Opinions on Hygiene Practice

	RDHAP	**RDH**
Professional Issues*	Percent Agreeing	Percent Agreeing
Would like Self Employment without Supervision	95.9%	39.1%
Would like General Supervision Only	91.8%	69.5%
Would like Prescriptive Authority	94.9%	64.8%
Would like to do Restorative Procedures	70.4%	40.1%
Is Not Practicing to Full Extent	59.0%	34.5%
Thinks Current Environment Good Fit	87.4%	93.9%
Would like to Work Outside Dental Office	95.8%	49.8%
Would like to be Directly Reimbursed	88.4%	28.1%
Desires to Work with Disadvantaged Patients	**88.7%**	**31.9%**
Desires Work with Underserved Community	**77.1%**	**30.0%**
Thinks Improving Access is Important	**94.9%**	**66.5%**
Thinks Current Regulatory Structure is OK	16.5%	58.0%
Would Agree to License Fee Increase for Self-Regulation	94.7%	56.7%
Would like to Interact with non-Dental Health Providers	95.8%	67.3%
Would Have Liked Loan Repayment Option	69.5%	51.9%
Would be part of Volunteer Emergency Registry	81.3%	53.7%
Is Interested in Job in DH Administration or Education	79.4%	57.6%

**Statistically significant difference in all categories*

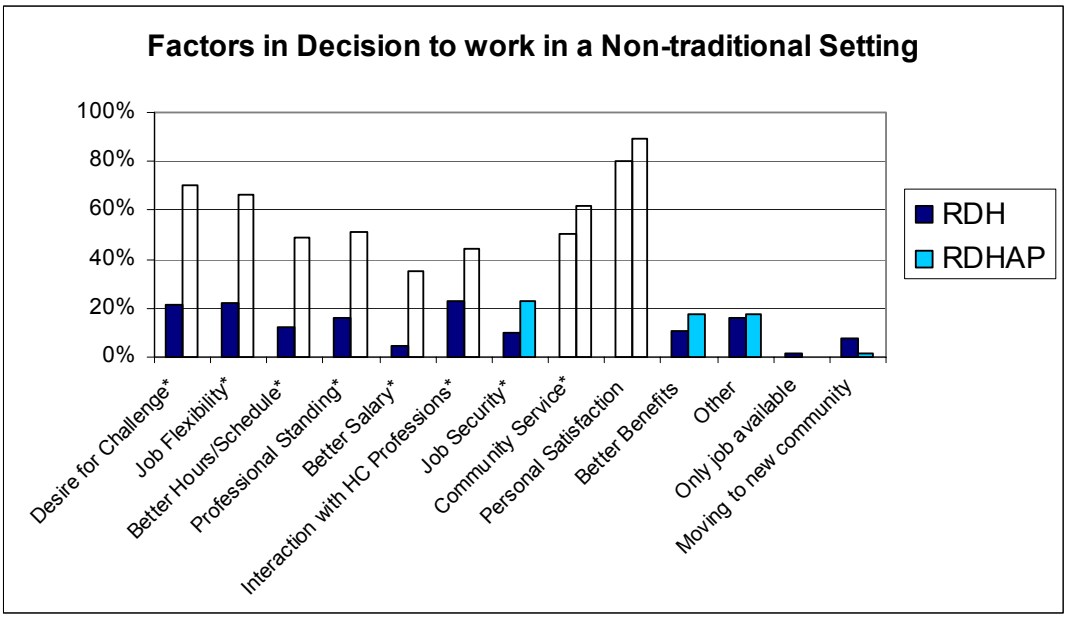
Non-Traditional Practice

Consistent with their scope of practice and restrictions on work settings, RDHAPs are significantly more likely to work in non-traditional settings. These are defined as any practice site that is not a private dental office or clinic. RDHAPs were more likely than RDHs to provide services in a non-traditional setting under general supervision of a dentist or other employer (67.0% vs 9.8%), to work unsupervised in a public health program (25.0% vs. 1.4%), and to desire to work in a non-traditional setting in the future (88.8% vs. 23.6%). Of those hygienists working in a non-traditional setting, RDHAPs are more likely than RDHs to be compensated by patients (60.8% vs. 3.5%), and less likely than RDHs to be compensated by an employer (20.3% vs. 32.3%). They are equally likely to be compensated by the institution they work for (33.8% vs. 34.0%).

Both RDHAPs and RDHs report personal satisfaction as the number one reason for choosing to work in a non-traditional setting. However, RDHAPs report different additional reasons for choosing a non-traditional setting than do RDHs. Overall, RDHAPs were more likely to feel

an alternative setting provided more challenge, flexibility, salary, professional standing and intra-professional contact than were RDHs.

Figure 5: Factors in Decision to Work in a Non-traditional Setting



RDHAP Workforce Profile Summary

These results are important in that they document the baseline practices against which the future characteristics of the profession can be measured. The RDHAP workforce is being educated and licensed to work independently with the goal of increasing access to care for underserved populations and communities. The survey results show that RDHAPs take this role seriously and are in fact fulfilling their mission in these preliminary stages of practice development. As a group, RDHAPs are more educated and diverse than RDHs. They are also more active in the labor market, work longer hours per week with more administrative time, and more likely to consult with other health care providers than are typical hygienists. As well, RDHAPs are more likely to see special needs patients, provide a broader range of services within their scope, work in non-traditional settings, and express a commitment to professional growth, improving access to care and providing services to underserved populations and communities.

It is essential to understand that this professional model is evolving rapidly, so the results presented here reflect the experiences of the first several cohorts as of 2006. Today, in 2008, there is almost double the number of RDHAPs, so their practices may have evolved. What is unlikely to have changed is the profile of the larger RDH workforce from which RDHAPs are drawn.

The RDHAP Experience

To explore the evolution of RDHAP practice, I interviewed a variety of RDHAP providers. The interviews focused on understanding the experiences RDHAPs are having setting up their practices, developing their business models, and providing services. While the development of alternative practice has been many years in the making, the RDHAP as a practicing provider is new to the dental care marketplace. Understanding what successes and barriers the new RDHAPs are encountering in finding employment and/or establishing practices with underserved communities will shed light on the oral health care landscape in these communities and identify ways to build on the expansion of access to dental care they have begun.

Pressing Practice Issues: 2005-2006

In 2005-2006 RDHAP respondents to a statewide sample survey indicated concerns in three areas. The first concern was the impact of structural issues arising from the regulatory, fiscal and administrative environment in which they work. The second concern was the business aspect of their work. The final concern was professional issues that both advance and hinder their practices. I structured my interviews around these themes and found that RDHAPs felt that while improvements had been made in the intervening years, many challenges remained. In the following section, I report on the main findings from my interviews with RDHAPs. I group these findings into four sections: a) motivations for practice, b) patient populations, c) business challenges and d) structural conditions. Responsibility for the interpretation of their statements is my own. However, whenever possible I try to use the RDHAPs' own words, so the reader may understand the experience of an RDHAP from their own perspective.

RDHAP Motivations to Practice

> *"To do things well it takes much effort and hard work. This whole vision takes a special person, not all hygienists would do this work."*

The RDHAP workforce is engaged in independent dental hygiene practice that is limited to underserved communities. Entrants into the field tend to be experienced, innovative and sincerely motivated to increase access to dental care.

> *"I think you really need to be a dynamic dental hygienist, a go-getter, seasoned, able to handle any situation. I really enjoy it."*

RDHAPs reported many attractions to their type of practice. The rewards of being able to serve patients in their communities, and the sense of accomplishment from building their own unique practices, were the two most common themes.

> *"I think it's people who have always worked with developmentally disabled, always worked with the elderly population, always worked in the schools. All of us had some extended involvement with the community outside of just working for three days, five days a week in a regular dental practice. We all were involved in a different capacity, and I think that's what this program attracts is people who really, sincerely want to help. It's not a money thing."*

RDHAPs feel their practices provide opportunities for teamwork and collaboration with medical and dental providers not normally afforded to a dental hygienist in a private practice[xxii]. The work itself, while challenging, is also interesting, rewarding, and needed in the community.

> *"There's enough business out there for all of us. I mean, I could work 24 hours a day 7 days a week and still not fill the void."*

The RDHAP provides a career opportunity for hygienists who are dissatisfied with private practice, allowing them to remain in the profession, but in a new capacity. Hygienists seeking alternative practice have expressed frustration with being bound to a private practice model that does not afford full employment or professional advancement for hygienists and where job conditions, security and satisfaction depend more on the quality of the interpersonal relationship with a dentist than the on the quality of their work.

> *"I have worked 20 years full time and have no pension plan or benefits to show for it, and certainly no respect. The dentist expects much but gives little. As an RDHAP I have become partners with a dentist who provides mobile services. I will not work for him, but with him."*

[xxii] As shown in Table 5, RDHAPs are two to three times more likely to collaborate with a non-dental health care professional than an RDH.

Hygienists also expressed dissatisfaction that within a traditional dental practice they are unable to provide the quality of services they want to provide, and work with the special populations in their communities they know need care.

> *"Our population was getting booted left and right out of dental care because of behavior issues. Many of our federally qualified health centers, our safety net clinics, are so busy putting out fires they don't have time for behavioral support and behavioral management. So many of the patients that I was seeing to route into care – there was no place to route them. It was a frustration for me. I even went to work at a community clinic so I could see – I took a job for a lot less money in a clinic so that I could actually provide good preventive hygiene care to these patients because I saw the need."*

In sum, the interviews showed that while each RDHAP has a unique and personal motivation to do the work they do, they share a commitment to working with underserved patients in a model of care delivery responsive to patients as well as personally and professionally satisfying.

RDHAP Patients and Communities

Central to any assessment of access to care is the question of "for whom." The law specifies which communities and institutions may be served by RDHAPs[xxiii]. The particular situation of individual providers is unique and specific to the communities in which they work and live. RDHAPs take the mission to work with vulnerable and marginalized populations seriously. The patients they are reaching out to, for the most part, have been neglected by the dental care system. This is particularly true of the homebound and institutionalized frail elderly patients for whom many RDHAPs provide care.

> *"The hygienists in my office, they in no shape, way, or form want to do this. One girl said, "I don't know how you could do that." But these patients are just like you and I -- they just haven't been seen in a while. There's a person attached to those teeth. She just thinks it's all yucky. But we've all seen that yuk. We just don't see it as much in private practice. Maybe once a month we'll get somebody who hasn't been -- or once every couple of months we'll get somebody who has not been seen in years. Where as, opposed to this, it's just daily.*"

[xxiii] Defined as (1) Residences of the homebound. (2) Schools. (3) Residential facilities and other institutions. (4) Dental health professional shortage areas. The specific populations they received training to treat are geriatric, pediatric, developmentally disabled and medically compromised patients. B&P Code 1073.3 (e)(1)(c).

Medicare does not provide dental benefits for the elderly population, adding dental disease to the already heavy burden of multiple health problems many older people shoulder. In nursing home and long-term care settings, dental health is usually neglected. Few dentists attend to the preventive health care needs of nursing home residents, and the nursing and medical staff in these homes is minimally trained in the provision of oral health care. One RDHAP who specialized in nursing homes provides a particularly graphic example of the implications of this neglect:

> *"They don't even know what's wrong with him and why he smells. But they're thinking maybe it could be his teeth because they kind of know nobody's really taken care of it. And when we- I had a nurse with me. I said, "Will you just open his mouth for me?" I took a picture, and there's blood everywhere. And there's no caries. It's just, you know, deep sub and no saliva, and the smell. The other nurse wouldn't come with me – but the RN wanted to come, and we finally put him on some medication. And then I had a nurse holding his arms. I asked the doctor yesterday what would be better. I would like something that is a little -- he doesn't want to flail like that, but it's involuntary. And so we've cleaned his teeth three times now, you know, gotten in there. And there are other cases like that. I think that, you know, you'll find degrees of that statewide. So the advent -- and I love this part too -- the advent of the RDHAP has opened a can of worms. Not only were these people underserved, they were underserved even when they were being served."*

RDHAPs report that they are choosing to focus on the people who need the most care in their communities. The homebound and institutionalized elderly population is often one of these underserved groups.

> *"We are there to provide services and to make these people have a sense of dignity and care because they are basically forgotten. Nobody wants to take care of their dental needs. Some of these people have been going to the dentist for years and then they get into a situation where they're in a nursing home and all of that is gone."*

The following list of the populations RDHAPs report working with is representative of the type of underserved communities the profession is reaching out to: homebound and institutionalized elderly, migrant farm-worker families, pregnant women on Denti-Cal, rural school children, developmentally disabled children and adults, wards of locked state institutions, and low income rural and urban families. Although they are unable to provide the restorative care their patients need, the preventive interventions they provide are making a difference for their patients. RDHAPs are creating accessible preventive dental services where none existed before, and improving the health of these communities in the process.

> *"I think that we have accomplished a lot with our fluoride varnish program, and we're talking about a rural area with limited access to care. I have seen children where literally people are living like squatters in a lot of these areas. It's just really sad. I see kids who are just filthy and never brushing yet the decay is arresting itself. I just last week, in two days, saw 137 children. Seven children that I actually saw that had caries three years ago still had not been treated. After treating them, none of them had pain. The tissue was healthy at those sites because the caries were arrested. It's just phenomenal. What we have seen from the program that we've done is just -- I honestly think if this kind of thing were adopted statewide it would just save taxpayers hundreds of thousands of dollars in restorative dentistry; it really would"*

A constant focus on the needs of communities and patients is a core value emphasized by RDHAP providers. Their practices engender a commitment to a patient-centered, consumer responsive model of care delivery. RDHAPs are dedicated to developing mechanisms for reaching out to patients and improving ways of managing care for patients with special needs.

> *"Most of us that have gone in there are not looking at the business, but as an opportunity to go serve all these people and make a difference and help. It's a helping vocation. And it's really pronounced with the RDHAP. Because this is what they really, really -- like once they get seeing these patients and they help these little ladies and the staff, they feel real good about what they're doing. And that's real common in almost all of them."*

In sum, the RDHAPs I interviewed all described a high level of commitment to the patients they provide services and advocate for. RDHAP patients fall squarely in the standard policy definition of "underserved populations." The number and diversity of their patients is emblematic of how many different people are unable to access services in the traditional way.

The Business of RDHAP Practice

RDHAPs are allowed by law to work independently in underserved settings. There are two ways to achieve this: they must either fill an existing position in an organization or develop their own business. RDHAP training programs (located at West Los Angeles College and The University of the Pacific) may devote a maximum of 25% of their curriculum to business development. Both programs cover business topics, and the WLAC program ensures that RDHAPs graduate with a business plan in hand. As there are rarely RDHAP positions waiting for graduates, a business plan is essential to their success. A number of RDHAPs are currently enrolled in, or have already finished, formal education programs in various fields (public health, education, geriatrics, business) to help them succeed in their practices. In the following section, I outline the multitude of successes and barriers RDHAPs are having developing their businesses.

Practice Diversity: The types of practices RDHAPs are developing vary as widely as the local populations they serve. Many RDHAPs continue to work part-time in a traditional hygiene practice as they develop their RDHAP business. Unfortunately, some dentist/employers, rather than seeing a partnership as an opportunity to improve community health, only see RDHAPs as competition. The result is that RDHAPs have been laid off from their hygiene job when their dental employer discovered they were attending the RDHAP program.

RDHAPs grandfathered in from the original HMPP, or those who work in a Dental Health Professional Shortage Area (DHPSA), are able to set up an independent dental hygiene clinic. The more common business model is to set up a mobile practice and work in skilled nursing facilities, long-term care or residential care homes, schools, or public health clinics, or some combination of settings, as this hygienist does:

> *"I work 2 days a week with elementary school children in a rural area conducting exams, and placing fluoride varnish applications and sealants. Two days a week, I treat patients at an FQHC facility. I work two days a week in my own practice, as well as many evenings. I incorporate my mobile practice within this two-day period."*

RDHAPs offering preventive treatment in all of these settings report collaborating with medical and dental providers in their communities. Regardless, it continues to be challenging to find restorative treatment options for patients who are immobile (such as the institutionalized or homebound), or unable to pay (such as the poor uninsured and some of those covered by Denti-Cal). A hygienist working in a rural area with very few dentists and no Denti-Cal providers recounts:

> *"The way I refer -- there's one gentleman in there. He had his last extraction -- he's had pain for the last two years. I went to my office and talked to my dentist about it -- my private office. He gave me a referral to the oral surgeon. I gave it back to nursing -- I made him an appointment. I went back to the social worker and said okay, I've got an appointment for him on this day. They gave the referral to his physician who has to write a referral. So he got to the oral surgeon. So I had to go a long way around… some of these people aren't able to travel. They're bed-bound. To get them in a wheelchair and to get them on the bus and get them to a dental office, and then just sit there for hours on end -- because they're Medi-Cal, they're Denti-Cal. They're not going to -- they'll filter them in with the rest of their patients. Somebody needs to come in."*

As this example shows, case management and developing referral networks are essential skills for RDHAP's in practice, in addition to clinical work (hygiene services, sterilization, client

charting) and business development and administration (billing, marketing). In some settings such as a regional center (part of the department of developmental services), or a public health department, case management and program management are what RDHAPs are hired to do full time. In sum, RDHAPs have a diversity of practice types, as well as the option of diversifying across traditional and alternative practices to balance their personal, professional and client needs.

The Logistics of Business: The logistical issues RDHAPs face in setting up their business are start-up costs, developing a record keeping system, creating a fee schedule and getting a provider number with Denti-Cal and other insurers. RDHAPs found these logistics to be the more tedious and frustrating aspects of developing their practices. Start-up costs for an RDHAP are far less than what would be required for a stand alone dental practice. However, most RDHAPs need a small business loan to get started as the mobile equipment costs about $25,000. Many providers do custom modifications to their mobile kits to make them more user and patient friendly. The dental equipment companies have reportedly been enthusiastic about working with RDHAPs; however, the equipment currently available is not entirely satisfactory, as one hygienist notes,

> *"A friend of mine went out and purchased the equipment and then we thought, "Oh my goodness. This is heavy. This is too noisy; patients do not like all the noise. I find the mobile equipment quite cumbersome and am waiting for better equipment to be made available."*

RDHAPs can set up their business as a sole proprietorship, or they may incorporate. They can work independently or contract as vendors with public and/or private health organizations and institutions. They need billing numbers, vendor numbers and malpractice insurance, all of which have been challenges to obtain.

> *"We also had trouble getting malpractice insurance. They don't know who we are and we have to send in COMDA. Even though I've had malpractice insurance for years, especially being with a regional center, I had to send you know, all this paperwork. They don't even know."*

If an RDHAP is employed by an organization (such as in a case management or public health program role) they may be paid as an employee. If working as a sole proprietor or corporation, an RDHAP may employ other RDHAPs and staff such as a receptionist or an unlicensed

dental assistant, but they may not employ a registered dental hygienist or any type of licensed dental assistant[xxiv].

RDHAP's are billable providers of clinical services for all major public and private insurance plans, including Denti-Cal. Both RDHs and RDHAPs are now billable providers in FQHCs. Most RDHAPs report setting up their Denti-Cal provider number right at graduation, due to the paperwork and time needed to secure a provider number. RDHAPs can only bill as a sole proprietorship, causing some frustrations with differentiating individual and business income for tax purposes. RDHAPs can legally incorporate with IRS the same as dentists, but the code does not list an RDHAP corporation as billable [xxv]. Many RDHAPs noted struggles with getting payors to recognize them as providers, particularly payors located in other states where RDHAPs do not exist. However, many of the California-based insurers now have RDHAPs in their system, so new providers can more easily get set-up.

Balancing payment sources and setting fees for private pay patients is an area of contention within the RDHAP community. RDHAPs expressed tension between what fees to charge in comparison with one another, in comparison to what they would make (and would be charged to the patient) in a private office, and in comparison to what patients they wanted to serve could afford. One AP states:

> *"Financially I know I'm not charging as much as some of these other people I've talked to, as far as private home visits. I don't know, I'm having an issue with what to charge."*

While RDHAPs do not want to undersell their services they also realize that if they charge rates equivalent to a private dental office they will exclude the very people they are trying to help. Insurance companies have a set rate of reimbursement that varies by insurer and can change over time, adding another layer of complexity.

In order to make their practices work financially, RDHAPs can balance the number of patients they accept from different payment sources and in different settings. A major concern

[xxiv] Laws on the regulation of dental assisting have changed significantly as of January 1, 2008. New laws state an RDHAP may not supervise a licensed dental assistant. http://www.danb.org/main/statespecificinfo.asp#CA
[xxv] Cal. Business & Professions Code §1775 (a) Responsibilities of RDHAPs & Welfare & Institutions Code Section 14132(q)(2)

expressed by RDHAPs is the projected changes in Denti-Cal billing for services provided to elderly residents of nursing homes and long-term care facilities. The Denti-Cal program, in an attempt to emulate private insurance plans (none of which are designed to cover these populations) is proposing restricting the preventive work that can be done for the frail elderly and other at-risk populations. As one RDHAP put it:

> *"Well that's not helping the patients at all. And the presumed care is just going to be worse because eventually that means I really can't see patients more than once a year -- a Medi-Cal patient. And the beauty of RDHAP over the last five or six years is you can see them four times a year and give good, preventive care. And it's amazing how well that has worked. I mean, we have pictures of before and after of at how easy these people get to be as far as agreeing to the treatment and not being combative, and having the treatment done."*

In sum, RDHAPs face many challenges in setting up their businesses, some of which are typical of any small business owner, and some of which are unique to the regulatory and fiscal environment of dental services. As RDHAPs become established some of these challenges may lessen.

Marketing and Building Awareness: RDHAPs are a new provider in the field of dentistry and health care. A major part of the business development RDHAPs are doing is in marketing the services to their local communities. Much of this marketing is simply raising awareness in the dental and medical community, as well as with patients and administrators, as to what RDHAPs are, what they can do and what added value their services can bring. Many RDHAPs noted that "word of mouth" was the primary way they found clients. In communities or institutions where people currently are not receiving any care, the RDHAPs have been a welcome addition.

> *"When I called her [the nursing home administrator], she said, "Where have you been all my life, you know? I didn't even know you did this." And I was in. And I'm still in.*"

Unfortunately, this outreach has not always resulted in positive attention, particularly from local providers who are determined to keep competition away from their dental practices. One frustrated RDHAP sums it up:

> "*And I think that comes down to, again, the fight – who wants to fight the fight. If we market ourselves then someone is going to come out of the woodwork and come up against us. And I know a lot of hygienist APs have said this to me: "I'm working way down here on the radar screen for the purpose of that. I've already run into trouble. I don't want to initiate it again." And it's really unfortunate because there is such a thing as fair trade, you know? And it is*

unfortunate that we feel like we can't go out there and toot our horns and say, "Look, we're providing a wonderful service."

Negative responses have varied and several lawsuits against RDHAPs have ensued. One dental provider mailed notices to every patient in his practice "warning" them about a local RDHAP, and a mobile dental company faxed slanderous leaflets to nursing homes across the states "warning" them against hiring RDHAPs. These tactics have not succeeded in stopping RDHAPs from practicing, but have cost them time and energy – both of which they would have preferred to spend on care provision.

Competition vs. Collaboration in the Business of Dental Care: The final business issue RDHAPs confront is how to develop a collaborative model of business practice within their communities when local dental providers view the RDHAP profession as competition. The business practice experiences of RDHAPs are contingent on the local community structure and resources, their prior relationships with other providers in the community, and the level of support from the institutions within which they work. One woman recounted how positive her experience had been:

"Oh, no, he's [the local dentist] real supportive. He's not in the least bit -- he's been in practice for 30 some odd years and he's getting ready to retire. He thinks I'm doing a wonderful service. He's in no way threatened that I'm going to steal all his patients. Actually, he's going to be getting patients, from my referral… if I get this one residential care facility, one of our patients is there. I plan on giving her the option to see if they still want to take her there, and I'm definitely going to tell him about it. I'm not out to steal anybody's patients. I have not come across anybody who's been negative. I'm sure I will, but all the ones that I've talked to think it's a real good idea. They don't want to see these people -- the people in the nursing homes. They know they've been neglected. A couple of the dentists say how can you stand to do that? I've seen what their hygiene's like…"

Despite some positive experiences, RDHAPs expect to encounter resistance, particularly in the nursing home arena. A woman who had been providing care for nursing home residents for months describes the backlash:

"So one day I come in, and the social services director says, "The dentist was here, and he yelled and screamed and swore at me that you were taking his patients." And I said, "Well you know that's not true. I'm just cleaning their teeth. And I swear to God, these teeth have never been cleaned before. So I'm really not -- " She goes, "I know that, but I don't know what to do, you know?" And I said, "Well, I don't know what you're supposed to do either."

This situation, unfortunately, is a common one, where providers at odds put patients out of options. Not only are RDHAPs losing the business they have developed, but patients who had been receiving regular preventive care return to being neglected.

> *"And we're seeing this on a daily basis and new dentists are coming into the facilities or wherever we are and they're threatening the facilities and saying "If you let that RDHAP come in I will go away and you will not be able to fill your state requirement." So I think a lot of APs are not willing to walk away from that safety home of a dental office and employment to risk their whole entire – everything they've built for their twenty years in dentistry to have some guy come in and put them out of business after they've already invested $25,000 in equipment."*

RDHAPs are very cognizant of their role and their mission. Given the restrictive nature of their practice, both in scope and community type, they do not see themselves as competing with dentists. RDHAPs feel very strongly that developing relationships with dentists willing to collaborate is essential to ensure the provision of restorative treatment to their patients. However, relatively few dentists take any sort of sliding fee, accept Denti-Cal, or work in nursing homes, hospitals or with disabled patients, thus restricting RDHAPs ability to get their patients the restorative dental care they need. This woman working with disabled patients describes a typical situation.

> *"I have a young lady who had a stroke. She's a respiratory therapist and she's got it made at this place. She needs a filling and she's in a huge wheelchair and she can't get to any dental office where I live in my community. We need help with dentists for us to refer to once we're out there and that's a big – we need someone that cares to go out there and do that as well. "*

In communities with an FQHC or some other safety net provider, RDHAPs find it easier to route patients to treatment than in communities with no dentist willing to provide this care. In this case the referral network can be divided between a dental clinic for low income people and a dentist who takes private pay, as this RDHAP describes:

> *"Well, I have a Dentist who I work with at the FQHC, and then I have another general dentist who years ago I filled in for him… I actually contacted his office when I opened my practice and said, "Look, if I have patients that have private insurance or self-pay and I need to send them to somebody and they're not already established would you take these?" And he said, "Absolutely." And I'll tell you, I have sent hundreds of patients. His whole staff takes me out to lunch and they're like, "We just love the patients you send. They're healthy, they're educated."*

In other cases dentists are the ones motivated to find better ways to manage their patients and initiate collaboration with an RDHAP, such as illustrated in this story:

> "A *dentist that I work for right now has five different facilities that he goes to and he needs a hygienist. And he doesn't want to do any of the cleanings. So he talked to me and he said, "Why don't you go and take the course and get your AP? I want to bring you in. I'm going to*

do the dentistry part, do the exams, do the restorations, and I want you to help me out. We'll be in partnership and you do the cleaning."

The possible avenues for productive collaborations that benefit providers and patients are numerous, however they are still in the beginning stages. As the RDHAP workforce grows, a further transformation of care delivery focused on improving access to care for underserved populations in California can be expected.

"I think it has a long way to go, but more and more dentists and the dentist communities in the different counties that I'm in are treating me more as a colleague rather than an auxiliary person. And I think once that is established, and again it's just a matter of time. "

In sum, there is no single career path for an RDHAP; the opportunities for practice are as diverse as the individuals and communities in which they live and work. Like any new business owner, RDHAPs face logistical issues and start-up costs. In order to succeed, RDHAP have developed unique and community-specific ways to practice. Given the small number of RDHAPs in the field, they face a considerable uphill battle in raising awareness among their colleagues, other health care providers, and the broader public, of the services they offer, while still fighting to overcome the historical negativity toward independent practice from within the dental community. RDHAPs have developed many positive, collaborative relationships with dental providers, organizations and patients from which there is great potential to transform access to care in their communities. There is a long way to go, and there are clearly major issues with the structural conditions of practice that impact RDHAPs ability to succeed.

The Structural Environment of RDHAP Practice

Much of the explanation for how any particular RDHAP practice develops can be linked to the motivations of the individuals who enter this practice, the strategies they develop to serve patients, and the business or employment opportunities that exist in their individual communities. What ties these strategies together into a common set of RDHAP practices is the structural environment in which they work, including the legal and regulatory framework, financing systems, other health care and social institutions, and the system of professional education. All RDHAPs share these common elements, although how they adapt within this

structure varies by community. Policy intervention at the state level can have an important impact on the components of this structural environment, and hence, the practices of RDHAPs.

State Laws & Regulations: As outlined in the regulatory review section of this report, there are a number of state laws and regulations that impact practice; who can be an RDHAP, how RDHAPs are trained, where an RDHAP can practice and under what conditions, what an RDHAP can do (scope), and who an RDHAP can bill. This regulatory framework was first codified with the establishment of RDHAP as a licensure category. Since 1998, "clean up" legislation has been introduced and passed to address continuing issues as needed[xxvi].

The RDHAPs in practice feel there are still many details that need to be changed by the legislature in order for them to be able to provide more effective services to underserved patients. The prescription requirement is felt to be an unnecessary administrative hurdle, (it was noted that the medical and dental providers who must provide the "hygiene" prescription are many times annoyed at the administrative paperwork and do not understand why they are being asked for it), as is the documented relationship with a dentist as a condition of licensure. RDHAPs felt that the law places too many restrictions on their practice. They feel that they should be able to work in any setting, all consumers should have a right to their services, they should have the full scope of dental hygiene practice that they are licensed for, and they should be able to prescribe the necessary treatments and medications required to provide comprehensive hygiene care. Some in the public health community feel that an expansion of scope of practice to allow for a few basic restorative services would help RDHAPs better serve patients who have no way to get restorative dental treatment. The rationale for these further modifications expanding the scope of what RDHAPs can do, as well as where they can do it, is to enable them to continue to build practices that are responsive and focused on serving the needs of their communities.

Oversight of the hygiene profession is another issue RDHAPs feel passionately needs to change, and they favor instituting a mechanism of state regulation specific to hygiene.

[xxvi] See Legislative Review Section for full history

> *"I feel that a board or a committee, or whatever you want to call it, is needed for oral hygiene for hygienists. This board should set the standards for hygienists and make sure they follow them to the best of whatever system we can develop. It's a tremendous policy issue."*

The current regulatory requirements for RDHAPs are a means of consumer protection. State boards are the entity legally required to enforce these protections, not other health care professionals (such as employers). It is particularly problematic to have one profession with a stake in the terms of employment of another profession also to regulate that profession, as is the history in dental hygiene. Binding RDHAP (or RDH) practices to the dentist sets up a dynamic where political actions are focused on regulating the terms of employment under the guise of consumer protection or quality of care.

> *"I think oversight is a big, big issue. And oversight for dentists stinks. Oversight for hygienists doesn't exist. If you think that the dentists are supposed to be providing oversight in the office are doing that when they don't even know what they're doing, you know, what the hygienist is doing, -- they don't allow us -- when I clean a person's teeth that has subcalculus and pockets, and we're not going to send them to the periodontist, I would like to see them in one month to see whether what I did worked. You cannot do that. So I have never been able to see the fruits of my own labor except when I go into the nursing home. It may not be economically feasible, but at least I'm learning whether or not I am actually producing –hygienists do not know what their outcomes are."*

The Dental Board of California (DBC) delegates the licensing function of hygienists to COMDA, but the complaint and disciplinary functions rest with the Board. When requested, the DBC could not provide data that differentiated among the complaints filed against the different types of dental professionals the board regulates. Therefore reporting how RDHAPs compare to the other dental professions is impossible.

> *"it's just absolutely important that a group who has a certain scope of practice be in control of that scope and be able to monitor their own licensees for the good of the public. And I think that's a tremendous issue. And how it has gotten to this point, you know, power and money speak a lot, but, you know, who's going to speak for the consumer down there and make sure that our own people are practicing to the extent that they promised to do."*

The process of continuing to modify and improve the legislation and regulation surrounding practice is a contested area, with opposition lining up along the traditional division between dentistry -- which prefers to restrict the practice of other professions -- and dental hygiene -- that seeks to expand the scope and reduce the supervision requirements of their practice. Both professional groups acknowledge the problem this contentious history is causing when trying to move forward:

> *"I don't believe that the fear and feelings that dentistry needed to be threatened by what may happen with hygiene exists in any way to the degree that it used to. And I think with that has come a much greater openness to reacting with an open mind about alternatives. And whether they really do make the most sense for the patient, as opposed to whether it just is something that we like or hygiene likes. But is this going to be the best way to get care to patient. If I ever see a day where leadership within hygiene and leadership within dentistry truly acknowledge the -- are actually respectful of one another's roles and approach discussions with an open mind and not in a fear-based way, I would say -- what that would do to really facilitate the collaboration would be tremendous."*

Both representatives of the dental and hygiene associations that I interviewed see access to care as an important issue to address and acknowledge each other's roles, however they continue to be unable to agree on a common strategy of action to address the problem.

State Financing of Dental Care: A second area of structural constraint is the pubic financing mechanisms for dental care through Denti-Cal, Healthy Families and FQHC payment systems. These payment systems are essential for the patients that RDHAPs treat. Whether an elderly patient in a skilled nursing facility on Medi-Cal, or a migrant farm worker receiving treatment at a FQHC, or a pregnant mom trying to get herself and her kids' dental needs addressed, these payment systems are essential to connecting underserved patients to the care they need. Ensuring that treatments and procedures that patients need are covered is of great concern to RDHAPs. The current financing system is inadequate, and what does exist is oriented to support private dental practices or clinics, not comprehensive preventive care. The vulnerability of these already fragmented and under-funded systems to political whims and budget negotiations is an area of serious concern. Indigent, medically compromised, or otherwise disabled patients must have, at minimum, a basic financing system to help them access both preventive and restorative dental care.

The Health Care Environment and Care Delivery Systems: A third structural issue affecting RDHAP practice is the organizational environment of the care systems they work with. While RDHAPs are "independent" providers, this independence refers only to supervision by a dentist. In fact, almost all RDHAPs are working in some capacity within complex institutional setting such as schools, long-term care facilities, residential care homes, FQHC clinics, grant or state funded public health programs, state prisons or wards, hospitals, skilled nursing facilities and regional centers. Each of these institutions has its own set of rules, customs,

certification processes, payment and patient tracking systems, as well as administrative and professional staff. RDHAPs are new to many of these organizational environments, and are creating working relationships that must bridge a professional and institutional divide that has traditionally kept dental care separated from the rest of health care.

As RDHAPs create new systems of integrating dental services into these institutions, it will be inevitable that rules and regulations will need to adjust to accommodate a new set of services and interactions. RDHAPs can help reformulate guidelines to make sure patients are not neglected and that health outcomes, not simply regulatory checkboxes, drive the decisions care givers and administrators make, as this AP explains:

> *"The MDS report is the guideline the nursing homes follow for the health of the patient. On admission, within the first 14 days of admission, all of these different things -- their diet has assessment, and if they can't feed themselves. If they can walk. If they need assistance in their bowels, or anything. And there is supposed to be a dental assessment within the first 14 days of admission. And that has never been done. I've never seen it done. Not since I started. And then if they haven't been to the dentist within the last six months, they are supposed to have a dental exam. And then every year thereafter. The MDS report on oral care should be extended in the dental category. The dental hygiene should be separate from hygiene care. It should not be whether they shaved that day and washed their hair and brushed their teeth. Dental care should be separate. It should be its own separate part in the MDS report."*

As RDHAPs gain more experience working across a variety of settings they will be a valuable resource for administrators and policy makers for their insight in how to incorporate oral health into institutional care delivery systems. Those who are working with homebound patients can be a source of referral for all sorts of services these homebound patients may need. RDHAPs have a skill-set of prevention-oriented dental care that is transportable across care delivery settings. This allows them to play a facilitative role in community health, adding value far beyond just the hygiene services they provide. In this example, an RDHAP describes how she helped severely disabled adults achieve better dental health:

> *"They're wards of the state, and they're disabled adults who can't live anywhere else; in group homes, or in their own home. They've tried everything. And they're really severe cases. I mean they are a danger to themselves and others. And they didn't want any part of going to the dentist. And they started this project with my practice in this one state developmental center so that -- too see how well it would work because they still have to take them out to the dentist somewhere. But by me being there, I'm there once or twice a month and I see as many people as I can that day, and we've got them all cleaned up, and they all now come in and sit down and open their mouths and we have a good time. And then when they go to the dentist, they're very good patients. They'll sit and have their work done."*

In sum, working across a variety of institutional and organizational settings in the community is both a challenge and a great opportunity for RDHAPs. While RDHAP practices are expanding access to care, they are also stimulating new collaborations, which is opening up new avenues to improving access to oral health care.

Professional and Continuing Education: Dental hygienists are educated at the upper division level in community colleges as well as four-year colleges. Either an associate or baccalaureate degree will qualify a graduate for the RDH license. All of these programs focus on educating hygienists for the private dental office environment.

> *The way that dental hygienists developed in California in the community colleges, it's a four-year program for which somebody gets a two-year degree. And focusing on the clinical as much as we do in some schools, instead of the bigger picture in terms of health outcomes-- it's a problem in education in general is that we tend to compartmentalize.*

The existence of a differentiated education system without differentiated practice is similar to the situation that nursing has struggled with for many years. The RDHAP provides a level of differentiated practice, as the current requirements for the RDHAP are higher than what an RDH requires. The current RDHAP education programs however, are not degree-granting programs, which some feel they should be, given the effort it takes to complete the curriculum.

> *"It's a certificate of continuing education, and I can tell you I've put in a lot more than 144 hours. That degraded what I had done and all the effort that I had put into it, and that to me was really, really frustrating."*

Also, the practice requirements (2000 hours in the last 36 months) for licensure restrict some qualified RDHs (those working in public health for example) from receiving an RDHAP license due to lack of clinical hours. Some practitioners felt that waivers for this clinical competence requirement should be provided. Others felt that more advanced education at the master's degree or higher should be provided for hygienists wanting to go on to roles in research and education.

Both education programs have been adapting as quickly as possible to the changing laws, financing rules and equipment available in order to best provide their students with all the information they need to practice. Each program must follow guidelines on the basic curriculum, but they structure the experience differently. The WLAC program meets in

person several times a year[xxvii], while the UOP program primarily a distance education program, meeting only at the start and end of the program. Balancing the curriculum content to meet the needs of students who will end up going into such diverse settings has been challenging for the programs.

RDHAP education programs have plenty of capacity for the current level of interest in the licensure category. The first few classes were the largest due to the backlog of demand for the program. Enrollment has evened out at around 10-20 students per class. It is not known whether interest in the program will grow as more providers graduate and develop awareness of the versatility of RDHAPs practice opportunities. RDHAP alumni resources include annual symposiums and regional meetings, as well as numerous dental and hygiene association meetings. The California Dental Hygienists' Association (CDHA) has also created a set of resources for RDHAPs, providing the current students and graduates access to helpful information and guidance as they set up their practices. The California Dental Association (CDA) has opened up an auxiliary membership status (not full membership) to all allied dental occupations, which includes RDHAPs, and has extended offers of assistance in finding dentists for RDHAP patient referrals. However, due to the contentious history between the CDA and CDHA, most RDHAPs remain suspicious of these efforts.

All of these structural systems are important in California, as they are a model for other states trying to implement similar measures to address the preventive dental care needs of their populations. This is happening on an informal basis already, as one AP notes.

> *I get people to call me back and I get calls from all over the country of different states that want to get started and why they want to do it, and how to get started. And then when they get their first patient they call me back and they're so happy to be doing what they're doing.*

California has been at the forefront of innovation in many fields, but in health care and technology in particular. RDHAPs have adapted to the constraints they are given, but as preventive care providers, they can only work on one end of the spectrum. The State should ensure that all constraints on practice balance ensuring the safety of the public with improving to access to affordable and quality health care.

[xxvii] Originally, the WLAC program met every three weeks for a 3-day weekend class. The implementation of internet technology has reduced the meetings required and shifted some of the learning to online format.

In summary, there is tension between the needs of individuals in communities, and the structural constraints on providers seeking to meet those needs. These interviews reveal a general consensus among practicing RDHAPs that there are barriers in place that prevent them from being able to provide the level of care that they are capable of providing. A number of regulations seem to be unnecessarily constraining practice, neither protecting the public's safety nor enhancing access to services, and in fact may be working against the public's welfare on both fronts by limiting their consumer choices. Financing care is an endemic problem for all underserved populations. RDHAPs, unlike dental practices with much greater overhead costs, have been successful within the constraints of the existing payment systems. However, if these financing systems are further constrained, this situation may change. When the benefits of RDHAP services become more recognized across a variety of other institutions, there will inevitably emerge a number of new avenues for innovative solutions to improving access. The RDHAP educational system will need to continue adapting to the changing needs of these practitioners as they create pathways for positive change.

Conclusions

The simple answer to the question, "are Registered Dental Hygienists in Alternative Practice (RDHAP) increasing access to care?" is yes. The combination of professional independence and a required focus on underserved populations is powerful in both motivating and structuring RDHAP practice. Their professionalism is central to their success. "The ideology of professionalism asserts above all else devotion to the use of disciplined knowledge and skill for the public good."[28] RDHAPs embody this devotion. The diversity of strategies employed by RDHAPs in developing their practices has opened up multiple pathways to creating and improving access to dental care. These include but are not limited to:

- Reaching out to individuals and communities who need care but can not get to a dental office;
- Creating new consumer choices for preventive treatments and services;
- Providing services in settings and at times that are convenient for patients;
- Decreasing the fear of dental treatment in people who are not used to having their dental care needs addressed, through a gradual introduction to dental procedures;

- Providing referrals for dental care for patients needing restorative treatment;
- Developing collaborative practice models with dental, medical and nursing professionals in a variety of settings;
- Developing data collection systems to track patient outcomes with the goal of showing how dental hygiene care can lead to improvements in oral health and overall health;
- Educating individuals, families, care givers and health providers on the basics of oral health and dental hygiene, and on oral health's connection to overall health and well-being.

The lack of access to dental care in California has created enormous need in populations that are underserved by the traditional system of care. RDHAPs are "social entrepreneurs," using entrepreneurial principles to create and manage a venture of social change, and measuring the impact of their success not only in profit and return, but in the impact on the health of their communities. By doing this, they are truly innovators, using their skill and passion to repackage oral health services to reach some of California's most vulnerable citizens.

Improving access to care, however, is not an undertaking that a profession with a limited scope of practice can do alone. The *independence* of RDHAPs as providers allows them the freedom and flexibility to reach out to patients in new and creative ways. To transform these innovations into comprehensive care delivery for patients, new *collaborative practice* models, with dental, medical, and other caregivers are needed. Many of these models are beginning to emerge in California, but much work remains to be done in both regulating practice and financing care. Meeting the challenge of transforming the system and reconnecting oral health with overall health will require a professional commitment to ensuring a high quality workforce, a regulatory environment flexible enough to allow for innovation, and a care delivery system that is consumer-responsive and affordable.

A central element of success of the RDHAP experience in California is the community-responsive and patient-centered strategies employed. National efforts to develop new models for the dental workforce should carefully review the experiences of RDHAPs. The process of

development of a new provider type, from legislative efforts, to developing education, to implementing practice holds many lessons for similar efforts in other states as these are necessary parts of any overall effort to improve the oral heath status of the nation.

Recommendations

Policy Framework

RDHAP practices provide great insight into both the care providers and underserved people who populate the oral health landscape. The sheer complexity of this landscape indicates many levels on which public policy may have an impact, and likewise, may be improved. To guide policy making toward improvements in access to dental care it may be helpful first, to provide a framework for thinking about the direct and indirect impact of policy on access to care, and second, to provide specific examples in several policymaking areas that exemplify strategies that can be employed towards this end.

Reform is needed in dental care for all the same reasons as health care reform is needed. The cost of care is high, access is problematic, and quality of care in dentistry is difficult for any consumer to determine. As policy-makers decide on funding, regulation, legislation and education they must consider whether the reforms they implement actually help people obtain affordable, accessible, and quality care. Alternative care delivery models such as the RDHAP are *essential* to improving oral health and reducing health disparities in California's diverse population. *Public policy should create an environment that supports innovation and creativity, has flexibility to meet needs, focuses on prevention-oriented solutions, and enhances consumer choice while ensuring consumer protection.*

The current policy environment is filled with incentives (statutory, regulatory, financial, educational, etc.) geared toward maintaining and sustaining the existing dental delivery system – a system not equipped to address the problems of cost, access and quality. Continuing to do more of the same is not going to solve these problems. Alternative models of care are needed. For these alternative practice models to succeed, the incentive structures

must adapt to support the new models of dental care. Incentives should encourage innovations in care delivery, as well as collaborative, patient-centered health care models that can be responsive to local communities and populations.

This study's findings indicate that the policy change that allowed for independent hygiene practice has succeeded in spurring innovations in care delivery and improvements in access to dental care. However, many restrictions on alternative practices remain which prevent more Californians from benefiting from these services. Further policy modifications could continue to reduce barriers to alternative practice, and enhance the workforce and financing available for care delivery.

Recommendations: Regulatory Systems

State laws restricting the provision of health care services are beneficial only when there is a clear need for public protection. Some of the current restrictions on RDHAP practice do not provide any clear consumer protection or contribute to the health of the public. Rather they place unnecessary limits and administrative burdens on practice, and restrict consumer choice. To help improve regulatory systems, policymakers should work to:

- Remove the mandated referral agreement as a condition of licensure for RDHAPs. Licensure should be granted based on qualifications. There is no precedent for requiring a practice agreement for *licensure,* nor for services delivered *within a professional's own scope of practice;*
- Remove the prescription requirement for dental hygiene services provided by RDHAPs. In practice, this is simply an administrative hurdle, time consuming for providers, and has not been shown to contribute to positive patient outcomes. Patients should have their choice of dental hygiene care provider, and the public should not need a prescription to receive *basic preventive care*.

It would be beneficial for state policy makers to continue to explore avenues (such as new health workforce pilot projects) for expanding the capacity of the allied dental workforce (including RDHAPs, dental hygienists and dental assistants) to facilitate more efficient and accessible care.[29] Any new models should be based on proven competency; therefore some

expansions would require additional training, while others would not. Examples of possible expansions of RDHAPs scope of practice might include:

- The duties of an RDH that they are already trained to do, but which currently require direct supervision (and hence are not within the RDHAP scope);[xxviii]
- Atraumatic restorative techniques (ART);
- Placement of glass ionomer fillings;
- Extractions of deciduous teeth.

To facilitate the expansion of options for increasing the capacity of the workforce, policy makers should *reform the system of reviewing proposed changes to scope of practice*.[30] Many of the issues brought to the attention of the legislature regarding dental practice are the result of the tension between the state dental society and the state dental hygiene society (or dental assisting society) around supervision, scope of practice and allowable duties. Pilot studies have consistently shown that high quality care can be achieved in expansions of scope of practice for the allied dental workforce,[31] yet concerns about quality of care are employed by organized dentistry to maintain strict requirements over allied personnel. Legislators in the middle of this professional turf battle have few objective resources at their disposal to help them understand the real costs and benefits for their constituents. To remedy this:

- Appoint an independent committee to review and make recommendations to the legislature on scope of practice matters, as has been done successfully in many other States and countries.[32]
- Develop competency based practice models that are more flexible and responsive than the current silos of professional practice that restrict health care from being responsive and adaptive.[33]

In addition to changing the administrative process for deciding on scope of practice and supervision matters, the state might restructure professional boards in a way that allows each profession to regulate members of their own profession to ensure the safety of the public.

- Dental hygiene, including RDHAPs, should be self-regulating. It is inherently a conflict of interest for the dental profession (which employs hygienists and thus has a significant stake

[xxviii] http://www.comda.ca.gov/lawsregs/dutytable3-20-06.doc

in reducing the autonomy of hygiene) to regulate the hygiene profession. Dental hygiene practitioners should be regulated by their own board or bureau, as has been proposed in the past few legislative sessions.

- California should work with other states to encourage reciprocity across state lines for all new models of the dental workforce, including but not limited to the Advanced Dental Hygiene Practitioner being developed in Minnesota [xxix] and the Dental Health Aide Therapist developed in Alaska.[14]

Recommendations: Financing Systems

A solid financing system is necessary for building any alternative models for dental care, as shown by the number of RDHAP patients who depend on Denti-Cal as an insurer or require lower cost or free services supported through grant funding. This funding should complement, not replicate, the private financing system, as the private system does not cover any of these vulnerable populations. Current funding structures need enhancement to ensure access to care for our most vulnerable populations.

- Denti-Cal needs to focus on meeting the needs of the population it serves, as well as the providers that it pays. Cuts in adult benefits have been shown to result in decreases in provider participation and patient utilization, resulting in extreme pressures on FQHCs and other clinics, and exacerbating unmet oral health needs.[34] The State can solidify its commitment to supporting access by strengthening Denti-Cal to support the dental health care needs of underserved populations.
    - The proposed cuts to adult Denti-Cal would decimate the RDHAP services now provided to our State's most vulnerable populations. Enhancements, not cuts in services are needed, particularly for preventive services.[35, 36] If the State cuts these basic preventive services, they will pay much more in treatment later on.[37]
    - Denti-Cal should expand reimbursement to RDHAPs for non-clinical services such as case management, health education and prevention services. These services are essential to RDHAP practice specifically, but also to the development of alternative oral health delivery systems in general.

[xxix] https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S2895.1.html&session=ls85

- The state should support new funding mechanisms such as AB 363/SB400 which allow FQHCs to bill for services provided outside their four walls. Because RDHAPs are mobile, they can treat individuals who are homebound and institutionalized. Legislation that allows for flexibility in payment will enhance flexibility in treatment locations.
- RDHAPs should be able to bill for their services as a corporation, as is common for dentists to do, not just a sole proprietor. This will allow RDHAPs to separate business and personal income for tax purposes.

Recommendations: Quality Improvement and Research

More research is needed to determine the most efficacious and appropriate treatments for health outcomes in vulnerable populations, and help define appropriate benefit levels. Efforts to systematize patient information and outcomes are needed. Dental insurers use a model of insurance based on the expectation of a healthy middle-to-upper income person. This model does not apply to many of the underserved populations that RDHAPs and other safety net providers work with.

- Tracking health outcomes from dental treatment is almost impossible due to the separation of financing and patient record systems between dentistry and medicine. Electronic information systems have been the backbone of many quality improvement initiatives. Recent research calls for better integration of these systems in order to reduce health disparities.[38] RDHAPs in some settings are in a position to begin re-integrating dental records into the medical patient record.
    - Denti-Cal participants are also Medi-Cal participants. While currently separate systems, they could be integrated. If the State were to integrate them, it would be in a unique position to develop a comprehensive data infrastructure able to track expenditures, utilization, diagnoses and health status, leading to an unprecedented research capacity for quality improvement (i.e. examining savings on health costs for diabetes resulting from treatments of dental disease).
- Policy makers might consider incentives for the oral health community to develop better measurements of quality of care that include health outcomes measures and track patient outcomes. Consumers have no resources from which to judge the quality of their dental

practitioner and hence have no information from which to make an informed health care choice.

Recommendations: Care Delivery System

The State should encourage new models of collaborative practice with a variety of new alternative providers such as the RDHAP. These collaborative models can exist across all levels of dental practice, but also across many medical and other care delivery models in the state. Having multiple models of care delivery provides actual options for consumers – convenience of location, choice of provider and ability to access basic preventive dental care.

RDHAPs have shown that more attention needs to be given to dental services provided in health care institutions. Regulation within health care industries, particularly long-term care and skilled nursing facilities, should include more specific standards and care delivery options for the provision of oral health care.

- RDHAPs should be eligible to fulfill the Title 22 provider requirement for a dental program in nursing homes. RDHAPs are well suited, both in skill set and practice model, to be on-site primary dental care practitioners providing preventive and educational services in these settings. In addition, RDHAPs can work as dental case managers for nursing home residents, working with administrators to develop referral networks of local dental providers to ensure avenues for necessary restorative and surgical treatment, and dentures.
- As has been suggested by a statewide taskforce on oral health for aging Californians, policy should support the development of new collaborative models of providing services in institutions such as long-term care settings, using new technology and practice arrangements.[39] One such pilot project is currently underway, funded by the San Francisco Foundation and run by the California Dental Association Foundation.[40]

Recommendation: Workforce Development

Ensuring a high quality workforce will be essential to expanding alternative models of dental care. Regulatory and financing systems will need to be flexible to be able adapt to these new models and support them, and the education system must be able to respond by providing the skills and competencies to new graduates so they are prepared to work in multiple settings.

- RDH programs are primarily located in community college settings, restricting the ability of educators to train the dental team together. New models of dental and hygiene education should be developed which provide training for teams of dental practitioners who can work collaboratively in a variety of health care environments.
- Medical and nursing education needs to have more oral health curriculum, and there needs to be more interdisciplinary educational models to ensure that oral health is not neglected by medical practitioners.
- Much policy discussion focuses on education and practice strategies to encourage doctors and dentists to work with underserved populations. In the case of RDHAPs it is a practice requirement. A set of similar mandates for dental practitioners may go a long way towards improving access to the restorative and surgical treatments needed by many underserved populations.

The preceding recommendations are just a sampling of key issues that need to be addressed if policymakers want to continue to support the success of alternative practice hygiene as well as create an environment that allows for future innovations in care delivery. Most of these recommendations echo previous studies' findings, as indicated throughout in the references provided. With out innovations, lack of access to care and disparities in health outcomes are sure to remain problems for many Californians in the future.

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Appendix 1: Glossary of Acronyms

ADHA	American Dental Hygienists' Association
CDA	California Dental Association
CDB	California Dental Board
CDHA	California Dental Hygienists' Association
COMDA	Committee on Dental Auxiliaries
FQHC	Federally Qualified Health Center
HMPP	Health Manpower Pilot Project (renamed HWPP, Health Workforce Pilot Project)
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienists in Alternative Practice

Appendix 2: Documentation of Relationship Form

DOCUMENTATION OF RDHAP RELATIONSHIP WITH DENTIST

RDHAP Name:_____

Address:_____

City/State/Zip:_____

RDHAP License Number:_____

Pursuant to Business and Professions Code Section 1775(g), I have an existing relationship with at least the following dentist for referral, consultation, and emergency services:

Dentist Name:_____
License Number:_____
Address:_____
City/State/Zip:_____
Telephone Number:___(_____)_____

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____
DENTIST Signature Date

_____ _____
RDHAP Signature Date

Pursuant to California Code of Regulations Section 1090.1, the dentist's license must be current, active and not under discipline by the Board. An RDHAP must report any changes to the Board, in writing, within 30 days following such change.