VIRGINIA BOARD OF DENTISTRY

AGENDA

March 12 and 13, 2009
Department of Health Professions
Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center -Richmond, Virginia 23233

March 12, 2009

9:00 a.m. **Formal Hearings**

March 13, 2009

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8:15 a.m. **Executive Committee – Dr. Gokli, Chair**

- Approval of Minutes
  - December 7, 2007
  - December 12, 2008
- Code of Conduct for Board Members – Dr. Levin
- Professional Code of Conduct – Dr. Levin
- Communication with Licensees – Ms. Reen

9:00 a.m. **Board Meeting**

Call to Order – Dr. Gokli, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- December 11, 2008 Formal Hearing 1-3
- December 12, 2008 Board Meeting 4-9

DHP Director's Report – Ms. Whitley-Ryals

- DHP Performs 10

Liaison/Committee Reports

- BHP – Dr. Gokli
- Executive Committee – Dr. Gokli
- Regulatory/Legislative Committee – Dr. Watkins
  - February 25, 2009 Draft Minutes 11-14
- SRTA – Dr. Watkins and Dr. Pirok
- Southern Conference of Deans and Dental Examiners – Dr. Pirok
- CODA UVA Site Visit – Dr. Pirok

Legislation and Regulation

- Regulatory Action 15-17
- Petition for Rule-making – Alden S. Anderson III 18-30
- Petition for Rule-making by Len Futerman, DDS 31-32
- Report of the 2009 General Assembly 33-40

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Board Discussion/Action

- CODA Notice to VCU 41-44
- Priority for AADE 45
- ADEX Correspondence 46-65
- CRDTS Correspondence 66-97
- Digital Impression Technology 98-99
- Thank you email 100

Report on Case Activity – Mr. Heaberlin

Executive Director's Report/Business – Ms. Reen

Board Counsel Report – Mr. Casway

Adjourn

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARINGS
DECEMBER 11, 2008

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 10:32 a.m. on December 11, 2008 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Richmond, Virginia.

PRESIDING: Paul N. Zimmet, D.D.S.

MEMBERS PRESENT: Jeffrey Levin, D.D.S., Vice President
Darryl J. Pirok, D.D.S.
James D. Watkins, D.D.S.
Misty Mesimer, R.D.H.
Robert B. Hall, Jr. D.D.S.
Augustus A. Petticolas, Jr. D.D.S.

MEMBERS ABSENT: Myra Howard, Citizen Member

MEMBERS EXCUSED: Meera A. Gokli, D.D.S.
Jacqueline G. Pace, R.D.H.

STAFF PRESENT: Sandra K. Reen., Executive Director
Huong Vu, Administrative Assistant

COUNSEL PRESENT: Howard M. Casway, Senior Assistant Attorney General

OTHERS PRESENT: James Schliessmann, Assistant Attorney General
Gail W. Ross, Adjudication Specialist
Lynn Aligood, Court Reporter, Capitol Reporting, Inc.

ESTABLISHMENT OF A QUORUM: With seven members present, a quorum was established.

Michael J. Hechtkopf. D.D.S.
Case No. 113849

Dr. Hechtkopf appeared with counsel, Brian O. Dolan, Esq., in accordance with a Notice of the Board dated July 30, 2008.

Dr. Zimmet admitted into evidence Commonwealth's exhibits 1 through 11.

Dr. Zimmet admitted into evidence Respondent's exhibits 1 through 34.

Dr. Zimmet swore in the witnesses then ordered that that all witnesses be sequestered with the exception of Dr. Hechtkopf.

Testifying on behalf of the Commonwealth were Robin N. Blanco and Matthew R. Cooke, D.D.S., M.D., M.P.H.

Testifying on behalf of the Respondent were William Conley Owen, M.D. (by phone), Michael J. Caplan, M.D., Fred M. Henretig, M.D., John A. Yagiela, D.D.S, Ph.D., Roger Wood, D.D.S., Bertrand Ross, M.D., and James Keeton, D.D.S.

Closed Meeting: Dr. Levin moved that the Board enter into a closed meeting pursuant to §2.2-3711.A.7 of the Code of Virginia for consultation with legal counsel in the matter of Dr. Michael J. Hechtkopf. Additionally, it was moved that Board staff, Sandra Reen, and Huong Vu, and Board counsel, Howard Casway attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in it deliberations.

Reconvene: Dr. Levin moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

Decision: Dr. Zimmet reported that the Board decided to adjourn for the day and to reconvene at 1:30 p.m. on Friday, December 12, 2008.

ADJOURNMENT: The Board adjourned at 7:30 p.m.

RECONVENED: The Board reconvened at 1:35 p.m. on Friday, December 12, 2008.

Dr. Hechtkopf testified on his own behalf.

Closed Meeting: Dr. Levin moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) of the Code of Virginia to deliberate for the purpose of reaching a decision in the matter of Dr. Hechtkopf. Additionally, it was moved that Board staff, Sandra Reen, and Huong Vu, and Board counsel, Howard Casway attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in it deliberations. The motion was seconded and passed.

Reconvene: Dr. Levin moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Dr. Zimmet asked Mr. Casway to report the Findings of Fact, Conclusions of Law and Sanctions adopted by the Board.

Dr. Watkins moved to adopt the Findings of Fact and Conclusions of Law as reported by Mr. Casway and to issue an order terminating the restriction on Dr. Hechtkopf's license and requiring Dr. Hechtkopf to complete continuing education in recordkeeping and risk management and to successfully complete the Board's Dental Law Examination. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 5:45 p.m.

Paul N. Zimmet, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

VIRGINIA BOARD OF DENTISTRY
MINUTES
DECEMBER 12, 2008

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:10 A.M. on December 12, 2008 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Richmond, Virginia.

PRESIDING: Meera A. Gokli, D.D.S., President

BOARD MEMBERS PRESENT:
Jeffrey Levin, D.D.S., Vice President
Jacqueline G. Pace, R.D.H., Secretary-Treasurer
Paul N. Zimmet, D.D.S.
Darryl J. Pirok, D.D.S.
James D. Watkins, D.D.S.
Robert B. Hall, Jr. D.D.S.
Augustus A. Petticolas, Jr. D.D.S.

BOARD MEMBERS ABSENT:
Myra Howard, Citizen Member
Misty Mesimer, R.D.H.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Sandra Whitley-Ryals, Director for the Agency
Elaine Yeatts, Senior Policy Analyst
Alan Heaberlin, Deputy Executive Director for the Board
Huong Vu, Administrative Assistant

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General

ESTABLISHMENT OF A QUORUM: With eight members of the Board present, a quorum was established.

PUBLIC COMMENT: **Ralph L. Howell, D.D.S.,** president of the Virginia Dental Association, asked the Board to:

- establish policies to stop the erosion of ethics in advertising and in competing fairly,
- address access to care by broadening the scope of practice of dental auxiliaries,
- track where licensees practice and how many days they work, and
- curb the practice of dentistry without a license noting that areas of concern were bleaching, grills, and snoring devices.

APPROVAL OF MINUTES:

Dr. Gokli asked if the Board members had reviewed the minutes in the agenda package. Dr. Watkins asked that the minutes be amended on page 4 in his report on SRTA to:

- state "Alabama is considering joining" instead of "Alabama has decided to join."
- correct spelling of "Spears" to "Speer", and
- on page 8, he stated that he did not recall including a change in the number of continuing education hours to be required in his motion on the agency subordinate recommendation.

Dr. Gokli tabled this matter so that Ms. Reen might check her notes from the September 12, 2008 meeting. When this discussion resumed, Ms. Reen reported that her notes do show that the motion did include increasing the number of hours of continuing education in implant placement and management from 4 hours to 16. Dr. Zimmet moved to accept the minutes of the September 12, 2008 meeting as amended on page 4. The motion was seconded and carried.

DHP DIRECTOR'S REPORT:

DHP Performs. Ms. Ryals reviewed the last quarter's results for the agency and the boards of Nursing, Medicine and Dentistry to show the progress being made on the 250 day goal for case resolution. She applauded the Board for its work on:

- reducing the backlog and achieving a 202% clearance rate,
- reducing the percentage of old cases to 45%, and
- closing 81% of new cases within 250 business days

Proposed Legislation. Ms. Ryals discussed three pieces of legislation:

- an amendment to §54.1-2722 which will allow the Department of Health to do a pilot on using dental hygienists more effectively to meet treatment needs in underserved areas.
- revisions of several Code sections addressing the Health Practitioners' Intervention Program (HPIP). She reported that she is negotiating with Virginia Commonwealth University to extend the current program and anticipates a signed agreement next week. Ms. Ryals noted that the legislative proposal will:
  - continue the program and the provisions for a stay of disciplinary action,
  - allow a fee to be charged for participation,
  - scale back the services offered and make clear that the program itself is not a treatment program, and
  - change the name of the program to the Health Practitioners' Monitoring Program (HPMP)

  Dr. Petticolas asked where in the bill it says that participants will pay. Ms. Ryals directed him to the permissible language in §54.1-2516 and talked about this and other options such as creating a scholarship fund for covering the costs of the program. Dr. Levin suggested a low interest loan might be another avenue to help participants. Dr. Gokli commented that it is important to keep this program.

- revisions to the Prescription Monitoring Program (PMP) which will allow prescribers to post notice rather than obtain consent and permit agreements for sharing information with other states.

Enforcement Discussion:

James S. Johnson, Enforcement Deputy Director, gave a power point presentation on enforcement activities highlighting the investigation of dentistry cases. Mr. Johnson introduced Shannon Roberson, Case Intake Analyst for Dentistry and stated that Mr. Roberson takes all the complaints, reads them, prioritizes them, and determines if there is enough information to develop the case. Included in the presentation was information on the:

- role of enforcement
- number of complaints received noting that 4152 complaints were received in Fiscal Year 2008 compared to 4454 in Fiscal Year 2007
- sources of complaints
- assignment of case priorities, and
- typical Investigation.

Dr. Zimmet asked if the problem with the production of x-rays had been solved. Mr. Johnson said progress has been made but there are still issues from time to time.

REPORTS:

Board of Health Professions (BHP), Dr. Gokli said she had no report because the BHP has not met since the last board meeting.

Executive Committee Meeting. Dr. Gokli reported that the Executive Committee met this morning and discussed:

- the Bylaws without identifying any changes to propose and
- possibly having the Board adopting codes of conduct which the committee will address further at its next meeting.

SRTA. Dr. Watkins reported that the SRTA board met three times in the last three months. He advised that Alabama has not yet joined and that SRTA met with the University of Florida about examining there. He also reported on an upcoming strategic planning meeting and indicated that SRTA is operating in the black. He asked anyone planning to do an exam to see him about examination assignments and said that Ms. Reen would send out assignments by e-mail. Ms. Reen reminded Board members that SRTA trips must be approved before their trips so she asked them to remind SRTA to send needed information as early as possible.

Regulatory/Legislative Committee. Dr. Watkins reviewed the 12-03-2008 Draft Minutes of the Regulatory/Legislative Committee Meeting noting the work on the regulation of dental assistants II (DAsII). He stated that the Committee is considering changing the meaning of "direction" and adding a third level of supervision to be required for the expanded duties. He also said the Committee wants to allow up to four DAsII per dentist and to increase the number of dental hygienists a dentist might supervise to four and to allow dental hygienists with

training to perform the new delegable duties. He asked for a sense of the Board on proceeding with the proposed delegable duties for DAsII indicating that it would help the Committee solicit information on training requirements from the accredited community college dental assisting programs. Following discussion, Dr. Gokli advised the Committee to proceed with its proposal. Dr. Watkins reported that over 1000 comments were received on the NOIRA and that most of the comments opposed allowing delegation of scaling to DAsII. He also noted that the Committee would ask specialty organizations to comment on the delegable duties once it has proposed language. He also reported that the Committee is working on a guidance document on sedation and anesthesia and resumed work on regulatory review.

Healthcare Workforce Data Center. Dr. Pirok reported on the October 3, 2008 meeting to discuss the new center at DHP. He reported that there are three states, North Carolina – Arizona – Iowa, currently collecting healthcare workforce data. He said the DHP center will address the supply and demand in the healthcare workforce with an initial focus on physicians and nurses. Dr. Levin asked if this is another vehicle to gather information. Ms. Ryals responded yes and that work has begun on developing surveys for licensees to complete as part of license renewals.

LEGISLATIVE AND REGULATION:

Ms. Yeatts noted that there is nothing further to report in regard to legislation that may be of interest to the Board and no action on regulations needed.

BOARD DISCUSSION/ACTION:

The following agenda items were received as information with no action being taken:

- **ADEX letter – Clinical Licensing Examinations**
- **Alabama Board Letter to ADA**
- **Louisiana Board Letter to ADA**
- **Mississippi Board Letter to ADA**
- **North Carolina Board Letter to ADA**
- **WREB Scoring**
- **VDHA Letters on CODA Standards**

REPORT ON CASE ACTIVITY:

Mr. Heaberlin thanked the Board for the significant strides made in processing cases so that the number of open cases has declined to 172 as of December 11, 2008. He advised that his focus was still on reducing the number of old cases to meet the 25% standard. He said cases are being sent out for probable cause review as they are received so there is no blitz day in the immediate future. Ms. Ryals extended her compliments and suggested that the Board use pre-hearing consent orders as much as possible to avoid waiting for informal conferences. Ms. Reen said the Board is using this tool as well as advisory letters and CCAs.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

Staff Update. Ms. Reen introduced Ms. Vu to the Board, stating that Ms. Vu is now serving as her administrative assistant for Board business. She said Ms. Vu will be working with Board members on travel planning and reimbursement.

Guidance Document 60-6. Ms. Reen presented a proposed amendment of Guidance Document 60-6 on the "Policy on Sanctioning for Practicing with an Expired License" which updates the policy to allow staff to use advisory letters for licenses that were lapsed for 30 days or less and allows either a board member or staff person to make probable cause decisions on cases where the license was lapsed for more than 30 days. Dr. Watkins moved to adopt the amended guidance document as proposed. The motion was seconded and carried.

Cosmetic Certification Application. Ms. Reen asked the Board to allow her to now use Oral Maxillofacial Surgeons with certification to review applications for cosmetic certification and to reduce the number of reviewers from 3 to 2. There was discussion of having the applications reviewed by one reviewer. Following discussion, Dr. Zimmet moved to use 2 reviewers from the pool holding certification. The motion was seconded and carried.

OMS Quality Assurance Review. Ms. Reen reported that the second Oral Maxillofacial Surgeon (OMS) Quality Assurance Review has started for the period of January 2005 to December 2007. She said this review addresses 19 OMS and that only 11 do these procedures in their offices. Investigators obtained 97 patient records for review and she is in the process of obtaining an out-of-state expert to review the records. No one from the adjoining states of Maryland and North Carolina has been found to take on this task and she is talking with two surgeons, one from Pennsylvania and one from Florida, who may be interested.

Probation. Ms. Reen advised the Board that it was important for reporting purposes for special conference committees to place respondents on probation when terms are being imposed to monitor practice due to patient care concerns. Mr. Casway supported this request saying that it would help other states understand the licensee's status. Following discussion, staff was instructed to add this language when needed.

BOARD COUNSEL REPORT:

Attorney Roundtable at AADE – Mr. Casway thanked the Board and Ms. Ryals for sending him to the annual meeting. He reported that the opportunity to discuss the management of current issues with other states was very helpful. He then reviewed the discussions that took place on the following topics:

- options for recuperating costs for disciplinary actions,
- actions to address teeth whitening by unlicensed providers,
- policy strategies on the use of overseas dental laboratories, and

- criminal background checks.

Litigation - Mr. Casway reported that:

- a motion made by Ms. Moore on behalf of the Board to dismiss Dr. Taylor's appeal of the Board Order denying reinstatement of his license is scheduled for February 18, 2009 in Hampton.
- Dr. Coleman has exhausted his appeals so the case is over. He added that the stay on the Board Order at issue in this case has been vacated by the Circuit Court.
- He is awaiting the final papers from the Fairfax Circuit Court to complete Dr. Zurmati's case.

Credentials Committee Recommendation: **Case # 11857**

Closed Meeting: Dr, Levin moved that the Board convene a closed meeting pursuant to § 2.2-3711.A(28) of the Code of Virginia for the purpose of consideration and discussion of a recommended decision from the Credentials Committee. Additionally, Dr. Levin moved that Board staff, Sandra Reen and Huong Vu, and board counsel, Howard Casway, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations.

Reconvene: Dr. Levin moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

Dr. Zimmet moved to accept the recommended Order of the Credentials Committee with amendments to require that the terms of the Order be met within 30 days. The motion was seconded and carried unanimously.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 12:45 p.m.

_____ _____

Meera A. Gokli, D.D.S., President Sandra K. Reen, Executive Director

_____ _____

Date Date

Key Performance Measures - Quarter Ending December 31, 2008

	Patient Care Case Processing			Licensure Processing	
Boards	Clearance Rate (Goal = 100%)	Age of Pending Casesload % Open Cases over 250 Business Days (Goal=25%)	% Cases Closed within 250 Business Days, last 8 quarters (Goal = 90%)	Customer Satisfaction (Goal = To Maintain 2-Yr Quarterly Average of 97% Positive Ratings)*	% Licensed within 30 Days of Complete Application (Goal = 97%)
Nursing	122%	13%	79%	Breakdown only	100%
Nurse Aide	99%	16%	69%	96%	100%
Nurses	135%	11%	83%	94%	100%
Medicine	110%	18%	94%	93%	100%
Dentistry	169%	33%	67%	98%	100%
Pharmacy	80%	10%	80%	96%	100%
Veterinary Medicine	132%	6%	100%	98%	100%
Counseling	55%	0%	100%	88%	100%
Social Work	150%	27%	100%	97%	100%
Psychology	83%	8%	100%	88%	100%
Long-Term Care Administrators	33%	0%	100%	97%	100%
Optometry	80%	0%	100%	99%	100%
Physical Therapy	250%	0%	50%	93%	100%
Funeral Directors and Embalmers	67%	0%	100%	100%	100%
Audiology Speech-Language Patholog	600%	0%	80%	94%	100%
DHP Overall	118%	15%	85%	95%*	100%

* DHP Overall data reflect the 2-year rolling average. Individual Board's data are from the 2nd Quarter FY2009 only.

VIRGINIA BOARD OF DENTISTRY
MINUTESOF REGULATORY/LEGISLATIVE COMMITTEE
February 25, 2009

TIME AND PLACE: The meeting of the Regulatory/Legislative Committee of the Board of Dentistry was called to order at 1:05 P.M. on February 25, 2009 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Richmond, Virginia.

PRESIDING: James D. Watkins, D.D.S., Chair

BOARD MEMBERS PRESENT:
Jeffrey Levin, D.D.S.
Jacqueline G. Pace, R.D.H.
Myra Howard
Meera A. Gokli, D.D.S.
Robert B. Hall, Jr., D.D.S.
Darryl J. Pirok, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director

OTHERS PRESENT: Howard M. Casway, Senior Assistant Attorney General
Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

ESTABLISHMENT OF A QUORUM: All members of the Committee were present.

PUBLIC COMMENT: **Ron Hunt, DDS,** the dean of the VCU School of Dentistry, stated that he has an alternate education proposal for training dental assistants II to present to the Committee. Dr. Watkins advised that it would be received during the discussion of that agenda item.

Roger Wood, DDS of the Virginia Dental Association stated that the Board of Directors of the VDA voted last week to support the current provision of allowing a dentist to supervise no more than 2 dental hygienists at the same time.

Charles Cuttino, DDS asked that the Committee make sure that the wording in its proposed administration guidance document NOT eliminate the ability of a person (DA I or DA II or DH) designated by the dentist to be able to give a patient an oral medication in the office at the time of the patient's dental appointment (e.g., a prophylactic antibiotic).

Bonita Miller, DDS advised that the Richmond Dental Society polled its members about the number of dental hygienists and

dental assistants II a dentist might supervisor. She reported that the RDS recommends that the limit be set to allow up to a total of four auxiliary staff in any combination of dental hygienists and DAsII to allow dentists the flexibility to decide based on his practice.

MINUTES:

Dr. Watkins asked if the Committee had reviewed the minutes of the October 29, 2008 meeting. Ms. Pace moved to accept the December 3, 2008 minutes. The motion was seconded and passed.

DENTAL ASSISTANT REGULATIONS:

Education Requirements for DAII Registration – Ms. Reen advised that as requested by the Committee she had worked with the program directors of the two accredited dental assisting programs in Virginia to develop a training proposal for DAsII and for dental hygienists to perform the delegable restorative duties. She asked Ms. Daniel of J. Sargeant Reynolds Community College and Ms. Porter of Centura College to assist in discussion of the proposal and their respective program models. The proposed program structure of a prerequisite 8 day course in tooth morphology to include wax carvings, 10 weeks of training in restorative practice and 15 weeks of clinical experience was discussed. Then Dr. Hunt presented his proposal for a total of 160 hours of training with 40 hours of didactic instruction, 120 hours of laboratory and 19 days of on-site instruction. The Committee and members of the audience discussed requirements for admission, content, the length of the program, the amount of time to be devoted to each requirement, the amount of instruction dental students receive for the planned duties, enrollment, addressing permissible instruments, program accreditation, facilities and instructors. During this discussion, Dr. Hunt noted that he had not included taking impressions in his proposal and that adding impressions would expand the number of hours needed to 200. Following discussion, the Committee adopted motions by Dr. Levin to require completion of at least 200 hours in the content requirements and to require 300 hours of clinical experience. The committee agreed to propose:

- Acceptance of training completed through a dental, dental hygiene or dental assisting program accredited by the Commission on Dental Accreditation of the American Dental Association
- An admission requirement of DANB certification or current practice as a licensed dental hygienist
- Setting the minimum expectations for training as:
    - 50 hours of didactic training with no more than 10 hours or 20% of this training being completed online
    - 150 hours of laboratory training with no more than 30 hours or 20% of office homework and
    - 1 day of review and final examination

- Requiring passage of a comprehensive examination given by the program

Training from Other Jurisdictions – The Committee decided to propose acceptance of credentials/training from other jurisdictions when training was substantially equivalent or two years of current experience using the language recently adopted for administration by dental hygienists as the model for development.

Inactive Registration – The Committee decided to include provisions for DAsII to register in inactive status.

Permissible Duties Chart – Ms. Reen said the chart in the agenda package is a homework assignment she would like the Committee to agree to complete individually to help in the development of the guidance document the Committee wants to issue with the DAII regulations. Following discussion, Ms. Reen agreed to change the headings and e-mail the chart to each member, then to compile the results and bring items with inconsistent responses back to the Committee for discussion.

Direction and Supervision – Ms. Reen reported that staff was having difficulty incorporating the new definitions of direction and the three levels of supervision into draft regulations. Mr. Casway advised that more work on the intended meaning and intended use of the terms is needed. After discussing the need for the word "direction" and language to distinguish between the three levels, the Committee agreed to have Ms. Reen send out the adopted language for review and comment by the members. The responses will be used to develop proposed regulatory language for the next meeting.

Number of Dental Hygienists and Dental Assistants II - Dr. Watkins asked the Committee if, in light of the comments received earlier, it wanted to change its proposal to allow up to 4 dental hygienists and 4 DAsII to be supervised by a dentist at the same time. Dr. Levin moved to allow one dentist to supervise up to 4 dental hygienists and DAsII at one time in any combination. The motion was seconded and passed.

PERIODIC REVIEW OF REGULATIONS:

Review of Licensing Provisions – Ms. Reen asked each Committee member to read the draft with proposed changes in the licensing provisions one more time for clarity and to let her know where further editing or development may be helpful.

Sedation and Anesthesia – Ms. Reen reported that she has begun work on this section of the regulations and is working with the 2007 ADA Guidelines and the 2006 Academy of Pediatric

Dentistry Guidelines. She noted that it may be advisable for committee members to review these documents along with the chart being developed. Ms. Yeatts asked if the Committee wanted an ad hoc committee or an advisor to assist with review of this section of the regulations. Dr. Watkins responded that an advisor would be helpful and asked Dr. Pirok if he would assist the Committee. Dr. Pirok agreed.

Guidance Document On Administering and Monitoring:

Ms. Reen noted the comments received from the Virginia Association of Nurse Anesthetists regarding possible conflicts in the policy and the scope of practice of nurses. She advised the Committee to defer discussion and action on adoption of the document to the next meeting to allow the Board of Nursing to review it. She asked the Committee to adopt a motion to recommend that the Board approve exempt action to amend 18VAC60-20-190 of the regulations to reflect that dental hygienists may parenterally administer local anesthesia to conform to Virginia Code provision §54.1-3408(J). Ms. Pace made the motion which was seconded and passed. Dr. Hall asked about amending the document at the provision for "placing a face mask or other delivery device on the patient" because it was too open. Following discussion, Ms. Reen was instructed to delete "or other delivery device" on the draft for the next meeting.

NEXT MEETING:

Dr. Watkins asked about dates in April for scheduling the next meeting. It was agreed to meet at 1:00 pm on Wednesday, April 22, 2009.

ADJOURNMENT:

Dr. Watkins adjourned the meeting at 4:45 p.m.

James D. Watkins, D.D.S., Chair

Sandra K. Reen, Executive Director

Date

Date

Agenda Item: Regulatory Action – Adoption of Exempt Final Amendments for Regulations on Non-delegable Duties

Enclosed is:

A copy of subsection J of § 54.1-3408, amended in 2006 to allow dental hygienists to administer Schedule VI local anesthesia to patients 18 years or older and a draft of final amended regulations – will be exempt from the Administrative Process Act to adopt amendments to conform regulations to changes in the Code.

Action: Motion to adopt final amended regulations to amend #3 under Non-delegable duties.

Excerpt from Code of Virginia

J. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.

In addition, a dentist may authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia.

Project 1815 – Exempt action

BOARD OF DENTISTRY

Administration of local anesthesia by dental hygienists

Part VI
Direction and Delegation of Duties

18VAC60-20-190. Nondelegable duties; dentists.

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-20-81, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

6. Performing pulp capping procedures;

7. Administering and monitoring general anesthetics and conscious sedation except as provided for in § 54.1-2701 of the Code of Virginia and 18VAC60-20-108 C, 18VAC60-20-110 F, and 18VAC60-20-120 F;

8. Condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth;

9. Final positioning and attachment of orthodontic bonds and bands;

10. Taking impressions for master casts to be used for prosthetic restoration of teeth or oral structures;

11. Final cementation of crowns and bridges; and

12. Placement of retraction cord.

Agenda Item: Response to Petition for rulemaking

Staff Note: A petition for rulemaking was received from Alden Anderson on behalf of the Roanoke Valley Dental Society. It was published on January 5, 2009 with comment requested until February 4, 2009.

Enclosed is:

A copy of the petition and the notice in the Register of Regulations

Copies of comments received during the comment period

A copy of the applicable section of regulations

Action: To accept the petitioner's request and initiate rulemaking (adoption of a Notice of Intended Regulatory Action) or to reject the request. Reasons for the decision must be stated.

COMMONWEALTH OF VIRGINIA
Board of Dentistry

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,)		
Anderson, Alden, S, III		
Street Address: 3650 Colonial Avenue, SW	Area Code and Telephone Number: 540-989-3639	
City: Roanoke	State: VA	Zip Code: 24018
Email Address (optional)	Fax (optional)	

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

   Regulations
   Part II. Licensure Renewal and Fees
   18VAC60-20-50 C

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

   Please amend by adding:
   16. The Roanoke Valley Dental Society

   Rational: The Roanoke Valley Dental Society, established over 75 years ago, should have no need to rely on the local dental hygienists' or dental assistants' organizations to sponsor its continuing education programs for them to be "approved continuing education for each renewal of license." The RVDS should be able sponsor its own approved continuing education programs in accordance with 18VAC60-20-50 (B).

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is <u>other</u> legal authority for promulgation of a regulation, please provide that Code reference.

   54.1-2709 E

Signature: L Scott Anderson III Date: 12/9/08

BITTEL AND ANDERSON, INC.
3650 COLONIAL AVENUE, S.W.
ROANOKE, VIRGINIA 24015

TELEPHONE (540) 989-3639
FAX (540) 989-4749

DAVID E. BITTEL, D.M.D.

A. SCOTT ANDERSON, III, D.D.S.,
DIPLOMATE, AMERICAN BOARD OF
PEDIATRIC DENTISTRY

December 9, 2008

Commonwealth of Virginia
Board of Dentistry
9960 Mayland Drive,
Suite 300
Richmond, VA 23233-1463

The Virginia Board of Dentistry:

We are writing to request that the Virginia Board of Dentistry amend **18VAC60-20-50 (C)** in order to make the Roanoke Valley Dental Society a recognized provider of continuing education for dentists, dental hygienists, and dental assistants in Virginia. We are including a completed **Petition for Rule-making**.

The Roanoke Valley Dental Society has been in continued existence since at least 1932. A copy of the current Constitution and By-Laws, most recently revised in 1987, is included. Please note in Article II that the object of the Roanoke Valley Dental Society *"is to promote the art and science of dentistry; foster fraternal relations and social intercourse amoung dentists; safeguard the material interests of the profession and the public; ..."*

Approximately one hundred and seventy (170) local dentists are listed on the RVDS membership rolls. Although there has been an apparent increase in the number of dentists locally, membership and attendance has shown a gradual decline in recent years. Local dentists were recently queried concerning this disconcerting trend. A recurring response was that the RVDS is not recognized by the Virginia Board of Dentistry as a sponsor of continuing education programs for dentists, dental hygienists, and dental assistants in Virginia. Therefore, participation in these RVDS sponsored educational activities does not contribute towards the fulfillment of the annual continuing education requirement for dentists and dental hygienists to maintain active licensure in Virginia.

We have reviewed the list of sponsors presently recognized by the Virginia Board of Dentistry for accreditation of continuing education for dentists and dental hygienists in Virginia: **18VAC60-20-50 (C)**. We have also reviewed the regulations concerning the relevance of continuing education programs as listed in **18VAC60-20-50 (B)**. On an ongoing basis, dentists who are members of the RVDS regularly attend continuing education programs sponsored by a number of these recognized entities, and

resoundingly, the RVDS members recognize that the scope and the quality of the programs offered by the RVDS consistently match that which is offered by these recognized sponsoring entities.

It is interesting to note that, according to **18VAC60-20-50 (C)**, continuing education credit would be available for RVDS continuing education programs if they would be sponsored by the local constituent and component/branch associations of the American Dental Hygienists' Association and National Dental Hygienists Association, the local constituent and component branch/associations of the American Dental Assisting Association, the local community college under the auspices of the dental hygienist program, or The Commonwealth Dental Hygienists' Society, but the continuing education credit is not available if the RVDS sponsors its own continuing education programs.

For over 75 years, the RVDS has sponsored and cosponsored continuing education programs of the highest caliber for dentists and their staff members. Continuing education offered and sponsored by the RVDS has consistently been useful for dentists and their staff members in their service to the public. Not only are the programs timely and educational, the associated meetings provide an ongoing opportunity for development of professional relationships among dental colleagues for the benefit of the dental health of our community.

The RVDS membership roster has included most of the local endodontists, general dentists, oral surgeons, orthodontists, pediatric dentists, periodontists, and prosthodontists. Most of the RVDS members are also members of other professional organizations such as the National Dental Association, the Academy of General Dentistry, and the American Dental Association. Numerous RVDS member dentists are members and/or diplomates of their ADA recognized specialty organizations. Members of the RVDS have served the public through the profession of dentistry in most of these organizations. Several members of the RVDS have served as members of the Virginia Board of Dentistry.

Speakers who have offered programs for the RVDS include teachers, researchers, and clinicians. Some of these individuals are nationally recognized in private practice while others are past and present faculty members of dental schools including MCV-VCU. On an ongoing basis, deans and administrators of dental schools including MCV-VCU have accepted invitations and presented programs for RVDS continuing education meetings. Members and representatives of the Virginia Board of Dentistry are our guest speakers on an ongoing basis. Names we all know appear on the RVDS speakers list.

With all due respect, we formally request that the Roanoke Valley Dental Society be named a Virginia Board of Dentistry recognized provider of continuing education for dentists, dental hygienists, and dental assistants in Virginia. Please consider this a letter of support for the included **Petition for Rule-making**. If there is any additional assistance we may provide in this petition, please inform us at your earliest convenience

in order that we may continue to be able to improve our service to our community through the RVDS.

Sincerely,

Sandra Andrew, D.D.S.,
President,
Roanoke Valley Dental Society

A. Scott Anderson, III, D.D.S.,
Co-chair, Continuing Education Committee,
Roanoke Valley Dental Society

Walter A. Gold, D.D.S.,
Co-chair, Continuing Education Committee,
Roanoke Valley Dental Society

TITLE 18. PROFESSIONAL AND OCCUPATIONAL LICENSING

BOARD OF DENTISTRY

Initial Agency Notice

Title of Regulation: **18VAC60-20. Regulations Governing the Practice of Dentistry and Dental Hygiene.**

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Name of Petitioner: Alden S. Anderson, III.

Nature of Petitioner's Request: To amend 18VAC60-20-50 to allow the Roanoke Valley Dental Society to present continuing education programs without being affiliated with local organizations to be an approved sponsor.

Agency's Plan for Disposition of Request: The board is requesting public comment on the petition to amend rules to recognize the Roanoke Valley Dental Society as a continuing education provider. Comment will be considered and a decision made on the petitioner's request at the board meeting scheduled for March 13, 2009.

Comments may be submitted until February 4, 2009.

Agency Contact: Elaine J. Yeatts, Agency Regulatory Coordinator, Department of Health Professions, 9960 Mayland Drive, Suite 300, Richmond, VA 23233, telephone (804) 367-4688, FAX (804) 527-4434, or email elaine.yeatts@dhp.virginia.gov.

VA.R. Doc. No. R09-10; Filed December 9, 2008, 3:32 p.m.

BOARD OF MEDICINE

Initial Agency Notice

Title of Regulation: **18VAC85-20. Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic.**

Statutory Authority: § 54.1-2400 of the Code of Virginia.

Name of Petitioner: Dr. Percy Ramos.

Nature of Petitioner's Request: To amend 18VAC85-20-122 to allow practice as a medical doctor in another state with an unrestricted license for a certain number of years to be counted in lieu of one of the two years of postgraduate training for graduates of nonapproved medical schools.

Agency's Plan for Disposition of Request: The board will receive public comment on the petition for rulemaking and will consider any public comment and the petition at a meeting of the board on February 19, 2009.

Comments may be submitted until February 4, 2009.

Agency Contact: William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Richmond, VA 23233-1463, telephone (804) 367-4621, FAX (804) 527-4426, or email william.harp@dhp.virginia.gov.

VA.R. Doc. No. R09-09; Filed December 4, 2008, 2:22 p.m.

JAMES C. KEMPER, D.D.S.
3 POPLAR AVENUE
SALEM, VIRGINIA 24153
TELEPHONE 387-2569

January 9, 2009

To: Ms. Sandra Reen
Executive Director of VA Board of Dentistry

Dear Ms. Reen:

The Roanoke Valley Dental Society has recently petitioned the VA Board of Dentistry to allow the society to become a sponsoring organization for continuing education. As a member of the Roanoke Valley Dental Society for over 30 years, I have attended many quality educational programs sponsored by our society. I certainly hope the Board of Dentistry will approve this request for our continuing education. Also, a big thank you for your years of service.

Sincerely yours,

James C. Kemper

James C. Kemper, D.D.S.

JCK/raw

Yeatts, Elaine J.

From: Bcwjoachim@aol.com
Sent: Tuesday, February 03, 2009 7:33 PM
To: Yeatts, Elaine J.
Subject: Roanoke Valley Dental Society as a creditable sponsor

The Roanoke Valley Dental Society (RVDS) has been the dominating force in this area for generations for dentistry. It has been a truly professional organization that has served us dentists with CE and healthy camaraderie and at the same time drawn out and developed local leadership.

The DHP would serve both the public and dentistry by granting the RVDS the status of an approved sponsor.

Richard Joachim DDS, FAGD

Great Deals on Dell Laptops. Starting at $499.

Gary A. Roach, D.D.S., Ltd.
Jonathan Lubeck, D.M.D.
Dudley Parks, D.D.S
G. Alan McClellan, D.D.S.

5004 BRAMBLETON AVENUE
ROANOKE, VIRGINIA 24018
(540) 774-1019

RECEIVED
JAN 22 2009
VA Bd. of Dentistry

January 13, 2009

Virginia Board of Dentistry:

Speaking as a member of the Roanoke Valley Dental Society, our society provides valuable continuing education for dentists in our area. The Roanoke Valley Dental Society is an appropriate organization for sponsoring CE programs and should be able to provide "approved continuing education" for license renewal for dentists and dental hygienists.

I support the amendment to have the Roanoke Valley Dental Society become a recognized sponsor of Continuing Education.

Sincerely,

Jlubeck

Jonathan Lubeck, D.M.D.

Gary A. Roach, D.D.S., Ltd.
Jonathan Lubeck, D.M.D.
Dudley Parks, D.D.S
G. Alan McClellan, D.D.S.

5004 BRAMBLETON AVENUE
ROANOKE, VIRGINIA 24018
(540) 774-1019

RECEIVED
JAN 19 2009
VA Bd. of Dentistry

January 13, 2009

Virginia Board of Dentistry:

Speaking as a member of the Roanoke Valley Dental Society, our society provides valuable continuing education for dentists in our area. The Roanoke Valley Dental Society is an appropriate organization for sponsoring CE programs and should be able to provide "approved continuing education" for license renewal for dentists and dental hygienists.

I support the amendment to have the Roanoke Valley Dental Society become a recognized sponsor of Continuing Education.

Sincerely,

Gary A. Roach, D.D.S.

18VAC60-20-50. Requirements for continuing education.

A. After April 1, 1995, a dentist or a dental hygienist shall be required to have completed a minimum of 15 hours of approved continuing education for each annual renewal of licensure.

1. Effective June 29, 2006, a dentist or a dental hygienist shall be required to maintain evidence of successful completion of training in basic cardiopulmonary resuscitation.

2. Effective June 29, 2006, a dentist who administers or a dental hygienist who monitors patients under general anesthesia, deep sedation or conscious sedation shall complete four hours every two years of approved continuing education directly related to administration or monitoring of such anesthesia or sedation as part of the hours required for licensure renewal.

3. Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.

B. An approved continuing dental education program shall be relevant to the treatment and care of patients and shall be:

1. Clinical courses in dentistry and dental hygiene; or

2. Nonclinical subjects that relate to the skills necessary to provide dental or dental hygiene services and are supportive of clinical services (i.e., patient management, legal and ethical responsibilities, stress management). Courses not acceptable for the purpose of this subsection include, but are not limited to, estate planning, financial planning, investments, and personal health.

C. Continuing education credit may be earned for verifiable attendance at or participation in any courses, to include audio and video presentations, which meet the requirements in subdivision B 1 of this section and which are given by one of the following sponsors:

1. American Dental Association and National Dental Association, their constituent and component/branch associations;

2. American Dental Hygienists' Association and National Dental Hygienists Association, their constituent and component/branch associations;

3. American Dental Assisting Association, its constituent and component/branch associations;

4. American Dental Association specialty organizations, their constituent and component/branch associations;

5. American Medical Association and National Medical Association, their specialty organizations, constituent, and component/branch associations;

6. Academy of General Dentistry, its constituent and component/branch associations;

7. Community colleges with an accredited dental hygiene program if offered under the auspices of the dental hygienist program;

8. A college or university that is accredited by an accrediting agency approved by the U.S. Department of Education or a hospital or health care institution accredited by the Joint Commission on Accreditation of Health Care Organizations;

9. The American Heart Association, the American Red Cross, the American Safety and Health Institute and the American Cancer Society;

10. A medical school which is accredited by the American Medical Association's Liaison Committee for Medical Education or a dental school or dental specialty residency program accredited by the Commission on Dental Accreditation of the American Dental Association;

11. State or federal government agencies (i.e., military dental division, Veteran's Administration, etc.);

12. The Commonwealth Dental Hygienists' Society;

13. The MCV Orthodontic and Research Foundation;

14. The Dental Assisting National Board; or

15. A regional testing agency (i.e., Central Regional Dental Testing Service, Northeast Regional Board of Dental Examiners, Southern Regional Testing Agency, or Western Regional Examining Board) when serving as an examiner.

D. A licensee is exempt from completing continuing education requirements and considered in compliance on the first renewal date following the licensee's initial licensure.

E. The board may grant an exemption for all or part of the continuing education requirements due to circumstances beyond the control of the licensee, such as temporary disability, mandatory military service, or officially declared disasters.

F. A licensee is required to provide information on compliance with continuing education requirements in his annual license renewal. Following the renewal period, the board may conduct an audit of licensees to verify compliance. Licensees selected for audit must provide original documents certifying that they have fulfilled their continuing education requirements by the deadline date as specified by the board.

G. All licensees are required to maintain original documents verifying the date and subject of the program or activity. Documentation must be maintained for a period of four years following renewal.

H. A licensee who has allowed his license to lapse, or who has had his license suspended or revoked, must submit evidence of completion of continuing education equal to the requirements

for the number of years in which his license has not been active, not to exceed a total of 45 hours. Of the required hours, at least 15 must be earned in the most recent 12 months and the remainder within the 36 months preceding an application for reinstatement.

I. Continuing education hours required by board order shall not be used to satisfy the continuing education requirement for license renewal or reinstatement.

J. Failure to comply with continuing education requirements may subject the licensee to disciplinary action by the board.

Date/Time Filed with Registrar of Regulations	VA.R. Document Number: R____ - _____
	Date of Publication in Virginia Register:

Commonwealth of Virginia

RESPONSE TO PETITION FOR RULEMAKING

Check one: ☒ **Initial Agency Notice** ☐ **Agency Decision**

Regulatory Coordinator: Elaine J. Yeatts
Telephone: (804) 367-4688 **E-mail:** elaine.yeatts@dhp.virginia.gov

Agency Name: Board of Dentistry, Department of Health Professions

Chapters affected:

VAC No. *(e.g., 4 VAC 20-490):*	**Chapter Name** *(e.g., Regulations Pertaining to Sharks):*
18 VAC 60-20	Regulations Governing the Practice of Dentistry and Dental Hygiene

Statutory Authority: 54.1-2400 of the Code of Virginia

Name of petitioner: Len Futerman

Nature of petitioner's request: To amend regulations for anesthesia in dental offices for consistency with guidelines of the American Dental Association, as amended in October of 2007.

INITIAL AGENCY NOTICE

Agency's plan for disposition of the request: The Board is requesting public comment on the petition and will consider the petitioner's request and any comment on the petition at its meeting on June 12, 2009.

Comments may be submitted until April 15, 2009

AGENCY DECISION

☐ **Request Granted**

☐ **Request Denied**

Statement of reasons for decision:

Agency Contact for Further Information:
Name: Elaine J. Yeatts
Title: Agency Regulatory Coordinator
Address: 9960 Mayland Drive, Suite 300, Richmond, VA 23233
Telephone: (804) 367-4688 **Fax:** (804) 527-4434 **Toll Free:** 1- -
E-mail: elaine.yeatts@dhp.virginia.gov

Date Submitted: 2/13/09

COMMONWEALTH OF VIRGINIA
Board of Dentistry

9960 Mayland Drive, Suite 300 (804) 367-4538 (Tel)
Richmond, Virginia 23233-1463 (804) 527-4428 (Fax)

Petition for Rule-making

The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition.

Please provide the information requested below. (Print or Type)

Petitioner's full name (Last, First, Middle initial, Suffix,) Futerman Len

Street Address 616 Va Beach Blvd Suite 102
City Virginia Beach State VA Zip Code 23451
Area Code and Telephone Number 757-769-7155
Fax (optional)
Email Address (optional)

Respond to the following questions:

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

18 VAC60-20-108. Administration of anxiolysis or inhalation analgesia.
18VAC60-20-120. Requirements to administer conscious sedation.
18VAC60-20-110. Requirements to administer deep sedation/general anesthesia.

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

In Oct of 2007 the ADA adopted a new set of guidelines for the use of sedation and anesthesia in the dental office. These guidelines propose terminology that is quite different from the VA Boards current accepted terminology. Examples include using mild, moderate and deep sedation to describe anesthesia levels versus anxiolysis and conscious sedation. Additionally some of the training and monitoring requirements for administering different levels of anesthesia differ significantly from the boards current regulations. I propose adopting regulations more in line with the ADA's guidelines to maintain consistantcy and clarity when describing and discussing anesthesia in the dental office.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

Signature: Len Futerman
Date: 2/9/09

Board of Dentistry

Report of the 2009 General Assembly

HB 1852 Health Professions, Department of; confidentiality of investigations.

Summary as passed House:
Department of Health Professions; investigations. Provides that, when a complaint or report has been filed about a person licensed, certified, or registered by a health regulatory board, a copy of the complaint or report shall be provided to the person who is the subject of the complaint or report prior to any interview of the person who is the subject of the complaint or report or at the time the person who is the subject of the complaint or report is notified of the complaint or report, whichever shall occur first, unless provision of the complaint or report to the person would materially obstruct a criminal or regulatory investigation. This bill clarifies that requirements related to confidentiality of information obtained during an investigation or disciplinary proceeding shall not prohibit investigative staff from interviewing fact witnesses, disclosing to fact witnesses the identity of the subject of the complaint or report, or reviewing with fact witnesses a copy of records or other supporting documentation necessary to refresh the fact witness's recollection.

Patrons: Morrissey, BaCote, Eisenberg, Hall and Ward

02/17/09 House: Placed on Calendar
02/18/09 House: Senate amendment agreed to by House (98-Y 0-N)
02/18/09 House: VOTE: --- ADOPTION (98-Y 0-N)
02/23/09 House: Bill text as passed House and Senate (HB1852ER)
02/24/09 House: Impact statement from DPB (HB1852ER)

HB 2058 Dentistry, Board of; recovering monitoring costs.

Summary as introduced:
Board of Dentistry; recovering monitoring costs. Allows the Board of Dentistry to recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of $5,000.

Patron: Hamilton

02/18/09 House: Bill text as passed House and Senate (HB2058ER)
02/18/09 House: Impact statement from DPB (HB2058ER)
02/18/09 House: Signed by Speaker
02/18/09 Senate: Signed by President
02/25/09 Governor: Approved by Governor-Chapter 89 (effective 7/1/09)

HB 2180 Dental hygienists; those who hold a license, etc., may provide educational and preventative care.

Summary as introduced:
Practice of dental hygienists. Provides that a dental hygienist who holds a license or permit issued by the Board of Dentistry may provide educational and preventive dental care in the Lenowisco, Cumberland Plateau, and Southside Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Department of Health, and that any dental hygienist providing such services shall practice pursuant to a protocol developed by the Department of Health. This bill is

identical to SB 1202.

Patron: Phillips

02/18/09 House: Bill text as passed House and Senate (HB2180ER)
02/18/09 House: Impact statement from DPB (HB2180ER)
02/18/09 House: Signed by Speaker
02/18/09 Senate: Signed by President
02/25/09 Governor: Approved by Governor-Chapter 99 (effective 7/1/09)

HB 2211 Prescription Monitoring Program; disclosure of information.

Summary as passed House:
Prescription Monitoring Program; disclosure of information. Removes requirement that a prescriber obtain written consent from the recipient of a prescription before requesting information on that recipient for the purpose of establishing his treatment history, and authorizes a prescriber authorized to access information in the possession of the Prescription Monitoring Program to delegate such authority to up to two health care professionals who are licensed, registered or rectified by a health regulatory board and employed at the same facility under the direct supervision of the prescriber. This bill incorporates HB 2259. This bill is identical to SB 1195.

Patron: Jones

02/11/09 Senate: Referred to Committee on Education and Health
02/19/09 Senate: Reported from Education and Health (15-Y 0-N)
02/20/09 Senate: Constitutional reading dispensed (39-Y 0-N)
02/23/09 Senate: Read third time
02/23/09 Senate: Passed Senate (40-Y 0-N)

HB 2405 Health Professions, Department of; may release information for determining shortage designations.

Summary as passed:
Department of Health Professions; submission of information. Expands the requirement to submit certain information to the Department of Health Professions to anyone applying for initial licensure, certification, or registration, and individuals licensed, certified, or registered by a health regulatory board. Also the bill allows the Department, and the Board of Nursing, to release any information for the purposes of determining shortage designations and to qualified personnel if pertinent to an investigation, research, or study, provided a written agreement between such qualified personnel and the Department, which ensures that any person to whom such information is divulged shall preserve the confidentiality of the information, is executed.

Patrons: Tyler and Amundson

02/17/09 House: Placed on Calendar
02/18/09 House: Senate amendments agreed to by House (98-Y 0-N)
02/18/09 House: VOTE: --- ADOPTION (98-Y 0-N)
02/23/09 House: Bill text as passed House and Senate (HB2405ER)
02/24/09 House: Impact statement from DPB (HB2405ER)

HB 2407 Health Practitioners' Intervention Program; revisions, changes name.

Summary as passed House:

Health Practitioners' Intervention Program; revisions. Changes the name of the Health Practitioners' Intervention Program to the Health Practitioners' Monitoring Program, and clarifies that the purpose of the Program is to monitor impaired health professionals, rather than to intervene or treat them. The bill provides that the Director of the Department of Health Professions shall work together with the Health Practitioner's Monitoring Program to develop contracts necessary for implementation of monitoring services. This bill also expands the membership of the Health Practitioner's Monitoring Program Committee to include a registered nurse engaged in active practice.

Patron: Hall

02/11/09 House: Impact statement from DPB (HB2407H1)
02/19/09 Senate: Reported from Education and Health (15-Y 0-N)
02/20/09 Senate: Constitutional reading dispensed (39-Y 0-N)
02/23/09 Senate: Read third time
02/23/09 Senate: Passed Senate (40-Y 0-N)

HB 2453 Electronic prescribing; Secretary of Health and Human Services, etc. to establish a website.

Summary as passed House:
Electronic prescribing. Requires the Secretary of Health and Human Services, in consultation with the Secretary of Technology, to establish a website with information on electronic prescribing for health practitioners, which shall contain information about the process and advantages of electronic prescribing, the availability of electronic prescribing products, links to federal and private-sector websites that provide guidance on selecting electronic prescribing products, and links to federal and private sector incentive programs for implementing electronic prescribing. The bill requires the Secretary of Health and Human Resources in consultation with the Secretary of Technology to regularly consult with relevant public and private stakeholders to assess and accelerate implementation of electronic prescribing in Virginia. This bill further provides that, beginning in 2010, any health practitioner who contracts with the Commonwealth for the provision of health services will be required to utilize electronic prescribing to the maximum extent practicable. This bill directs the Department of Medical Assistance Services to develop programs and incentives to encourage the adoption of electronic prescribing by Medicaid providers.

Patron: Sickles

02/11/09 Senate: Referred to Committee on Education and Health
02/19/09 Senate: Reported from Education and Health (15-Y 0-N)
02/20/09 Senate: Constitutional reading dispensed (39-Y 0-N)
02/23/09 Senate: Read third time
02/23/09 Senate: Passed Senate (40-Y 0-N)

SB 1154 Copies of medical bills and charges; no cost to patient up to three times every twelve months.

Summary as passed Senate:
Copies of medical bills and charges; no cost. Provides that a patient%92s account balance or itemized listing of charges maintained by a health care provider shall be supplied at no cost up to three times every twelve months to either the patient or the patient%92s attorney.

Patron: McDougle

02/25/09 House: Read third time
02/25/09 House: Committee amendments agreed to

02/25/09 House: Engrossed by House as amended
02/25/09 House: Passed House with amendments BLOCK VOTE (100-Y 0-N)
02/25/09 House: VOTE: BLOCK VOTE PASSAGE (100-Y 0-N)

SB 1275 Privileged communications; provides communications between physicians and patients thereof.

Summary as introduced:
Privileged communications. Provides that communications between physicians and their patients are privileged and cannot be disclosed, except at the request or with the consent of the patient. Currently, physicians cannot be required to disclose such communications, but may voluntarily disclose such communications.

Patrons: Obenshain; Delegate: Albo

02/20/09 House: Read second time
02/23/09 House: Passed by for the day
02/24/09 House: Read third time
02/24/09 House: Passed House BLOCK VOTE (99-Y 0-N)
02/24/09 House: VOTE: BLOCK VOTE PASSAGE (99-Y 0-N)

SB 1282 Health Professions, Department of; prohibited from providing personal information of individuals.

Summary as passed Senate:
Department of Health Professions; information concerning health professionals. Provides that the Department of Health Professions shall collect an official address of record that shall not be provided to any private entity for resale to another private entity or to the public. Also provides that the Department provide health professionals the opportunity to provide a second address for the purpose of public dissemination, and that if no second address is provided, the official address shall be made public. The bill also directs the Enterprise Application Public-Private Partnership Office to take appropriate action to prevent the sale of any list of home addresses and other personal information of individuals licensed as health professionals by Virginia Interactive or any other private entity.

Patron: Newman

02/24/09 House: Engrossed by House - committee substitute SB1282H1
02/24/09 House: Passed House with substitute BLOCK VOTE (99-Y 0-N)
02/24/09 House: VOTE: BLOCK VOTE PASSAGE (99-Y 0-N)
02/25/09 Senate: House substitute agreed to by Senate (37-Y 0-N)
02/25/09 Senate: Title replaced 093291280-H1

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 54.1-2722 of the Code of Virginia, relating to practice of dental hygienists.

[H 2180]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2722 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing, and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of an accredited dental hygiene program offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B of this section; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection U of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. Notwithstanding any provision of law or regulation to the contrary, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Cumberland Plateau, Southside, and Lenowisco Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol developed jointly by the medical directors of each of the districts, dental hygienists employed by the Department of Health, the Director of the Dental Health Division of the Department of Health, one representative of the Virginia Dental Association, and one representative of the Virginia Dental Hygienists' Association. A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of these districts, shall be prepared and submitted by the medical directors of the three health districts to the Virginia Secretary of Health and Human Resources by November 1, 2010. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

2. That the Department of Health shall seek consultation and information from all relevant parties, including agencies of government, in its development of any regulations or policies to implement the provisions of the act.

3. That the provisions of this act shall expire on July 1, 2011.

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend the Code of Virginia by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.2, relating to recovering costs of disciplinary action by the Board of Dentistry.

[H 2058]

Approved

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1 of Chapter 27 of Title 54.1 a section numbered 54.1-2708.2 as follows:

§ 54.1-2708.2. Recovery of monitoring costs.

The Board may recover from any licensee against whom disciplinary action has been imposed reasonable administrative costs associated with investigating and monitoring such licensee and confirming compliance with any terms and conditions imposed upon the licensee as set forth in the order imposing disciplinary action. Such recovery shall not exceed a total of $5,000. All administrative costs recovered pursuant to this section shall be paid by the licensee to the Board. Such administrative costs shall be deposited into the account of the Board and shall not constitute a fine or penalty.

2/19/2009 - Proposed Budget Amendment by DA

Item 303

Notwithstanding the provisions of Chapter 27 of title 54.1 of the Code of Virginia, the Board of Dentistry shall revise its regulations pertaining to the licensure of dentists and dental hygienists to require that mobile dental clinics and other portable dental operations meet certain requirements to ensure that patient safety is protected, appropriate dental services are rendered, and needed follow-up care is provided. The revised regulations shall include, but not be limited to requirements for registration by the mobile clinics, locations where services are provided, reporting requirements by providers and other regulations to insure accountability of care rendered. The Board shall have the authority to promulgate emergency regulations to implement this amendment within 280 days or less from the enactment of this act.

CODA
Commission on Dental Accreditation

211 E. CHICAGO AVENUE SUITE 1900 CHICAGO, IL 60611-2678
MAIN 312 440 4653 FAX 312 440 2915

RECEIVED
FEB 2 3 2009
VA Bd. of Dentistry

VIA FEDERAL EXPRESS/TRACKING REQUESTED

February 13, 2009

Dr. Eugene P. Trani, president
Office of the President
Virginia Commonwealth University
910 W. Franklin Street
Richmond, VA 23284-2512

Re: Advanced Specialty Education Program in Endodontics, School of Dentistry

Dear President Trani:

As you may recall, at its July 26, 2007 meeting, the Commission considered notification, dated March 8, 2007, from Dr. Ronald J. Hunt, dean, School of Dentistry, regarding a change in program director for the advanced specialty education program in endodontics. Based on a review of the notification, the Commission determined that the endodontic program is not in compliance with Standard 2 of the Accreditation Standards for Advanced Specialty Education Programs. Standard 2 – Program Director and Teaching Staff states: "The program **must** be administered by a director who is board certified in the respective specialty of the program. (All program directors appointed after January 1, 1997, who have not previously served as program directors, **must** be board certified.)"

Intent: The director of an advanced specialty education program is to be certified by an ADA-recognized certifying board in the specialty. Board certification is to be active. The board certification requirement of Standard 2 is also applicable to an interim/acting program director. A program with a director who is not board certified but who has previous experience as an interim/acting program director in a Commission-accredited program prior to 1997 is not considered in compliance with Standard 2.

Examples of evidence to demonstrate compliance include:

For board certified directors: Copy of board certification certificate; letter from board attesting to current/active board certification.

(For non-board certified directors who served prior to January 1, 1997: Current CV identifying previous directorship in a Commission on Dental Accreditation- or Commission on Dental Accreditation of Canada-accredited advanced specialty program in the respective discipline; letter from the previous employing institution verifying service.)

At its February 1, 2008 and July 31, 2008 meetings, the Commission considered reports, dated November 28, 2007, addressing compliance with Standard 2. The Commission understood that Dr. Karan J. Replogle, who is board eligible, continues to serve as Interim Program Director, and has successfully completed Parts I and II of the American Board of Endodontics examination. She is scheduled to take Part III in April 2009 in time to meet the Commission's July 2009 deadline for achieving full compliance with Standard 2.

Accordingly, the Commission adopted a resolution at these meetings to grant the accreditation status of "approval with reporting requirements" for the advanced specialty education program in endodontics. The Commission specified that continued accreditation of the program will be dependent upon the program achieving full compliance with Standard 2 no later than July 2009.

At its January 29, 2009 meeting, the Commission considered the November 23, 2008 report of noncompliance on the program and determined that Standard 2 remains unmet. Accordingly, at this time, the Commission is notifying your institution of its **intent to withdraw** the program's accreditation at the Commission's July 31, 2009 meeting unless Standard 2 is met and the program achieves full compliance by that time. The definitions of accreditation classifications are enclosed.

Specifically, the Commission requests that documentation demonstrating that the program director is board certified (i.e., a copy of board certification certificate; letter from board attesting to active/current board certification) or that, if appointed after January 1, 1997, he/she has previously served as program director be submitted (i.e., current curriculum vita identifying previous directorship in a Commission on Dental Accreditation accredited advanced specialty program in the respective specialty; letter from the previous employing institution verifying service).

The Commission requested three (3) copies of a report addressing further progress on compliance with Standard 2 be submitted to this office by **May 15, 2009** for consideration at the Endodontic Education Review Committee's July 12, 2009 meeting and the Commission's July 31, 2009 meeting.

Institutions/Programs are expected to meet established deadlines for submission of requested information. If an institution fails to comply with the Commission's request, it will be assumed that the institution no longer wishes to participate in the accreditation program.

In addition to the number of paper copies requested elsewhere in this correspondence, please be advised that the Commission requires that all accreditation correspondence/ documents/reports and related materials submitted to the Commission for a program's permanent file be done so electronically. The attached Electronic Submission Guidelines will assist you in preparing your report. If the program is unable to provide a comprehensive electronic document, the Commission will accept a paper copy and assess a fee of $250 per general correspondence/report (major change, increase in enrollment, transfer of sponsorship, progress report, response to site visit report, etc.) to the program for converting the document to an electronic version.

By copy of this letter and in accord with Federal regulation, the Commission is providing written notice of its decision to place the program on "intent to withdraw accreditation, July 2009" to the Secretary of the United States Department of Education as well as the appropriate accrediting and state licensing/authorizing agencies. Notice to the public is provided through the Commission's listing of accredited programs.

It should be noted that Commission policy allows for the program to appear before the Endodontic Education Review Committee to supplement the written information contained in your progress report. A written request for a special appearance should be submitted to Dr. Anthony J. Ziebert, director, Commission on Dental Accreditation, by **June 12, 2009**.

If the special appearance request is approved, a representative of the institution will be permitted to appear before the Endodontic Education Review Committee to present additional information. The special appearance will occur at a specified date and time period prior to the committee's consideration of the program's accreditation classification.

A copy of the Commission's Evaluation Policies and Procedures is enclosed. Please review the policy titled "Intent to Withdraw Accreditation." It states:

> "In the event accreditation is withdrawn from a program by the Commission, students currently enrolled in the program at the time accreditation is withdrawn and who successfully complete the program will be considered graduates of an accredited program. Students who enroll in a program after the accreditation has been withdrawn will not be considered graduates of a Commission-accredited program. Such graduates may be ineligible for certification/licensure examinations. In view of this, the, Commission advises programs that the "intent to withdraw" accreditation may have legal implications for the program and suggests that their institutional legal counsel be consulted regarding how and when to advise applicants and students of the Commission's accreditation actions."

The Commission has authorized use of the following statement by institutions or programs that wish to announce their programmatic accreditation by the Commission. Programs that wish to advertise the specific programmatic accreditation status granted by the Commission may include that information as indicated in italics below (see text inside square brackets); that portion of the statement is optional but, if used, must be complete and current.

> The program in endodontics is accredited by the Commission on Dental Accreditation *[and has been granted the accreditation status of "approval with reporting requirements with intent to withdraw accreditation, July 2009"]*. The Commission is a specialized accrediting body recognized by the United States Department of Education. The Commission on Dental Accreditation can be contacted at (312) 440-4653 or at 211 East Chicago Avenue, Chicago, IL 60611.

If this office can be of any assistance to you, please contact me by telephone, at 1-800-621-8099, extension 2714 or by e-mail, at horanc@ada.org.

Sincerely,

Catherine A. Horan

Dr. Catherine A. Horan, manager
Advanced Specialty Education
Commission on Dental Accreditation

CH/vdc
Enclosures: CODA Accreditation Status Definitions
Evaluation Policies and Procedures
Guidelines for Preparation of Reports and Documentation Guidelines for Selected Recommendations
Electronic Submission Guidelines

cc: Dr. Ronald J. Hunt, dean, School of Dentistry
Dr. Karan J. Replogle, *interim* program director, Endodontics
Ms. Carol Griffiths, program director, Accreditation and State Liaison United States Department of Education
Dr. Belle S. Wheelan, president, Southern Association of Colleges and Schools, Commission on Colleges
Ms. Sandra I. Reen, executive director, Virginia Board of Dentistry
Dr. James J. Koelbl, chair, Commission on Dental Accreditation (CODA)
Dr. Laura M. Neumann, senior vice-president, Education/Professional Affairs
Dr. Anthony J. Ziebert, director, CODA

Reen, Sandra

From: Lili [lili.reitz@den.state.oh.us]
Sent: Tuesday, February 10, 2009 3:50 PM
To: Reen, Sandra
Subject: Important Question

*This message has been forwarded to you from the **AADA Message Board**.*
Click here to reply to this message.

AADA Miscellaneous

Important Question

From: **Lili** 02/10/09
To: **All** 02:49:39 PM
Attachments: **None** 2KW0CAI1U

Hi Everyone.

As you recall, prior to attending the AADE Executive Council Retreat in December, I sent an email on behalf of the AADE Executive Council to ask you what other guidelines the AADE could create similar to the sexual boundaries and prescribing guidelines that would be beneficial to the Boards. In response to that, a few of you commented that you would rather have them look into the uniform licensure exam issue. As a result of that, Diane sent a separate email to ask about whether all were supportive of this position. I received several responses, and all were supportive, and I shared these with the Executive Council. (Since that meeting I have received one state not in support).

As I believe I informed you, the Executive Council has asked that I send another request to all of the state boards and get as many detailed answers as possible to assist them in deciding if and how to proceed.

This is the information I shared with the Council in December in memo form:

I explained that "Many comments [from all of you to the original email] were made asking me to suggest redirecting AADE's focus to getting closerto one uniform national clinical licensure examination. As a result of these comments, another question was sent to the members, asking if whether all were in agreement with this request. All responses regarding this question were supportive of this request. Therefore, on behalf od AADA, I suggest that there be a focus by AADE, as the national organization of state dental boards, to come to consensus on the direction to a uniform national clinical examination. It seems that the states should be directing that their regional board or exam organization make this happen. It appears that somewhere along the way the states wishes became secondary to the politics and strategies of the regional exam entities. If the states desire one national clinical licensure examination, then the regional boards should work with the states and any other interested parties to make that the number one goal."

THE AADE Executive Council was suprised that all states I heard from at that point were supportive. However, they asked me to provide them with a more detailed synopsis of what the states want, and what the AADE could possibly do, etc.

Please provide me with your state's position on this issue. Please be as specific as possible, and please provide any information you think will be helpful. I plan to present this information at our Executive Council meeting in April in Chicago.

THANK YOU!!!

*This message has been forwarded to you from the **AADA Message Board**.*
Click here to reply to this message.

Reen, Sandra

From: info@adex.org
Sent: Friday, December 19, 2008 7:26 PM
To: info@adex.org
Subject: Response to Recent Communications from CRDTS
Attachments: ADEX Letter to Boards.pdf; ADEX 2007 Dental Exam Technical Rpt..pdf; ADEX 2007 Hygiene Tech Report.pdf; ADHLEX Scoring Procedures-Littlfield-Klein Memo.pdf; Klein-Littlefield E-mail Correspondence.pdf; Memo to Hawaii Board.pdf; Has Security of ADEX's Computer Exams Been Breached.pdf; House of Representatives.pdf; ADEX Board of Directors.pdf; Dental Exam Committee.pdf; Dental Hygiene Examination Committee.pdf

PLEASE FORWARD THIS TO YOUR BOARD PRESIDENTS. THANK YOU.

Date: December 19, 2008

To: Presidents and Executive Directors, State Dental Boards

From: Dr. Scott Houfek, President, ADEX

Subject: Response to Recent Communications from CRDTS

The Central Regional Dental Testing Service, Inc. (CRDTS) recently sent out two communications to state dental boards and ADEX indicating that it would no longer be administering the ADEX examinations beginning June 30, 2009. These two communications detail CRDTS' reasons and have prompted many calls and inquiries to ADEX. As a result, ADEX is sending this letter in order to correct misrepresentations in the communications from Dr. John Cosby, the new President of CRDTS.

Contrary to the assertion that "...ADEX has evolved into a de facto joint venture between CRDTS and NERB, with no joint venture agreement, so that in reality the decision making process is driven by the two testing agencies rather than the member state boards," ADEX's structure ensures that the examination committees and ADEX itself are directed by the member state dental boards and educators, rather than potentially partisan testing agencies in developing the examinations. The ADEX House of Representatives is the ultimate governing authority in the organization and appointments are made directly by each member state dental board with each state appointing one member. The ADEX Board of Directors is elected by the member state representatives from districts that were unanimously approved in the initial bylaws and patterned closely after the American Student Dental Association (ASDA) and, in some respects, American Dental Association (ADA) districts. To ensure that the member state dental boards direct the ADEX process, appointments to the ADEX Dental Examination Committee are also made directly by each member state dental board with each state designating one representative. The Dental Hygiene Examination Committee is represented by district members directly elected by the member state dental board's representatives to the ADEX House of Representatives. None of the appointments are made by testing agencies. In the end, the governing mechanism is one state, one vote, with each state having the same input as any other state.

The letters seem to indicate a desire for an alternative governmental structure, i.e., a joint venture between NERB and CRDTS. This was not the intention when ADEX was formed. There are currently three participating testing agencies, CRDTS, NERB, and Nevada. There are three states (Kentucky, Oregon and Nevada) with no connections to CRDTS or NERB. The goal of ADEX was to develop a governmental structure which would allow additional member states to join and additional testing

agencies to participate. ADEX is involved with ongoing dialogues with state dental boards to encourage membership and participation. A joint venture between participating testing agencies potentially disenfranchises the member state dental boards, many of which are members of multiple testing agencies or are independent. ADEX is predicated on the principle that a uniform national examination in dentistry and dental hygiene must be based on a consensus of the active state dental boards rather than by competing testing agencies.

The statement that the activities at ADEX represent bloc voting on the part of NERB and CRDTS is not supported by the facts. The overwhelming majority of recommendations and decisions from the Examination Committees, the Board of Directors and the House of Representatives have been reached by consensus. The Board of Directors has never changed a recommendation from the examination committees. If bloc voting had occurred, I would not have been elected ADEX President, and the Chairs of both the Dental and Dental Hygiene Examination Committees would have never been elected.

One of the concerns that has been expressed as a major factor in CRDTS' decision to withdraw from ADEX was the recent approval of the ADEX ADHLEX Dental Hygiene Licensing Examination. The description of events portrays a seemingly partisan process where conflicting opinions were not considered. The actual process was an in-depth study of the examination to correct deficiencies identified in the ADEX 2007 Dental Hygiene Technical Report, and final adoption with input throughout the process. The 2007 Technical Report of the dental hygiene examination, completed by ADEX's psychometrician, Steve Klein, PhD, found significant psychometric flaws, which rendered at least one section of the examination - the oral inspection - unreliable, and thus invalid. Upon review of the Technical Report, the ADEX Board directed the ADEX Dental Hygiene Examination Committee to recommend solutions to correct the issues. In 2008, the ADEX House of Representatives was informed that the hygiene examination was still in development and authorized the ADEX Board of Directors to approve the hygiene examination upon the recommendation of the Dental Hygiene Committee. The ADEX Dental Hygiene Examination Committee proposed exam was subsequently approved by the ADEX Board at the October 2008 meeting.

There have been references to a letter from Dr. John Littlefield, the psychometrician asked by CRDTS to evaluate issues on the dental hygiene examination, on the initial dental hygiene licensure examination. After the Technical Report was completed, Dr. Littlefield and Dr. Klein consulted on the data analysis. An April 25, 2008 joint memo and a September 20, 2008 communication to Dr. Klein from Dr. Littlefield indicated that their conclusions on the oral inspection section were essentially the same and that this section needed to be corrected. (See Attachments)

ADEX is supplying a copy of the completed 2007 Technical Reports for dentistry and dental hygiene for your independent review and analysis. ADEX will also provide the 2008 Technical Report when it is completed in early 2009. The 2008 Technical Report contains data for analysis obtained from NERB and Nevada's administration of the ADEX ADLEX examinations in dentistry. The data from the CRDTS' administration of the ADLEX is not included. CRDTS was unable to provide the data from the administration of their examinations requested by the psychometrician performing the analysis of the 2008 examinations. Lacking an operating scoring program, CRDTS was forced to "hand grade" portions of all candidates' examinations. Certainly the ADEX Technical Report had intended to include the data from CRDTS but this was not possible due to the unavailability of the required data. Therefore, the ADEX 2008 Technical Report is unable to evaluate the reliability and validity of the examinations administered by CRDTS for the 2008 academic year.

In its letter, CRDTS also stated that the Computer Simulated Clinical Examination (CSCE) utilized in the ADHLEX examination might be compromised. This statement was made without any psychometric analysis. ADEX has just completed a psychometric review of the results of the Dental Simulated Clinical Examination (DSCE) and CSCE and found that the validity of the results of the examinations remains excellent and unchanged for the last four years. (See Attachments)

In summary, ADEX encourages each state dental board that accepts the ADEX examinations for licensure to continue membership and involvement in the examination development. Every state that accepts the examinations has a stake in the process and is encouraged to participate. Each member state has equal representation and ADEX is committed to direct government by the member state dental boards. ADEX encourages states that are not members to review the technical reports on our examinations and to consider acceptance and membership. ADEX is committed to continuing dialogue with the dental testing agencies that are not participants and encourage them to consider participation. We welcome the opportunity to work with all state dental boards and administrative testing agencies. At our expense, ADEX will send a representative to any state dental board or testing agency wishing to discuss the ADEX process and examinations. It should be kept in mind that the CRDTS criticisms are political rather than substantive issues with the examination. ADEX will continue to focus on developing the most reliable and valid examinations as possible in dentistry and dental hygiene to fulfill our mission of public protection. Please don't hesitate to contact me if you have any further questions.

Attachments:
ADEX Letter to State Boards
ADEX 2007 Dental Examination Technical Report
ADEX 2007 Dental Hygiene Technical Report
ADHLEX Scoring Procedures – Littlefield and Klein Memo
Klein-Littlefield E-mail Correspondence
Memo to Hawaii Board
Has the Security of ADEX's Computer Administered Examinations Been Breached?
ADEX House of Representative Membership
ADEX Board of Directors Membership
ADEX Dental Examination Committee Membership
ADEX Dental Hygiene Examination Committee Membership

TECHNICAL REPORT: Class of 2007

AMERICAN DENTAL LICENSING EXAMINATIONS (ADLEX)

Approved by
THE AMERICAN BOARD OF DENTAL EXAMINERS, INC.
(ADEX)

Adopted and Administered by
THE NORTH EAST REGIONAL BOARD OF DENTAL EXAMINERS, INC.
(NERB)
and
THE CENTRAL REGIONAL DENTAL TESTING SERVICE, INC.
(CRDTS)

Prepared by Dr. Stephen P. Klein
January 3, 2008

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ACRONYMS

AADE	American Association of Dental Examiners
ADEX	American Board of Dental Examiners
ADLEX	American Dental Licensing Examination
BIACO	Buros Institute for Assessment Consultation and Outreach
CFE	Clinical Floor Examiner
CIF	Curriculum Integrated Format
CRDTS	Central Regional Dental Testing Service
CTP	Comprehensive Treatment Planning
DOR	Diagnosis, Oral Medicine, Radiology
DSCE	Dental Simulated Clinical Examination
NERB	North East Regional Board of Dental Examiners
PPMC	Prosthodontics with Periodontal and Medical Considerations
SRTA	Southern Regional Testing Agency
WREB	Western Regional Examining Board

ACKNOWLEDGEMENTS

Dr. Joseph Rossa of NERB and Ms. Lynn Ray and Ms. Kimber Cobb of CRDTS provided very helpful reviews of previous drafts of this report. Dr. Roger Bolus of the Research Solutions Group, Mr. Clint Durr of Sapient Data Systems, and Dr. Michael Harbison of MDB and Associates, Inc. provided data and analyses that were used in this report.

OVERVIEW

The ADLEX series of examinations provides a final check that the candidates applying for state licensure as dentists can practice safely and effectively on their own; i.e., without supervision from dental school instructors or other practitioners. In short, the goal of these exams is to protect the public by identifying candidates who have not yet achieved sufficient competence and proficiency to practice independently.

The ADLEX series consists of five separately scored tests that are administered at various times during the school year as well as in the traditional post-graduation format. As a set, these tests sample the knowledge, skills, abilities, and judgments (KSAJs) that an occupational analysis found to be important and essential for beginning practitioners. For this purpose, "importance" is defined as the KSAJs that are used frequently in practice and/or are critical to a patient's oral or overall health. Thus, the five tests comprise a comprehensive sample of important tasks that recently licensed dentists should be able to perform competently. The occupational analysis that served to establish the content validity of the ADLEX tests involved a national sample of practicing dentists.

Most candidates take the five tests during their fourth-year of dental school. Candidates must pass all five tests within an academic year in order to pass the ADLEX series. A high score on one test cannot offset a low score on another. In the Curriculum Integrated Format (CIF), each test is administered at least twice during the school year so that candidates may remediate and retake a test failed previously and if successful on the retake, pass the ADLEX series before graduation.

One test is administered on a computer, two use simulated patients (manikins), and two use actual patients. The five tests, their formats, and the number of times a candidate may take a test during the academic school year are shown below.

The ADLEX Curriculum Integrated Examination Series

Test Name	Format	Frequency
DSCE	Computer	3 times/year
Endodontics	Manikin	3 times/year
Fixed Prosthodontics	Manikin	3 times/year
Periodontics	Patient	2 times/year
Restorative Dentistry	Patient	2 times/year

Two organizations, the CRDTS and NERB, administer and score the ADLEX series. The DSCE is administered at Prometric testing centers across the country. The other four tests are administered at dental schools.

Candidates generally sign up for the ADLEX series with the agency that administers the examinations at their school or with the agency that is most closely affiliated with the state(s) in which they plan to practice. Candidates who successfully complete the ADLEX receive ADEX, CRDTS and NERB credentials ("status"), thus qualifying them as having completed the clinical licensure examination requirement of states accepting the results of the ADEX, CRDTS and/or NERB clinical examinations in dentistry. All the states that accept a passing status on the ADLEX (the ADEX, CRDTS and NERB clinical examinations in dentistry) do so regardless of whether it was earned on exams administered and scored by CRDTS or NERB. There also are several states that accept a passing status on the ADLEX (the ADEX, CRDTS and NERB clinical examinations in dentistry) even though this examination series is not administered in their jurisdiction.

Responses to the 280 DSCE questions are machine scored. The quality of a candidate's work on the other four tests is graded in accordance with detailed analytic scoring guides and specific scoring criteria for each component of each task. Each test component is graded independently by three examiners. If two or more examiners agree on the score that should be assigned to an exam component, then that is the score assigned. Otherwise the candidate receives the median of the three examiners' scores on that component.

Grading is done independently and anonymously; i.e., an examiner does not have access to the scores assigned by the other examiners and the examiners do not have any knowledge of or interaction with the candidates whose work they evaluate. Thus, they do not know a candidate's race, gender, or age. All the examiners are practicing dentists.

Candidates must earn at least 75% of the maximum possible raw score on a test to pass it. However, on the four performance tests, the scoring system imposes a heavy penalty on candidates who commit critical errors. Relatively few candidates come close to passing but fail or come close to failing but pass. By how much a candidate passes or fails is irrelevant because the purpose of the exam is to distinguish between those who are versus are not ready to practice competently on their own. Dental schools receive feedback regarding the performance of their graduates on the different sections of each test.

Passing rates for first timers range from about 82% on the Restorative Dentistry test to over 95% on the Fixed Prosthodontics test. About 70% of the candidates pass all five tests on their first try and 94% of those pursuing all opportunities provided pass all five tests within the academic year limit; i.e., after as many as three attempts with intervening remediation on some tests.

Whether a candidate passes or fails one test is unrelated to that candidate's pass/fail status on any of the other tests. This finding supports the policy of requiring applicants to pass all five tests in order to pass overall. It also is consistent with the practice of using enough different types of tests to allow for adequate sampling of all of the KSAJs that were deemed important by the occupational analysis.

CHAPTER 1 - BACKGROUND AND PURPOSE

State Dental Boards have as their mission the protection of the health, safety and welfare of the public by assuring that only competent and qualified individuals are allowed to practice dentistry and dental hygiene in their jurisdiction. To that end, candidates seeking to be licensed to practice dentistry in a state must pass one or more clinical examinations. These examinations are constructed and administered by individual state boards of dentistry and by regional testing agencies. The goal of these examinations is to help protect the public by providing an independent third party assessment of whether candidates are able to practice competently on their own; i.e. without the oversight or supervision of dental faculty or licensed practitioners.

Clinical competence depends on the candidate's ability to use clinical data and evidence to diagnose and develop treatment plans as well as the manual dexterity, knowledge, clinical ability, and judgment to perform dental operations. In that sense, the tests are "job samples" of the kinds of tasks candidates perform in practice. The only examination outcome that matters is whether a candidate passes or fails. By how much a candidate passes or fails is irrelevant because scores are used solely to determine pass/fail status.

Empirical analyses of examination data have found that a candidate's ability to perform one type of task, such as the identification and removal of mineralized deposits (calculus) on teeth, is usually unrelated to that candidate's ability to perform other important tasks, such as the identification and removal of decay (caries). Consequently, to become licensed, candidates must pass all the tests. They cannot use a high score on one test to offset a low score on another. Since the combination of all the tasks tested is designed to be a representative sample of the kinds of important tasks candidates are likely to have to perform in practice, the decision to include or exclude a task from the examination process is based on the frequency with which it is performed in practice and/or its importance to the patient's overall and dental health. Decisions about which tasks to test are not based on whether they are easy or difficult to perform.

Organizational History and Structure

This section describes the organizations that are involved in the dental licensure examination process and their respective responsibilities and roles.

The American Association of Dental Examiners, Inc. (AADE)

The American Association of Dental Examiners, Inc. (AADE) is a not-for-profit organization that provides a national forum for state boards of dental examiners. In January 2004, the AADE created a committee composed of subject matter experts of the four regional testing agencies (CRDTS, NERB, SRTA and WREB), as well as independent testing agencies including the states of California and Florida, to collaborate on common criteria for components of a clinical dental examination for licensure.

In June 2004, as the AADE Criteria Committee was continuing its work on common criteria for dental licensure examinations, a meeting was held with representatives of all of the regional and most of the independent clinical testing agencies, including the state boards of California and Florida. All members of the examining community, either through the regional organizations or independent states, agreed to proceed with developing a common, uniform clinical examination that would provide dental and dental hygiene candidates with national mobility (i.e., portability of licensure across jurisdictions).

The American Board of Dental Examiners, Inc. (ADEX)

The American Board of Dental Examiners, Inc. (ADEX) was incorporated in Kansas in 2005 and is a private not-for-profit 501.c.3 organization. The mission of the ADEX is to provide the dental examination community with test construction and administrative standardization for national uniform dental and dental hygiene clinical licensure tests.

The ADEX is a membership corporation, the voting members of which include the State Boards of Dental Examiners of the participating states throughout the United States and its territories that are responsible for the qualification and licensure of dentists and dental hygienists. ADEX is governed by a Board of Directors and House of Representatives. The ADEX functions as a national examination committee. It was organized through the cooperation of existing testing agencies, including the Central Regional Dental Testing Service (CRDTS) and the North East Regional Board of Dental Examiners (NERB).

The ADEX developed the American Dental Licensing Examinations (ADLEX). This examination series was designed to (a) enhance the quality of the clinical examination process and (b) make that process uniform across agencies and states in order to facilitate the portability of licenses across jurisdictions. The ADLEX consists of five tests that were developed in collaboration with existing dental testing agencies, including the CRDTS and NERB. These five tests are uniformly administered by individual state and regional testing agencies on behalf of their dental licensing boards. An applicant's pass/fail status on an ADLEX test is independent of whether the CRDTS or NERB administered it.

The North East Regional Board of Dental Examiners, Inc. (NERB)

The North East Regional Board of Dental Examiners (NERB) participated in developing the ADLEX series and it administers it in several states. The NERB was incorporated in 1969 as a non-profit corporation organized under the laws of the District of Columbia. The NERB is a consortium of 16 state dental boards that collaborated in the development and administration of clinical examinations for use in the licensing or credentialing of dentists, dental specialists, dental hygienists, and other dental paraprofessionals. The NERB adopted the ADLEX series as the NERB dental examination in 2005.

The member jurisdictions of the NERB are Connecticut, District of Columbia, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont and West Virginia.

The Central Regional Dental Testing Service, Inc. (CRDTS)

The Central Regional Dental Testing Service, Inc. (CRDTS) also participated in developing the ADLEX series and administers it in several states. CRDTS was incorporated in Kansas in the early 1970's and is a testing service made up of 15 state boards of dentistry that collaborated in the development of examinations of competency to practice dentistry and dental hygiene in their respective jurisdictions. CRDTS also established a system for the administration and conduct of uniform dental and dental hygiene examinations for its participating member states. The CRDTS adopted the ADLEX in 2005. The members of CRDTS are the state boards of Colorado, Georgia, Hawaii, Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Washington, Wisconsin, and Wyoming.

Eight states in addition to the ones noted above also accept ADLEX results when the tests are administered by the CRDTS or NERB. These states are Kentucky, Louisiana, Montana, New Mexico, Oregon, Texas, Utah and Virginia. Starting in the fall of 2007, Nevada will be administering the ADLEX and accepting ADLEX results from the CRDTS' and NERB administered examination series.

In addition to the jurisdictions named above, Arizona accepts the results of the ADLEX (whether administered by CRDTS or NERB) on a year-to-year basis upon request by a candidate for licensure and review by the dental board. Thus, all told, nearly 40 states and the District of Columbia accept ADLEX results. In short, the development of ADEX has contributed to making a uniform, national clinical examination for dentistry a reality.

American Dental Licensing Examination (ADLEX)

The American Dental Licensing Examination (ADLEX) is a test battery used by regional associations and states. Passing this battery is not sufficient by itself for licensure. Other state requirements must be met. Candidates must therefore contact the state boards of dentistry where they are applying for licensure to learn about state-specific requirements.

By October 2004, the five dental examinations comprising the ADLEX test battery and proposed by the participating agencies were agreed to unanimously by all of the regional testing agencies and by almost all the independent state testing agencies.

In January 2005, a scoring rubric was created and adopted for use with the ADLEX series starting in August 2005. This rubric was developed with advice from two independent measurement specialists, Chad Buckendahl, PhD., affiliated with the Buros Institute for Assessment Consultation and Outreach (BIACO), A Division of the Oscar and Luella

Buros Center for Testing, University of Nebraska - Lincoln and Stephen Klein, PhD., who at the time was affiliated with the RAND Corporation and GANSK & Associates.

In March 2005, the ADEX Board of Directors and House of Representatives reiterated its approval of the content, criteria and scoring for all five examinations comprising the ADLEX series. ADLEX, the first uniform, national clinical licensure examination in dentistry, was administered for the first time in August 2005 for the dental school classes that graduated in the spring of 2006.

Pages 11-42 of this document
and
The entire ADEX 2007 Hygiene Techical Report of 34 pages are not included

4/25/08

ADHLEX Scoring Procedures

This memo discusses four concerns regarding the ADHLEX's scoring procedures and the views of Drs. Stephen Klein and John Littlefield regarding these concerns.

A. Oral Evaluation. A valid test of a candidate's ability to recognize whether a patient has oral conditions that are not within normal limits requires that candidates be shown patients (or pictures of patients) who do and do not have these conditions and then be asked to identify which of these patients do and do not have the conditions. The ADHLEX Oral Evaluation does not do this in a systematic or comprehensive manner; therefore, we recommend the following:

1. Eliminate the oral section from the ADHLEX and include on the CSCE items that require candidates to identify whether a patient has or does not have the various types of oral conditions of interest.

2. Instruct candidates to make a brief note in their patient's health history if that patient has an oral condition that should be brought to a dentist's or physician's attention.

3. Penalize or dismiss candidates from the test session if they do not document that their patient has a condition that should be brought to the dentist's attention because this would be considered a critical error.

4. Examine the correspondence in scores, pass/fail decisions, item types, test specifications, and psychometric characteristics between the CSCE and the National Board of Dental Hygiene Examination to assess whether these exams are redundant.

B. Periodontal Measurements. Examiners are currently asked whether they agree or disagree with the candidate's measurement of pocket depth. That practice may introduce noise into the assessment because some but not all examiners may tend to give candidates the benefit of the doubt. There also are concerns about the actual degree of agreement between examiners in their measurements of gingival sulcus depth. Specifically, it would not be fair to hold candidates to a higher standard of precision than now exists among the examiners themselves. Given this situation, we recommend conducting a study in which examiners make their own measurements (i.e., without seeing the candidate's or the other examiners' measurements). If the level of agreement among the examiners in this study is not high, then an alternative examination procedure and scoring algorithm should be considered.

C. Treatment Selection Procedures. There is a concern about the level of inter-examiner agreement in their assessment of whether patients satisfy treatment selection (i.e., case acceptance) requirements. Specifically, should there be a second or third examiner involved in making this decision since it so critical in determining a candidate's pass/fail status? Currently a second examiner is used only if the first examiner does not agree with the candidate's treatment selection, however, if there is a second examiner, then it is apparent that some disagreement is present and this might affect the final judgment.

Given these considerations, we recommend conducting study of this issue with data from the NERB hygiene exam and/or the ADLEX Periodontal exam because these exams already have three independent examiners making case acceptance decisions. However, we recognize that the decision to have multiple examiners for case acceptance is more than just a statistical issue because having two or three examiners for every candidate has cost and logistical implications. Nevertheless, it serves as an automatic appeal process.

D. Surface Selection for Scaling. Candidates currently submit a treatment selection plan that satisfies certain criteria. For example, "at least 14 surfaces of qualifying subgingival calculus must be selected on a minimum of six teeth" and "at least 9 of the 14 qualifying surfaces must be on posterior teeth with at least 3 of those located on permanent molars." We endorse the use of such requirements because they help to standardize case severity.

We also agree that a candidate should lose points (i.e., have a lower total exam score) for nominating a surface to treat if that surface does not meet the criteria for calculus removal. Where we differ is on what happens next. Dr. Littlefield prefers having an examiner select the surfaces for the calculus removal portion of the exam whereas Dr. Klein prefers requiring that candidates clean all the surfaces they selected for treatment, but only receive credit for the ones that were accepted for cleaning and were cleaned adequately.

Dr. Littlefield's rationale for permitting substitution is that it contributes to standardization by requiring that all candidates have the same number of surfaces evaluated for the calculus removal portion of the exam.

Dr. Klein contends the scoring system should reflect that calculus detection and calculus removal are not independent skills. Instead, they are inextricably connected because successful removal of calculus requires that candidates be able to recognize when a surface is or is not free of calculus. Dr. Klein also is concerned about the challenge candidates could make if examiners select the surfaces to be cleaned and he notes that the standardization argument is undermined when some candidate nominated surfaces are not approved for treatment and there are not enough replacement surfaces available (or of comparable difficulty to clean) to use as substitutes.

MEMORANDUM

TO: Dr. Jeffrey Miyazawa, Chair, Hawaii State Board of Dental Examiners

FROM: Dr. Stephen Klein, Psychometric Consultant to ADEX
Dr. Chad Buckendahl, Psychometric Consultant to SRTA

SUBJ: Professional Opinion Regarding Hawaii's Dental Examinations

DATE: December 17, 2008

The following questions were discussed during the Board's December 12, 2008 meeting.

- Is the oral health evaluation portion of the CRDTS dental hygiene examination a valid and reliable measure of a candidate's ability to detect and identify potentially serious oral health conditions?

- Is there any evidence of a breach in the security of the Computer Simulated Clinical Examination (CSCE) or the Dental Skills Examination (DSE), which was formerly referred to as the Dental Simulated Clinical Examination (DSCE)?

- Should Hawaii accept a passing status from any testing agency?

Our answer to these questions is NO, but some Board members seem to think otherwise. Our professional opinions are based on generally accepted measurement principles and the following specific considerations: (a) the oral health portion of the CRDTS hygiene exam is not a valid or reliable measure of what it purports to measure (as documented in reports that have already been released to the public), (b) CRDTS' own psychometric expert, Dr. John Littlefield, agrees that the oral health section does not measure what it claims to measure (see Drs. Klein and Littlefield joint report and their discoverable email exchanges), and (c) there is no empirical evidence to suggest that any alleged breach in the CSCE's or DSE's security affected scores or pass/fail decisions.

To assist the Board in making a decision about which test to use, the remainder of this memo summarizes the evidence we considered in forming our opinions. The last portion of this memo describes some of the documents we relied on in forming these opinions, all of which are attached to this memo.

ORAL HEALTH SECTION'S VALIDITY

The oral health section of the CRDTS hygiene examination is intended to assess a candidate's ability to recognize and identify various types of potentially serious oral health conditions. A national occupational analysis found that it was important to test these abilities and to do so, a candidate must examine patients who do and do not have these conditions (or see pictures of patients with these conditions), and identify which patients have which conditions.

The CRDTS oral health section does not do this because a candidate only examines the patient that the candidate brought to the test center and almost none of these patients have any of the conditions that candidates need to detect. Hence, this section is not a valid measure of the important skills it purports to assess. CRDTS' own psychometric expert, Dr. John Littlefield, agrees with this conclusion. See Klein and Littlefield email exchange and joint statement.

The dental hygiene examination (approved by the ADEX Board of Directors in October 2008) does not have a separate oral health section. Instead, it asks the candidate to note in their patient's oral health history if that patient has any potentially serious oral health conditions. Candidates fail the ADEX exam if they neglect to document potentially serious conditions in their patient's history. Questions also have been added to the CSCE to test a candidate's ability to recognize and identify many types of potentially serious oral health conditions.

Documenting a patient's health history in the ADEX exam would not, by itself, be sufficient. However, the inclusion of oral health questions in the CSCE portion provides the necessary supplemental information. Specifically, it serves as better representation of the critical domain of patient assessment beyond what can be determined by a candidate's assessment of a single patient that has been specifically selected for a different exam purpose (namely calculus detection and removal.

ORAL HEALTH SECTION'S RELIBILITY AND WEIGHT

On licensing exams, "reliability" refers to how much chance affects a candidate's pass/fail status—the greater the effect of chance, the lower the reliability. Weight refers to how much influence a section carries in determining a candidate's pass/fail status.

Empirical data show the oral health section is one of the least reliable portions of the CRDTS hygiene exam; i.e., the scores on it are highly susceptible to chance. This is a serious concern because this section is the second most important factor (after calculus detection and removal) in determining a candidate's pass/fail status on this exam. In fact, this section carries more than three times as much weight as does the pocket depth, supragingival plaque/stain removal, and soft tissue management sections combined. These findings undermine the

interpretation of the test scores and thereby the validity of the exam. This is documented in the Technical Report on the CRDTS dental hygiene examination.[1]

SECURITY BREACH

There is no empirical evidence to support the allegation of a breach on either the CSCE or the DSE. The percent passing these tests has been nearly constant over the past five years. The slight variation that has occurred has not been consistently up or down. Specifically, the annual first timer passing rates on the CSCE in 2004 through 2008 were 94, 94, 98, 93, and 94 percent, respectively. The corresponding rates on the DSE were 94, 96, 93, 96, and 94. In addition, contrary to the breach allegation, the "p-values" of repeated items (i.e., the percentage of candidates answering an item correctly that was used more than once) have remained flat. There also is no consistent decrease in item discrimination or test reliability as would occur if a breach affected scores.

Test preparation materials that can be purchased over the web include study guides and sample items that are similar to those that are already provided to all candidates who sign up to take the tests. Staff did not find any fully operational test questions. As Dr. Peter Yaman noted at the meeting, it is easy to allege a breach (or an entrepreneur to claim to have a copy of the test), but it is quite another to steal or recreate a true copy.

Finally, the high passing rate on the computer based tests (all over 90%) should not be construed as evidence of a breach because these rates are consistent with those that are routinely found on the hands-on performance test sections of various dental and dental hygiene examinations, including those administered by several testing agencies. See technical reports for documentation.

DIFFERENCES BETWEEN TESTS

All tests are not created or scored equally. The examination developed and administered by one agency may be more difficult than those developed and administered by other agencies. This occurs even when different tests use the same passing score (such as a "75") because it may be more difficult to achieve that score on one test than it is on another test. This difference in difficulty may only be evident from a careful inspection of the specific criteria examiners use in determining whether a candidate's work is "adequate" or "satisfactory."

[1] Inter-examiner consistency affects but is not the sole determiner of score reliability and the number of points assigned to a section does not determine its weight.

For example, one agency awards a 75 to a candidate who appropriately removes calculus from 50% (4 of 8) surfaces while another agency awards a 75 for appropriately cleaning 6 of 8 surfaces (which is an actual 75%). Clearly, one test sets a higher standard for what constitutes adequate performance than the other.

Another example is the agency that awards a 75 to a candidate with an endodontic overfill that is 3 mm while another agency awards a 75 for an endodontic overfill that is 1 mm. In short, the degree of competency required to earn a 75 varies substantially across agencies. There also may be significant differences among agencies in how they *apply* similar standards.

A licensing board that accepts a passing status from two or more testing agencies may lead applicants (and possibly dental schools) to pick the easiest test to pass, which is not something a licensing board would want to encourage given its fiduciary responsibility to protect the public. In addition, different tests assess somewhat different skills, and thus, their scores are not interchangeable. For example, as discussed above, the dental hygiene examination administered by CRDTS is not nearly as valid or reliable as the exam currently approved by ADEX. Thus, to fulfill its mission of protecting the public, the Board should select the test that best conforms to the Board's specifications and recognized testing standards. That is where its professional judgment (and the advice of qualified measurement experts) comes into play.

DOCUMENTATION

The following materials were used in forming our opinions:

- Technical reports for the examinations administered to candidates seeking licensure as dentists. These reports document the reliability and validity of the pass/fail decisions that are based on these tests as well as first-timer and repeater passing rates, and inter-examiner agreement rates. Reports are available for the exams administered by CRDTS and NERB to the class of 2007 and for the exams administered by NERB and Nevada to the class of 2008. CRDTS did not provide 2008 data because it was unable to convert its examiners' evaluations to machine readable files.

- Technical report for the CRDTS examination for the class of 2007 candidates seeking licensure as dental hygienists. This report discusses and provides the documentation for concerns about the validity and reliability of this test, such as the excessive weight given to the oral health evaluation section.

- Specifications for the ADEX approved test for the class of 2009 candidates seeking licensure as dental hygienists.

- Statement endorsed by Drs. Klein and Littlefield detailing the shortcomings of the oral health portion of the CRDTS dental hygiene examination and e-mails between them regarding this and other problems with this examination.

- Dr. Klein's white paper that discusses his analysis of a possible breach in the security of the CSCE and DSE.

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January 19, 2009

RECEIVED
JAN 23 2009
VA Bd. of Dentistry

MS SANDRA K REEN
EXECUTIVE DIRECTOR
VIRGINIA BOARD OF DENTISTRY
9960 MAYLAND DRIVE SUITE 300
RICHMOND VA 23233-1463

RE: CRDTS withdrawal from ADEX

Dear MS SANDRA K REEN,

Recently, there has been a barrage of communications from both ADEX and CRDTS with regard to the withdrawal of CRDTS from ADEX. It is my intention to clarify my previous letter, and to respond to the letter sent by Dr. Houfek December 19, 2008.

I have characterized ADEX as becoming a de facto joint venture between CRDTS and NERB, and that is the view that CRDTS maintains. ADEX was established to serve as a collaborative entity with member states working together to create a national uniform dental credentialing test. It was to this end that procedural safeguards were instituted to limit the influence of any single state or testing agency in the decision making process. However, CRDTS members cannot ignore the fact that votes and decisions on substantive issues have been decided on regional lines. These regional lines tend to follow individual states' membership in NERB or CRDTS. While this is not inherently evil, it has prevented CRDTS member states from being adequately represented in decisions on examination content and procedure.

The current composition of the ADEX Board is instructive. Though individuals are to be elected by districts composed of states, the results of that process show that the composition of the ADEX Board is heavily dominated by able, knowledgeable, people who have long experience in dental testing and who are closely identified with either CRDTS or NERB.

Bruce Barrette, DDS - Past President Elect and President of CRDTS
Gayle Chang, RDH, BEd - Member CRDTS Dental Hygiene ERC
Peter DeSciscio, DMD -NJ NERB examiner
Marv Dvorak, DDS - Past President of CRDTS
Ms. Judith Ficks - WI Lay Member (CRDTS State)
Scott Houfek, DDS - Past Chair CRDTS ERC
Stan Kanna, DDS - Member CRDTS Steering Committe
Kim Laudenslager, RDH, MPA - Past Vice President of CRDTS
Frank Maggio, DDS - Member NERB Steering Committee
David Narramore, DMD - President of SRTA
Robert Ray, DMD - D.C. NERB Examiner
Joseph Rossa, DDS - Chief of Staff and General Counsel of NERB
Guy Shampaine, DDS - Vice Chairman NERB

Mr. Zeno St. Cyr, II - MD Board (NERB State), Consumer
Cathy Turbyne, EdD, MS, RDH - Member NERB Dental Hygiene ERC
Peter Yaman, DDS - Chair ERC NERB; Chair ADEX ERC
Ross Wyman, DDS - Past Chairman of NERB
-- Non voting
Ms. Molly Nadler - Executive Director of AADE
Vince Jones, DDS - Past President of CRDTS

It is true that many decisions of the ADEX Board were made by unanimous consent and that votes of individual members were not often documented; however, on those divided votes, for those who were there the divisions were evident and the blocks clear. Unfortunately, you had to be there to understand it.

There is, however, a clear example in the October 16, 2008 meeting in which the ADEX Board voted on clearly defined regional lines to abandon use of the ADEX Dental Hygiene Examination and to adopt what is essentially the NERB Dental Hygiene Examination instead. The vote on that question was recorded and a copy of those Minutes is attached.

The reality is that essentially all of the testing agencies came together to form ADEX in an attempt to create a true national examination. As of June 30, 2009, it appears that only NERB and one individual state, Nevada, will continue to administer the ADEX examination.

The vision of jointly developed examinations in dentistry and dental hygiene developed within ADEX and administered by all the regional organizations and independent states never came to fruition. A widely accepted dental examination was developed by ADEX and administered by CRDTS and NERB, but NERB refused to participate in using the dental hygiene examination adopted by ADEX until the October 2008 meeting, at which the NERB examination was adopted by ADEX and the prior ADEX dental hygiene examination abandoned.

Dr. Houfek suggests that CRDTS is interested in continuing ADEX with a restructured governance structure. CRDTS is not interested in restructuring ADEX. CRDTS is instead reaching out to other testing organizations and states and is scheduling meetings with the view to beginning again to develop high quality national examinations in dentistry and dental hygiene.

CRDTS welcomes all those state boards of dentistry who may be interested in participating in this process. Its recent withdrawal from ADEX may be seen as its own declaration of independence, though CRDTS did not choose to outline all of the "abuses and usurpations" which have been endured in this process.

Dr. Houfek did go into some detail with respect to the issues underlying the dental hygiene examination. We appreciate that many are confused about the statements, allegations, and opinions referenced in the eleven documents attached to his letter dated December 19, 2008. For those concerned with these issues, I am attaching five documents to this letter that may clarify the position of CRDTS and demonstrate the goodwill and effort that we have previously committed to ADEX and the examination processes:

1. Document "A": This document is a detailed summary of the history of the Dental Hygiene Examination compiled from reports and documents submitted from a number of CRDTS dental hygienists who have participated in examination development, its administration and many ADEX/NERB meetings.

2. Document "B": The technical report of the current CRDTS dental Hygiene Examination, authored by Dr. John Littlefield and Dr. Juanita Wallace. Please pay particular attention to the discussion of the CSCE exam and their opinion of the oral inspection.

3. Document "C": The October Hygiene Minority Report, which was neither accepted by the ADEX Hygiene Committee nor attached to the ADEX Hygiene Committee report as presented to the ADEX Board of Directors.

4. Document "D": Recommendations made by CRDTS representatives concerning the NERB November 9, 2008 meeting in Silver Springs, Maryland. Subsequently, none of these recommendations were adopted or implemented by NERB or ADEX to our knowledge.

5. Document "E": The DSCE review report.

6. Document "F": Legal opinion of Goodell, Stratton, Edmonds and Palmer, LLP, dated October 13, 2008, on the defensibility of the Dental Hygiene Examination.

CRDTS invites and encourages those State Boards with additional questions or concerns to respond either to the undersigned at 803-754-9160 or to the CRDTS office at 785-273-0380 with questions or comments. We invite and encourage participation with us as we move forward in the development and administration of licensure examinations in dentistry and dental hygiene.

Very truly yours,

John C. Cosby, Jr., DMD, President

Encl.
A172875

FACTS AND INCIDENTS RELATED TO THE CRDTS/ADEX EXAMINATION

- The Oral Evaluation of the Dental Hygiene Examination has a long history that goes back many years prior to Dr. Stephen Klein's recent and limited critique. Its inclusion in a prototype clinical dental hygiene examination was initially recommended by a national Task Force of dentists and dental hygienists participating in the ADHA Clinical Evaluation Study which was funded by the federal government. Over 20 field tests were conducted from coast to coast during that study, and John Eisner, DDS, PhD, served as the Evaluation Specialist. CRDTS adopted the prototype exam in 1978 and the Oral Evaluation has remained part of CRDTS' clinical dental hygiene examination to this day.
- The content of the original ADEX Dental Hygiene Examination was developed from June, 2004, through 2005 by a committee with national representation: WREB, CRDTS, NERB, CITA, SRTA, Hawaii and Florida. The committee reviewed the content of all the examinations of the participating agencies and developed the ADEX content through a process of consensus. The resulting examination was not identical to ***any one*** of the examinations of the participating agencies; neither was it a significant departure from any of the existing examinations; it incorporated the best aspects of each examination.
- Both CRDTS and NERB conducted field tests of the ADEX examination in early 2006. The content, criteria and scoring were reviewed by two independent measurement specialists. The proposed examination was adopted unanimously by the ADEX Board of Directors and the ADEX House of Representatives and was first administered in 2006 by CRDTS.
- NERB refused to administer the examination in 2006, saying that "they did not have sufficient time to prepare" for the new examination, despite the fact that NERB had two representatives on the ADEX Dental Hygiene Committee while all other agencies had one. NERB's representatives professed to be as surprised and dismayed by NERB's decision as everyone else. NERB offered assurances that they would make their "best effort" to be prepared to administer it in 2007.
- In 2007, despite specific protocols outlined in the ADEX by-laws regarding elections for Committee Chair persons, Dr. Houfek announced to the Dental Hygiene Examination Committee prior to their meeting that a representative from NERB would be the Committee's new chairperson. This individual had not been involved in the dental hygiene examination development from the beginning, nor was NERB administering the examination at that time. Therefore, this individual was not an "examiner for the Corporation" as stipulated in the by-laws. Despite his earlier announcement, Dr. Houfek proceeded with an election with the ADEX BOD and the current Chair was elected according to the by-laws. However after the election was held, this new Chair was pressured by Dr. Houfek and others to resign immediately to reverse the election results in order to insert the NERB representative as the Dental Hygiene Committee Chairperson.
- In 2007, NERB reported that they could not administer the exam due to "logistical reasons", i.e., increased number of examiners, numerous small clinics in their schools that could not accommodate an adequate examiner station, etc. Nevertheless, NERB managed to overcome those logistical problems in time to unilaterally decide to start administering the ADEX Periodontal Examination as the NERB Dental Hygiene Examination.

- At some time in 2006, NERB apparently retained Dr. Stephen Klein to conduct various psychometric evaluations, including the cross-match between the ADEX Dental Examination and the occupational analysis. ADEX never conducted a national search for a measurement specialist, nor was a motion ever presented to accept Dr. Klein in that capacity. Dr. Klein has been moved into that position by default and continues to dictate decisions normally afforded to content experts.
- In August 2007, Dr. Klein came to an ADEX Dental Hygiene Committee meeting to make a presentation on examination principles. In the midst of that presentation, he raised two concerns about the ADEX Dental Hygiene Examination ***before*** an analysis of that examination had even been done. Those concerns were the Oral Evaluation and the treatment selection process. Ironically, these are the same concerns that Dr. Rossa had been raising to certain parties in ADEX once time and logistical concerns were no longer relevant excuses for NERB's refusal to administer the exam. Once again, NERB refused to administer the ADEX Dental Hygiene Examination in 2008, even though the examination was again approved by the ADEX House of Representatives in June 2007. A great deal of time and energy was spent in an effort to educate Dr. Klein about the development and documentation for the original ADEX Dental Hygiene Examination.
- Throughout 2007, Dr. Rossa withheld the ADEX Dental Hygiene Occupational Analysis from the Dental Hygiene Examination Committee. He apparently also withheld it from Dr. Klein, the measurement specialist he had retained to conduct the cross-match between the occupational analysis and the examination, because in January, 2008, Dr. Klein suggested to CRDTS that a dental hygiene occupational analysis be done. When Dr. Klein was apprised of the fact that the analysis had already been done, a meeting was scheduled in late March, 2008, to do the cross-match in order to document validity. Incredibly, the Occupational Analysis was withheld even from the Committee assigned to do the cross-match so as not to "bias" the group. In the appendix of the 2007 ADEX Dental Hygiene Technical Report, data from the dental hygiene occupational analysis is reported. It is relevant to note that the ***Oral Evaluation is rated as highly important to life criticality*** second in importance only to infection control.
- In December, 2007, CRDTS retained John Littlefield, PhD, from the University of Texas Health Science Center at San Antonio, to review and critique the ADEX Dental Hygiene Examination. In his position working with both the Medical and Dental Schools at UTHSCSA, Dr. Littlefield is far more familiar with clinical evaluation than most measurement specialists. In conducting the critique, Dr. Littlefield collaborated with Juanita Wallace, RDH, PhD, Director of the Dental Hygiene Program at UTHSCSA. In their report Drs. Littlefield and Wallace opinion about the Oral Evaluation was quite different from Dr. Klein's:

  "The *Oral Evaluation* includes a defined Extra-oral and Intra-oral assessment. Because patients present with a variety of findings, this portion of the exam is designed to demonstrate a candidate's ability to discriminate between normal and abnormal structures and to use critical thinking skills to determine significant findings. Candidates are expected to assess their patient's head and neck and oral cavity for unusual or abnormal hard and soft tissue findings and document them on the ADHLEX prescribed form. Candidates are instructed to write a one-line comment describing the finding and its location or designate that it is *Within Normal Limits (WNL)*. Oral assessment is an essential skill that Dental Hygienists provide in private practice. This preliminary screening provides the dentist/employer with information that can be further evaluated and/or diagnosed as appropriate. Consequently, a candidate that overlooks a significant extra- or intra-oral finding compromises good clinical care. We believe that this portion of the exam is an important skill demonstration and support continued inclusion."
- Regarding the computer-based CSCE, Drs. Littlefield and Wallace recommended that a study be done comparing the CSCE and the NBDHE for redundancy. They stated:

"In reviewing the exam content outline in the 2007 ADHLEX Candidates' Manual, there seems to be considerable overlap with the exam content and purpose of the NBDHE. ...We recommend a formal comparison of CSCE content with the NBDHE. ... Since candidates must pass the NBDHE as one of the prerequisites for licensure, we believe the resources currently used to create the CSCE would be better spent on the Patient-based Exam. Therefore, we recommend considering a satisfactory score on the NBDHE as certification of theoretical and cognitive preparation to practice Dental Hygiene."

- Dr. Klein has never observed an ADEX Dental Hygiene Examination and has persisted in misinterpreting the purpose of the Oral Evaluation in the clinical exam, despite having been informed repeatedly that it is NOT limited to screening for oral cancer. As stated in the 2009 CRDTS' Dental Hygiene Candidate's Manual the purpose is:

  "... to evaluate the level of a candidate's competency in performing an extra/intraoral examination as part of gathering and documenting baseline data about the patient's oral health status. The candidate is expected to assess and document conditions as being within normal limits, or deviations that are either atypical or abnormal. Atypical or abnormal findings, whether pathological or non-pathologic, must be identified by location and briefly described as part of the patient's record, as specified in the criteria. This documentation aids the dentist and hygienist in promoting patient health by identifying possible subclinical disease processes, oral habits, conditions that may bear watching over time or require special home care instructions, assisting with dental forensics and in the case of cancer or precancerous lesions, possibly preventing premature death."

- In April, Drs. Klein and Littlefield were asked to consult via telephone and come to some agreement on their disparate opinions regarding the Oral Evaluation. In recent correspondence, Dr. Littlefield's opinions have been selectively quoted out of context, and it is significant to note that Dr. Klein wrote the joint report. In the spirit of compromise, Dr. Littlefield agreed to a recommendation that the Oral Evaluation be moved to the CSCE. But both Dr. Klein and Dr. Littlefield also agreed that the CSCE and the NBDHE should be compared for redundancy, and if the contents are as similar as they appear to be in examination manuals, the CSCE should be eliminated. CRDTS' examiners and content experts have concerns that a multiple choice exam cannot adequately assess the clinical skills of uncued observation, palpation and documentation that are essential to the Oral Evaluation. Multiple choice items are cued and limit one to testing only certain aspects of the Oral Evaluation such as oral pathology and head/neck anatomy, subjects that are already well-covered in both the CSCE and the NBDHE.

- The Chairperson of the ADEX Dental Hygiene Committee was directed to find a resolution to the concerns raised by Dr. Klein or the hygiene examination would be decertified by the end of 2007. When the Chairperson attempted to schedule meetings in order to address these issues, she was informed that there were insufficient funds to support a meeting or conference call. She was also instructed to involve any necessary content experts or psychometric consultants to accomplish an acceptable resolution. In the fall of 2007 CRDTS' Director of Analysis was asked by two members of the ADEX Executive Committee to serve as a consultant to the Dental Hygiene Committee and she was officially appointed early in 2008. Subsequently, Dr. Houfek issued a memo indicating that consultants to either the Dental Hygiene or Dental Examination Committees were no longer allowed. This action was taken despite the formal protests of the Dental Hygiene Committee Chairman and the fact that the ADEX Bylaws state that "The Dental Hygiene Examination Committee may secure the assistance of such consultants in dental hygiene as the committee or its Chairman may deem necessary from time to time." Ultimately, the only consultant allowed a voice within ADEX or the Dental Hygiene Committee was Dr. Klein.

- The Dental Hygiene Examination Committee was allowed to meet in May and in September. In May, Dr. Klein presented an outline of the revised content and scoring that he recommended in the examination, even though there was no consensus among the Committee members about the proposed changes. The majority bloc of NERB representatives did not allow the report from Drs. Littlefield and Wallace to be considered or discussed. Dr. Klein's proposed examination was circulated to all members of the CRDTS Dental Hygiene Examination Committee for review and feedback which was directed independently to the Chairperson of the CRDTS' Examination Committee. A full report was submitted to the CRDTS' Executive and Steering Committees. In September, the agenda and background reports were circulated in advance to the ADEX Dental Hygiene Examination Committee. At the meeting, the agenda was usurped by the majority bloc, the report from Drs. Littlefield and Wallace was again not allowed to be discussed, and policy decisions from CRDTS' Steering Committee were excluded. Contrary to Dr. Houfek's assertions that ADEX has always operated by consensus, none existed at that meeting. At a meeting in Silver Springs, MD on November 9, even Dr. Guy Shampaine repeatedly stated to six CRDTS' representatives that the minority has the right to be heard and the proceedings at the September ADEX Dental Hygiene Committee meeting "should not have happened". The minority report from the CRDTS' representatives to the ADEX Dental Hygiene Examination Committee is attached to this document.
- In 2007 and 2008, three CRDTS representatives were invited to attend a meeting in Silver Springs, MD to review and revise the CSCE. In each instance, they reported concerns about the process; it did not appear to them that NERB was employing "best practices" in the development of the exam. At the 2007 meeting, 15 non-scored field test items were prepared for the 2008 exam to purportedly test the Oral Evaluation. In 2007, CRDTS began receiving reports that many of the questions from the CSCE were being circulated on the internet. In 2008, the Director of CRDTS' Dental Hygiene Examination Development and Administration ordered a copy online of the CSCE study material from AndyRDH. An item-by-item comparison was done between the actual examination and the items from Andy RDH. A majority of the items, complete with distractors and answers, were either identical or markedly similar. The comparisons were demonstrated to the NERB CSCE Committee, which included Dr. Guy Shampaine, and the group agreed that the degree of exposure was a serious concern and many items were revised accordingly. Of additional concern, eleven of the 15 field test items were exposed. An exam that has lost security has no validity. Yet, Dr. Klein and the NERB representatives continue to insist that the CSCE is not only a valid instrument, but also an appropriate modality to replace the clinical, patient-based Oral Evaluation.
- On November 9, six CRDTS' representatives were directed to appear in Silver Springs, MD to meet with two NERB representatives, Dr. Guy Shampaine and Dr. Ellis Hall. No agenda was provided in advance, but it was announced at the meeting that the purpose was to discuss any concerns about the CSCE or the DSCE. The CRDTS representatives believed that those concerns had already been aired. Dr. Shampaine suggested that the group put together recommendations to resolve any concerns about the computer simulation exams. Those recommendations outline the proposals that need to be implemented to bring the development and revision of these examinations up to standards. The report that was prepared is attached to this document, along with a report on the review of the DSCE. Dr. Klein continues to assert that the DSCE and CSCE are valid, reliable and secure and that a NERB group has investigated the exposure on the internet and concludes that there is no problem. Dr. Klein further asserts that there has been no change in the psychometric analysis of the DSCE in the past four years. But the exposure of the DSCE that CRDTS found on the internet was from 1995 to 1998; Dr. Shampaine reported that NERB released a copy of the DSCE around 1996. Yet incredibly, NERB continues to use some of the same items that were released over ten

years ago. Perhaps it is not surprising that Dr. Klein's analysis shows no change because the exposure has existed for a number of years.

- Dr. Klein's allegiance to NERB was evidenced in more than a dozen drafts of both the dental and dental hygiene 2007 Technical Reports which Dr. Klein was being paid by ADEX to write. The electronic versions of those drafts, distributed for proofing by Dr. Klein, showed the author to be Dr. Joe Rossa. This almost comical gaffe was not corrected until after it had been pointed out to ADEX officers. CRDTS expects not only examiners, but also measurement specialists, to evaluate independently and with objectivity.
- It should be noted that the ADEX Periodontal Examination did not have the broad-based national input from content experts that the ADEX Dental Hygiene Examination had. In 2004-05 the ADEX Subcommittee on Examination Content decided that the CRDTS Periodontal Examination would be adopted as the ADEX Periodontal Examination, and this was approved by the ADEX Interim Board. At a meeting of the Interim Board in March, 2005, NERB reported that they had "overlooked" the fact that they were supposed to use the CRDTS Periodontal Examination, and they had already gone to print with their 2006 Dental Candidate's Manual, presenting the NERB Periodontal Examination as the ADEX Periodontal Examination. They asked that the ADEX Board either authorize ***both*** the CRDTS and the NERB Periodontal Examinations as approved ADEX examinations, or designate the NERB Periodontal Examination, sight unseen, as the only approved ADEX Periodontal Examination. The Interim Board, which still included broad-based national representation, determined that ADEX could not approve two disparate examinations as ADEX examinations; therefore, a small Ad Hoc group of representatives from CRDTS and NERB were designated to resolve the issue.
- The NERB representatives made an urgent call for NERB's Executive Director, Dr. Joe Rossa, to come to the meeting of the Ad Hoc group. Dr. Rossa said that NERB could not endorse CRDTS' Periodontal Examination because no documentation had been provided, even though CRDTS manuals and statistical reports, which contained a full exposition of the Perio exam, had been provided to ADEX/NERB months before. Dr. Rossa claimed that NERB's Periodontal Examination was valid and reliable; but, ironically, no documentation was provided to confirm that assertion and the Ad Hoc group was given approximately five minutes for five people to review one copy of the NERB manual. Dr. Rossa ultimately collected his materials and said that if ADEX did not adopt the NERB Periodontal Examination, NERB would withdraw from ADEX. The Ad Hoc group agreed to recommend that ADEX adopt the NERB Periodontal Examination for one year—2006— with the assurance that the issue would be reviewed and reconsidered by a special Task Force prior to 2007. Despite numerous exam construct concerns that have been expressed by the ADEX Periodontal Subcommittee and ADEX Periodontal Examiners about weaknesses in the ADEX Periodontal Examination, the ADEX Board has not provided priority or funding to implement the Task Force. Although the ADEX Dental Examination Chair appointed a Periodontal Task Force to address the issues highlighted by the Periodontal Subcommittee, he was subsequently informed that the Periodontal Task Force had been disbanded without further explanation or documentation.
- The Periodontal Examination that ADEX was manipulated into adopting has undergone numerous evolutions in the areas of criteria and scoring just to be able to ensure effective and uniform administration. There has been a great deal of miscommunication surrounding the organization of the case acceptance criteria for this exam as well as uniform scoring in the areas of periodontal measurements and case acceptance criteria. As recently as August of 2008, CRDTS became aware of the fact that NERB had been scoring the Treatment Selection criteria differently from the template laid out by Dr. Rossa in 2006. In addition to the cumbersome paperwork, the ADEX Periodontal

Subcommittee outlined exam construct concerns in the areas of treatment selection and competency. In the current construct, when the candidates prepare their treatment selection, they determine in advance which 12 surfaces the examiners must evaluate and those 12 surfaces are the ***only*** surfaces the candidate treats. If, for instance, 3 of the 12 surfaces in the treatment selection do ***NOT*** meet the criteria in the judgment of at least two examiners, the candidate's scaling will ultimately only be evaluated on 9 rather than 12 surfaces. This creates non-standardized test samples and therefore, the number of surfaces each candidate is required to treat may vary. Additionally, candidates with 4 or more errors in the area of calculus detection have already failed the examination before they even begin treatment. Despite the fact that an area of incompetence has been identified for these candidates, they are allowed to continue treatment on a live patient. This practice is not allowed in any other portion of the clinical examination process.

- Dr. Houfek's letter asserts that "ADEX is predicated on the principle that a uniform national examination in dentistry and dental hygiene must be based on a consensus of the active state dental boards rather than by competing testing agencies." However, he fails to mention that it has been ADEX policy to convene quarterly meetings of the Executive Officers of ADEX, NERB and CRDTS at which reportedly no agenda or minutes are kept.
- Dr. Houfek's letter states that "...the CRDTS criticisms are political rather than substantive issues with the examination." No one should know better than he does the substantive issues that CRDTS has with the examination because he has chaired CRDTS' Dental Examination Review Committee for the past six years and led the meetings when CRDTS' examiners have iterated their concerns with the ADEX exam. Unfortunately, it is the political machinations within ADEX, such as those revealed in this document, that have subverted any meaningful resolution of issues with the examination and have caused ***three other regional testing agencies to withdraw from ADEX*** prior to CRDTS' withdrawal.

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Psychometric Recommendations for the American Dental Hygiene Licensure Exam

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Background

CRDTS requested that we review, evaluate, and make psychometric recommendations regarding the American Dental Hygiene Licensure Exam (ADHLEX). ADHLEX is an integrated exam constructed by incorporating components from three regional dental hygiene exams (CRDTS, NERB, and SRTA). The goal of this review is to identify areas of strength and weakness in the ADHLEX psychometric procedures and to recommend improvements. The review will address ADHLEX purpose, content, examiners, exam procedures, exam scoring, setting score standards, and validity and reliability. For each area we will offer specific recommendations. Recommendations in this review are the authors' professional opinion and do not represent official policy of CRDTS, ADHLEX, or the University of Texas Health Science Center at San Antonio.

Purpose of ADHLEX

The first step in reviewing an exam is to understand its purpose and what inferences are to be drawn from its scores. An explicit purpose guides the activities of the exam constructors as they assemble content, decide on scoring procedures, and engage in efforts to ensure that the resulting scores are meaningful. It also makes clear what candidates can expect when taking the exam and how the public can use the results.

The 2007 Dental Hygiene Examiner's Manual describes the ADHLEX purpose as "...to assess the competency of the candidates; but there are many variables in clinical evaluation which can contaminate that assessment process, such as variables in patient conditions, the candidates understanding of and preparation for the examination process; clinical facilities and examiner differences."(p. 6). This statement acknowledges four extraneous factors that affect performance on licensure exams with actual patients and commits ADHLEX to minimizing those factors so the scores will be a valid measure of candidate competency. We recommend keeping this explicit commitment to minimizing the influence of extraneous factors on the examination process.

Content of ADHLEX

ADHLEX consists of two parts: 1. Computer-based Exam and 2. Patient-based Exam. We will review content of the two exam parts separately.

The *Computer-based Exam* (CE) consists of 115 items of which 15 are being pilot-tested and 100 are used to determine a candidate's score. The CE is designed to assess complex knowledge, skills, and abilities required in diagnosis and treatment planning. It is designed as a case-based or patient simulation exam, using photos, radiographs, images of study/working models, lab data and other pertinent information. While it is presumed to be different from the National Board DH Exam (NBDHE), CE addresses similar topic areas. The NBDHE consists of 200 multiple-choice items addressing three major areas (Scientific Basis for Dental Hygiene Practice, Provision of Clinical Dental Hygiene Services, and Community Health/Research Principles) plus 150 case-based exam items. These cases present information dealing with adult and child patients by means of patient histories, dental charts, radiographs, and clinical

photographs. Each examination includes at least one case regarding patients of the following types: Geriatric, Adult-Periodontal, Pediatric, Special Needs, and Medically Compromised. The topics assessed by NBDHE are listed on page 21-22 of the Candidate Guide.[1] The stated purpose of the NBDHE is, "...to assist state boards in determining qualifications of dental hygienists who seek licensure to practice dental hygiene."). In reviewing the exam content outline on page 10 of the 2007 ADHLEX Candidates' Manual, there seems to be considerable overlap with the exam content and purpose of the NBDHE.

We recommend a formal comparison of CE content with the NBDHE. A numerical comparison of scores could be done by identifying a group of recent examinees and computing a correlation coefficient between their ADHLEX Computer-based Exam scores and their NBDHE scores. We predict if one knows a candidate's NBDHE score, one can accurately predict the candidate's probability of passing ADHLEX Computer-based Exam. We conducted an analogous study with Dental Hygiene students at the University of Texas Health Science Center at San Antonio using a practice exam to predict NBDHE performance. We correctly predicted NBDHE passing status with 75% accuracy using a practice exam that was taken with no incentive to perform well (i.e., scores were used for research purposes only).[2] Constructing a high quality multiple-choice exam is very resource intensive. Since candidates must pass the NBDHE as one of the prerequisites for licensure, we believe the resources currently used to create the CE would be better spent on the Patient-based Exam. Therefore, we recommend considering a satisfactory score on the NBDHE as certification of theoretical and cognitive preparation to practice Dental Hygiene.

The *Patient-based Exam* consists of four parts: Oral Evaluation, Periodontal Probing, Scaling/ Calculus/Plaque/Stain Removal, and Treatment Standards. This exam appears to evaluate the fundamental skills that dental hygienists are expected to perform in all states. Further, the criteria for each segment are clearly delineated in the Candidate Manual and require reasonable expectations of performance for each area.

The *Oral Evaluation* includes a defined Extra-oral and Intra-oral assessment (page 30 in Candidate Manual). Because patients present with a variety of findings, this portion of the exam is designed to demonstrate a candidate's ability to discriminate between normal and abnormal structures and to use critical thinking skills to determine significant findings. Candidates are expected to assess their patient's head and neck and oral cavity for unusual or abnormal hard and soft tissue findings and document them on the ADHLEX prescribed form. Candidates are instructed to write a one-line comment describing the finding and its location or designate that it is *Within Normal Limits (WNL)*. Oral assessment is an essential skill that Dental Hygienists provide in private practice. This preliminary screening provides the dentist/employer with information that can be further evaluated and/or diagnosed as appropriate. Consequently, a candidate that overlooks a significant extra- or intra-oral finding compromises good clinical care. We believe that this portion of the exam is an important skill demonstration and support continued inclusion.

The *Periodontal Assessment* requires that a Candidate demonstrate the ability to use a periodontal probe accurately to chart the depth of 6 aspects of 4 assigned teeth that are different from scaling area (2 anterior and 2 posterior selected by examiner). Probing is standardized by specifying the use of the UNC 15 probe for both the Candidate and Examiners. The Candidate Manual provides clear criteria for probing, including pictures of probe placement (page 31). Dental hygienists are educated to perform a periodontal assessment on every patient as a part of the overall assessment. Accurate probe readings assist the dental hygienist in formulating a dental hygiene treatment plan as well as provide the dentist with critical data

regarding a patient's periodontal health status. This segment of the exam is well designed and requires Candidates to demonstrate their competence in performing this essential skill.

The third segment of the exam evaluates a Candidate's *Scaling/ Calculus/Plaque/Stain Removal* skills. The Candidate Manual outlines the scoring criteria (page 12), which incorporates Treatment Selection, Subgingival and Supragingival calculus removal, Tissue Management, and Treatment Standards. Candidates are expected to carefully select a patient who meets the established criteria (pages 27-29) and submit to the examiners for final approval. This practice is consistent with most other state and regional board exams. It demonstrates a Candidate's ability to detect subgingival calculus using a standardized #11/12 explorer. All Candidates are required to chart the location of calculus on all surfaces of the teeth within their treatment selection, which must include at least 14 surfaces of detectable subgingival calculus (min of 9 on posteriors, 3 on molars). Examiners validate the location and amount of calculus using the same explorer so that there is consistency in the approval process. If the treatment selection fulfills the criteria, examiners pre-select the 14 surfaces that will be evaluated for calculus removal, taking care to minimize variabilities in patient difficulty by assuring that each candidate is evaluated on the same number of surfaces, types of teeth, etc. In addition, each Candidate must submit a diagnostic series of radiographs (page 28) that reflect the current condition of the patient. It is the responsibility of the Candidate to determine that the quality of the radiographs meets the established criteria. While these are not graded, failure to include this diagnostic series will result in a failure of the exam. Approved patients are then taken to the clinic where the Candidate proceeds with the required assessments and removal of hard and soft deposits. Clear guidelines for the examination process are presented in the Candidate Manual on pages 32-34.

In addition to the demonstration of clinical skills, each Candidate must exhibit appropriate *Treatment Standards* before, during, and after the examination. These include time management, professional behaviors, patient management, asepsis and other appropriate behaviors as outlined in the Candidate Manual (page 13). Violations in any of these areas may result in Penalty Deductions. If a Candidate commits a *Critical Error* (one that causes patient injury or jeopardizes the patient's well-being), this may result in an automatic failure on the exam. All of these exam components are designed to determine the Candidate's qualifications for licensure to practice dental hygiene. Recent writing on validity of examinations in the health professions asserts that identifying unsafe clinicians is the most important aspect of exam validity.[3] The ADHLEX exam tasks appear to be carefully designed to assess important elements of dental hygiene clinical care and to detect those individuals who do not meet these criteria for licensure. We recommend that the professional tasks required by the four parts of the Patient-based Exam remain in their current form.

Examiners

The Patient-based Exam (PE) is scored by clinician Examiners who observe and evaluate the candidate's work. To ensure the integrity of the examination, it is important that they 1) have the appropriate expertise to start, 2) receive adequate training and are given ongoing feedback about their performance.

PE Examiners are initially nominated by the participating state boards with a requirement that not more than two new examiners be among their 21 representatives. Nomination criteria are clearly stated in the Examiner's Manual (p. 1). CRDTS annually identifies no more than two examiners per state to be added with State Board approval to the examiner pool. In our view, the Examiner selection process is reasonable and allows confidence that dentists and dental hygienists with the appropriate expertise are being chosen.

Examiners are trained for PE in a two-stage process: 1. Visit a test administration as an observer, 2. Participate in examiner training exercises that are conducted for all examiners the day prior to administering a PE. The manual defines an accuracy level of 80% or greater and step by step examiner procedures are provided. There is strong emphasis on confidentiality and candidate anonymity. Three examiners independently assess performance and 2 of 3 must agree for validation of errors. Examiner ratings are statistically analyzed after each testing cycle and compared for intra- and inter-rater agreement. This provides quality control data to ADHLEX staff and corrective feedback to individual examiners (self-assessment). We believe the process for ADHLEX examiner training and feedback process is an exemplary model and should be maintained.

Exam Procedures

Conducting a performance-based clinical exam is a very complex logistical operation that requires integrating the efforts of numerous patients and examiners in addition to the candidates. ADHLEX has developed exemplary Dental Hygiene exam procedures by designing examinee clinical tasks that can be accomplished within the specified time period. Equally important, CRDTS has recruited a cadre of knowledgeable and competent Examiners who have expertise in the field and are then trained and continually calibrated to conduct the exam. These experienced Examiners are critically important to smooth efficient operation of the Exam. The CRDTS staff and leadership apparently have created a working environment that encourages Examiners to continue their affiliation with licensure testing despite the rigor of the work. This working environment should be carefully maintained. We have no recommendations to improve the ADHLEX exam procedures.

Exam Scoring

There are many reasonable ways to score an exam. Exactly which methods are chosen is typically not of tremendous importance, so long as they meet minimum technical standards and the processes used to derive them are credible to experts, candidates, and the public. ADHLEX utilizes a criterion-based grading system to differentiate between acceptable and unacceptable performance. Criteria have been established for each clinical procedure. Three examiners independently evaluate all treatments and apply the criteria in assessing performance. Points are awarded for each scorable item that fulfills the criteria as independently identified by 2 or more examiners. This review will focus on scoring Treatment Selection, Oral Evaluation, Periodontal Measurements, Scaling/Subgingival Calculus Removal, Supra-deposit Removal, Tissue Trauma, and Treatment Standards (penalty points assessed for violations of standards).

An acceptable *Treatment Selection* is a prerequisite for being able to complete the examination, and is an important factor in controlling variables in patient difficulty. One examiner evaluates every surface in the candidate's treatment selection to see if it fulfills the criteria. If the examiner cannot confirm surface(s) of calculus that the candidate has identified, or if they detect qualified surfaces of calculus that the candidate has not charted, a second examiner must evaluate those surfaces following a standardized protocol. Even if some of the surfaces the candidate charted are disqualified by the examiners, if the remaining surfaces fulfill the criteria, the treatment selection is approved and the candidate proceeds with no penalty. If two examiners have agreed that the treatment selection does not fulfill the criteria, the selection is disapproved, the candidate receives a 7 point penalty, the clock starts running on the candidate's 2½ hour treatment time, and the candidate is allowed to submit another treatment selection for the same patient or a different one. If a second treatment selection is

disapproved, the candidate incurs another 7 point penalty; additional treatment selections may be submitted without further scoring penalties other than loss of time.

Oral Evaluation is scored by having three examiners independently evaluate whether the candidate correctly identified any significant findings or that the patient is within normal limits for each of three extraoral and four intraoral areas. Each area is worth 2 points and scores can range from 0 to 14.

Periodontal Measurements are scored by having three examiners independently check the Candidate's measurements on six aspects of two assigned teeth. Candidates are required to use a UNC-15 Probe to help standardize the depth of the gingival sulcus to the nearest millimeter. Each measurement is worth 1 point and scores can range from 0 to 12.

Scaling/Subgingival Calculus Removal is scored by having three examiners inspect each of 14 surfaces chosen for evaluation after the candidate completes treatment. Each examiner scores 'Yes' or 'No' for each of the 14 surfaces. Each surface is worth 4 points and scores can range from 0 to 56.

Supra-deposit Removal is scored by having three examiners inspect six teeth. Each tooth is scored as 'Yes' or 'No' for deposit removal. Scores can range from 0 to 6.

Tissue Trauma is scored by having three examiners inspect all teeth in the Treatment Selection and surrounding areas. Acceptable performance is demonstrated if 100% of all tissue surfaces exhibit no unusual mechanical damage. Examiners mark 'Yes' or 'No' for Tissue Well-Managed on each of 6 teeth. If a Tissue Trauma Critical Error occurs (defined on p. 35 of Examiner Manual), automatic failure of the examination is scored. Otherwise scores can range from 0 to 12

Treatment Standards is scored by subtracting points. Two examiners evaluate Professional Conduct (automatic dismissal from exam), Patient Management (minus 5 points), Professional Demeanor (minus 2 points), Infection Control (minus 2 points), Recordkeeping (minus 2 points), and Time Penalty (minus 10 point for 1-15 minutes late and automatic failure for 16 or more minutes late)

Total score for the Exam is the sum of procedural points minus any penalty points for Treatment Standards. If the total score ≥ 75, the candidate passes the exam. We find the scoring procedures easy to understand and a defensible method for judging the quality of a candidate's performance. We recommend maintaining exam scoring procedures in their current form.

Setting Score Standards

As with scoring, there are many reasonable ways to set minimum passing standards. Currently, the Examination Review Committee sets standards and those standards identify a relatively small proportion of failures from the total group of candidates. A recent review article on establishing passing scores notes there is no 'gold standard' method.[4] One formal approach to setting minimum passing standards would be to have a group of experts take the exam and be scored as normal candidates (i.e., examiners are not informed). The *Contrasting Groups* method for determining the minimum passing standard could then be applied to determine the minimum passing score that most accurately distinguishes experts from the rest of the candidate group.[4] We recommend that CRDTS consider this formal approach for setting score standards.

Validity and Reliability of ADHLEX

There is ferment among testing and measurement specialists because the current 'unitary' approach to validity doesn't provide practical guidance for constructing tests. A recent article in the flagship journal of the American Educational Research Association notes that validation has become an 'out of reach' goal and recommends analyzing exam content validity then reliability as the first concern.[5] Therefore, our recommendations regarding ADHLEX validity will focus on exam content validity and then score reliability.

The first step in validating ADHLEX is to clearly define the link between the CODA Standards, ADHA Standards, and ADHLEX exam content. The professional tasks ADHLEX requires Candidates to complete (i.e., exam content) directly reflect the requirements for clinical education and competency outlined in the Commission on Dental Accreditation (CODA) [6], Accreditation Standards for Dental Hygiene Education (pages 22-23). These standards also are consistent with ADHA Standards of Dental Hygiene Practice.[7] CODA Standards require that students develop competence in Assessment, Planning, Implementation, and Evaluation. The Oral Evaluation and Periodontal Assessment portions of the ADHLEX require that the Candidates demonstrate their ability to assess their patient's needs, plan their treatment to meet these needs, implement the procedures required (Scaling/Plaque/Stain Removal), and evaluate their results before submitting the patient for final evaluation. Our review of ADHLEX Content (Computer-based and Patient-based sections) convinced us that ADHLEX is a representative sample of professional skills from the CODA and ADHA Standards and, therefore, content validity is excellent.

ADHLEX score reliability is primarily a concern for the Patient-based exam. Score reliability is affected by two factors: 1. inter-examiner agreement and 2. variability of individual candidate performance from one clinical procedure to the next. Inter-examiner agreement is maintained at a high level via ADHLEX exam scoring policy that requires three independent assessments of every scorable task and at least two examiners must agree (identical score). The 2007 CRDTS Examiner Profile Service reported that percent confirmed judgments (2 or 3 identical scores) ranged from 90.3% (Scaling) to 98% (Tissue Management). This is consistent with research showing that examiners who are well trained display infrequent disagreements when judging the same performance. Inter-examiner agreement is not a serious threat to score reliability.

Variability of individual candidate performance from one clinical procedure to the next is the major source of error in performance-based exams.[8] ADHLEX uses *compensatory scoring* (i.e., add scores across all sections of the Patient-based exam) to reduce the impact of performance variability from one section of the clinical procedure to the next. We believe the ADHLEX content validity is excellent and reliability is as good as is possible when using only one patient as the candidate's exam.

Summary and Conclusions

The goal of this review is to assist CRDTS by identifying areas of strength and weakness in the ADHLEX psychometric procedures and recommending improvements. The review addresses seven topics and emphasizes ADHLEX content, scoring, and validity and reliability. We have made seven general recommendations that are restated below:

1. *Purpose of ADHLEX:* Maintain explicit commitment to minimizing the influence of extraneous factors on licensure decisions

2. *Content of ADHLEX:* a. Consider a satisfactory score on the NBDHE as certification of theoretical and cognitive preparation to practice Dental Hygiene and discontinue the Computer-based Exam, b. Retain the professional tasks required by the four parts of the Patient-based Exam in their current form.
3. *Examiners:* Maintain the current process for ADHLEX examiner training and feedback.
4. *Exam Procedures:* Maintain the current ADHLEX procedures.
5. *Exam Scoring:* Maintain the current ADHLEX exam scoring procedures.
6. *Setting Score Standards:* Consider Contrasting Groups approach for setting score standards.
7. *Validity and Reliability:* ADHLEX Patient-based exam content is a representative sample of Dental Hygiene professional skills required by CODA and ADHA standards and, therefore, content validity is excellent. Score reliability is as high as is possible given the constraints of only one patient per each Candidate.

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Minority Report

ADEX Dental Hygiene Committee

Tunde Anday, RDH, District 6, Elizabeth Thompson, RDH, District 2, Jane Criser, RDH, District 3, JoNell Bly, RDH, District 4

It is with deep regret that we find it necessary to file this minority report. We, the above representatives from ADEX Districts 6, 2, 3, and 4 attended two meetings of the ADEX Dental Hygiene Committee in 2008. The events which transpired at those meetings have demonstrated that there is no interest from the majority bloc in the discussion of any minority viewpoints. This minority report is an attempt to provide the voice for the ADEX Districts that we represent. At no time at either 2008 meeting was any attempt made to review the Dental Hygiene test which had been approved by ADEX and administered by CRDTS. The focus of the ADEX Dental Hygiene Committee meetings was to advance the exam espoused by the majority of the ADEX committee members-the ADEX Dental Perio Exam.

MEETING AGENDA:

We disagree with the manner of substitution of the planned agenda for this meeting. A committee member informed us as the onset of the meeting that the agenda must follow the Sturgis format, and we were presented with a template and a new agenda which did not include any items from the agenda that had been prepared and circulated to all committee members in advance by the Chairman. A member of the majority bloc moved to amend the agenda. We were assured that the items from the original agenda could be put into this new agenda. In good faith, the new agenda was approved. A vote was then taken on each item in the previous agenda, and the majority bloc of the committee refused to include any of the preannounced agenda items. These omitted agenda items were concerns voiced by the CRDTS Dental Hygiene Exam Review Committee, and approved by the CRDTS Steering Committee. It would appear that this action was taken specifically to remove any mention of the concerns emerging from the CRDTS Annual Meeting. We feel that this report is necessary to voice those concerns to the ADEX Board of Directors.

A close examination of The Standard Code of Parliamentary Procedures by Alice Sturgis states that the purpose of an agenda is to provide a systematic plan for the orderly conduct of business, which the original agenda accomplished. Sturgis states that "all meetings must be characterized by fairness and by good faith." Further, it is emphasized that trickery and overemphasis on minor technicalities can invalidate any actions taken by the committee.

COMMITTEE STRUCTURE:

It is understood that there must be one representative from each district as mandated by the ADEX By-laws. It is also mandated that there be an educational consultant and a dental consultant, each with one vote. It is evident that the current consultants are most familiar with the dental hygiene examination currently being administered by the NERB. The committee structure is such that there is no parity in voting, as the appointed consultants' votes serve to consistently advance the NERB agenda. This is especially egregious in light of the fact that ADEX By-laws state that Committee Chairs have the discretion to include non-voting consultants as needed; however, consultants requested by the current ADEX DH Chair have not been allowed to participate or attend any meetings in 2008.

SCORING SYSTEM:

A new scoring system was introduced by Dr. Klein at the September 5th ADEX Dental Hygiene Committee meeting. While this document is dated June 26, and is clearly intended for the Dental Hygiene examination, we were not aware of the existence of this document. While the majority voting bloc was ready to adopt this new scoring rubric immediately, it was agreed that this issue could be tabled until September 7th to allow all committee members an opportunity to review this document carefully.

The scoring system is obviously an important aspect of the examination. We question several aspects of this new rubric and do not think that this is a fair scoring system for candidates for the following reasons:

1. Candidates are asked to remove calculus from all of the 14 surfaces they selected. (Dr. Klein unilaterally reduced the sample size this from the previous committee recommendation of 16). We are unclear what happens to the candidate that has 3 surfaces of calculus denied at check in. Does this candidate who now has 11 surfaces of calculus to remove fail due to the fact that they only have 11 surfaces? Or if this candidate treats all submitted surfaces sufficiently, do they pass having had an easier task than their fellow candidates who fulfilled the treatment selection criteria? When questioned Dr. Klein responded that it affected so few candidates it was insignificant, but we disagree with that assumption. In this rubric Dr. Klein establishes the policy of applying a 15 point penalty (which would cause a candidate to fail the exam) if the sum of their Calculus Detection and Removal scores is 66 points or less (i.e. the candidate did not detect and/or clean 4 or more surfaces properly), which sets a standard of 85% of the 78 points weighted for calculus detection and removal. Dr. Klein stated that this is "transparent and manipulates the pass rate to approximately 93%." We have a serious problem with any assertion that the pass rate should be manipulated. In addition, we don't know what data Dr. Klein was using to state that setting a standard of 85% for calculus detection and removal would manipulate a pass rate of 93%. In the 2008 ADEX/CRDTS Dental Hygiene Examination, the mean score for calculus removal was 82.7% of the possible points for scaling. Enforcing a 15 point penalty for achieving less than 85% of the detection/removal points would result in an inappropriately low and legally indefensible pass rate.

2. Dr. Klein's document states that candidates lose 15 points if only 2 of the 3 teeth from those selected for treatment have a 4 mm pocket dept on the surface indicated by the candidate, and lose 30

points and fail the exam if 1 or none of the 3 teeth have a 4 mm pocket depth on the surface selected by the candidate. We cannot understand the reasoning for this policy. These are reportedly not evaluation surfaces and we cannot understand why this should carry such a severe penalty, especially since there is no logic behind this requirement. This 15 point penalty is even more severe than what is initially assessed in the ADEX Dental Periodontal Exam. This does absolutely nothing toward ensuring that all candidates have standardized case severity and difficulty. You do this by verifying that all candidates meet the criteria both on paper, and in the mouth.

3. A 100 point penalty is assigned to candidates who make critical errors at any point during the examination, such as their failing to note the presence of possible cancerous lesions in the patient's medical history. This is extremely problematic in that no responsible clinician would diagnose a cancerous lesion without a biopsy. As experienced clinicians we have observed many lesions that looked suspicious but were completely benign, and innocent appearing lesions that were cancerous. Also, are these lesions only in the oral cavity or does this also include the skin of the face and neck as well? It would be difficult if not impossible to calibrate examiners to one standard.

4. We disagree that the addition of 10 questions to the CSCE is an adequate replacement for the Oral Evaluation portion of the clinical examination. At this time there are several serious issues related to the security of the CSCE, which is appropriately under review at this time. If this review reaches the conclusion that the security of the CSCE has been breached it will seriously affect the reliability and validity of this test. Even without the security issues, we also question how it is possible to transfer the skill set of the oral evaluation to a multiple choice test. Is a gloved hand holding the side of the neck an adequate test on the accurate palpation of lymph nodes? It must be recognized that the CSCE has only 100 questions, with approximately 15 new questions field tested each year. This is a very small exam which does not take a great deal of effort for candidates to recall. At this time there is an individual selling a product on the internet that claims to contain the answers to the CSCE. This product is now marketed as a "review". Regardless of the name-it must be understood when a test contains such a limited number of questions it is only a matter of time before the test questions become "discussion points". It takes a great deal of time and resources to produce a valid, reliable, and defensible computer examination. This has been demonstrated in the manner by which the National Board Dental Hygiene Examination (NBDHE) is constructed. We are also concerned with the apparent duplication of subject content between the NBDHE and the CSCE. Various consultants have indicated that an <u>independent</u> study to compare these 2 examinations is in order. This was a recommendation from the May ADEX Dental Hygiene meeting but no action has been taken at this time. Until these issues with the CSCE are resolved, it is premature and irresponsible to even consider transferring the existing Oral Evaluation to the CSCE.

5. The rubric calls for a maximum score of 4 points for the Tissue Management section of the examination, as per the criteria for these standards that have been set forth on the ADLEX Periodontal Examination. There appears in the current examination little guidance and standardization for this criteria. We also would raise the question to the defensibility of an exam that seems to carry so little weight on potential harm to a patient.

ADEX DENTAL PERIO TEMPLATE:

As mentioned earlier, at no time was there any attempt to visit the issue of the ADEX Dental Hygiene test that was unanimously approved by the ADEX BOD and HOR in 2006, and administered in good faith by the CRDTS organization. That test was developed by a group of dedicated hygienists from all over the country who attended a series of ADEX meetings over a period of approximately 2 years. The committee referenced 2 key documents used to standardize clinical licensure exams: *Standards for Psychological and Educational Testing* and *AADE's Guidelines for Clinical Licensure Examinations in Dentistry.* Only the most standardized components with a history of validity and reliability were incorporated into the construct of the examination.

Despite concerns by the minority members of the current ADEX DH Committee, the ADEX Dental Perio Exam was approved as the new template for the DH Exam at the May 2008 DH Committee meeting. This template with the proposed revisions was reviewed carefully by the CRDTS Dental Hygiene Exam Review Committee (ERC) members. This committee met in August 2008 to discuss the relative merits and compared it to the current ADEX dental hygiene examination as administered by CRDTS. The committee raised several serious issues in regard to this revised template, outlined in Attachments A and B. (See attached). While it would be redundant to repeat these concerns in this report, it must be stated that this effort was a result of a careful, thoughtful, and most importantly, an independent study of the template. The collaboration that took place at the ERC meeting was an open discussion with a unanimous conclusion. The assertion that "CRDTS voted against giving this test without even knowing what it was" could not be further from the truth. This does a grave disservice to the hardworking members of the CRDTS ERC committee who put in many hours of study to learn about and understand the ADEX Dental Perio Exam. It is unfortunate that the majority bloc chose to ignore these concerns and refused to allow any discussion of the report presented by a member agency of ADEX.

AUTONOMOUS DENTAL HYGIENE EXAM

It is vitally important for a clinical test to adequately asses a candidates knowledge, skills, judgments, and abilities. We question whether one portion of a five part dental exam accurately assesses the KSJA's of a dental hygienist? As experienced dental hygienists we can state that it is so vitally important for our profession to be more than a "scaling" exam. The scope of practice for dental hygienists cannot be adequately represented by one portion of a dental exam. The minority members of this committee had letters from member State Boards of ADEX expressing such concerns, but again we were not allowed to present or discuss these issues at the meeting. The ADEX Dental Hygiene test deserves to have forms, criteria, and scoring compatible with the skill sets that a dental hygienist must possess. The purpose of administering an exam to all dental hygienists applying for licensure is to protect the public. It is imperative that the dental hygiene examination continue to demonstrate fidelity-true life application.

PSYCHOMETRIC REPORT:

It is of the utmost importance to ensure that an exam is valid, reliable, and defensible and for this reason it is essential for an exam to undergo constant scrutiny to ensure that this goal is accomplished. ADEX has chosen to rely solely on the opinion of one testing specialist, Dr. Stephen Klein. It has been

our experience that psychometric evaluation is an art, rather than a science, and results can vary greatly with the messenger. We have a report from Dr. John Littlefield stating that the original ADEX Dental Hygiene exam as administered by CRDTS is indeed fair, reliable, and valid. (See attached) Dr. Littlefield did raise a question to the validity of the CSCE and questioned the relevance when candidates are also required to complete the NBDHE. Dr. Littlefield has excellent credentials in the area of psychometric protocols as well as a great deal of experience in clinical evaluation. The minority members of this committee feel his input and voice to be invaluable regarding the issues before us.

Dr. Littlefield and Dr. Klein did issue a joint report dealing with the Dental Hygiene exam currently administered by CRDTS. In the spirit of compromise, Dr. Littlefield did agree to make adjustments to the Oral Evaluation. Dr. Littlefield and Dr. Klein did disagree however in the manner by which surfaces are chosen. Dr. Littlefield prefers having an examiner select the surfaces for the calculus removal portion of the exam whereas Dr. Klein prefers requiring that the candidates clean all the surfaces they selected for treatment, but only receive credit for the ones that were accepted for cleaning and were cleaned adequately. (See attached) We agree with Dr. Littlefield that examiners should choose the surfaces to be cleaned from the teeth submitted by the candidate. This method ensures that all candidates taking the test will have the same testing conditions, and ensures that all candidates will adequately treat all surfaces of the submitted teeth.

The ultimate goal of a uniform national exam is of vital importance to our profession. We share this belief with our colleagues on the ADEX Dental Hygiene Committee. In an effort to advance this goal we would propose moving forth on the recommendation to initiate dialogue with other agencies involved in clinical testing. The Dental Hygiene Examination unanimously approved by the ADEX governance in 2006 was built upon a consensus of many individuals. We would like to believe that this spirit continues to exist, and should be called forth as we all work together to achieve this goal.

Recommendations to ADEX BOD and NERB Steering Committee Re: DSCE/CSCE

1. Develop and publish ethics policy, code of conduct and confidentiality agreement regarding responsibilities of candidates, faculty and test constructors as outlined in the JCNDHE document.
   - Confidentiality of the examination cannot be breached before, during or after the administration of the examination
   - Policy shall be published in the Candidate Manuals and the candidate must electronically agree to adhere to the policy on the first screen of the examination at a Prometric testing center; candidates who do not agree to the policy may not proceed with the exam.
   - Verification that the candidate is actually the applicant
   - Candidate may not participate in blogs, international chat rooms, brain dumping
   - Determine disciplinary policy for breaches

2. Test development and construction for both the dental and dental hygiene examinations, including the DSCE and the CSCE shall be conducted by the ADEX Dental and Dental Hygiene Examination Committees respectively. The DSCE and the CSCE examination development may be delegated to respective subcommittees as determined by the Dental and Dental Hygiene Examination Committees.
   - Develop a protocol for the selection of test construction subcommittee members
     - qualifications
     - terms
     - meeting schedule
     - sufficient representation to assure quality, not more than 8
   - Assure that the test construction committees have:
     - appropriate resource materials and documentation readily available to them during each committee meeting to facilitate the test construction and analysis process.
     - History of items in the test bank, including statistics and the evolution of the wording of the question, distractors, etc. over a period of five years.

3. The Dental Hygiene Subcommittee shall conduct a comparison study of the CSCE and the dental hygiene National Boards to determine the extent of content duplication and adherence to mission and bylaws.

4. ADEX will explore the services and costs of a test security analysis company, such as Caveon.
   - Internal security audit
   - Data forensics

5. Define qualifications for candidates to take the examination in order to limit exposure of the items, e.g. AADE.

6. Build a larger test item bank. Develop and fund a policy for securing case-based problems and beta testing them.

7. Consider expanding both the DSCE and the CSCE to be 30" longer. Publish two different versions per year so that double the number of items can be beta tested.

8. The respective examination committees shall develop and approve all changes to their respective examinations. The final form shall be delivered to Prometric, loaded on the system, and representatives of each scoring agency shall coordinate the proofing and editing process to assure one final correct form(s) of the scorable items.

9. No administering agency will release scores until a sufficient number of results have been analyzed and there is agreement mutually among the authorized representatives of the scoring agencies to release the scores.

10. The test administration and scoring agencies shall maintain clear, complete and continuing communication.

DSCE-CSCE Rx-Nov 9, '08.doc

DSCE REVIEW
November, 2008

In order to determine the degree of potential exposure a review book was purchased over the Internet for $95. The Internet link purported to offer many questions that had been used on the NERB written exams in the past and claimed that many of the questions were still in use on current examinations. There is also a smaller version available with actual photos for a lesser amount.

The product that arrived was a large bound paperback book 8-1/2" x 11" and approximately ¾" thick, containing many hundreds of questions from the DOR, CTP and PPMC examinations from the years 1995-1997. The book was apparently compiled as a study guide for review courses taught by a Dr. Neill Serman. The copied pages are heavily marked up with lots of notations in the margins. In many instances, it is apparent that the items were acquired by "brain dumping". That is, candidates who had taken the examination had retained and recorded from memory certain questions for which they described the "gist" of the stem and the image that accompanied it, listed the distractors and identified the correct answer. In other instances, it appeared that questions had been copied verbatim and pasted into the book.

Because the review book contained questions from exams 10-13 years ago, only a cursory review was done over a period of a few hours. There were 8-10 items from the current DOR exam that were the same or very similar. That is perhaps not too surprising because there are a number of oral and radiographic lesions and anatomical landmarks that one would expect to be covered in a Diagnosis, Oral Medicine and Radiology Exam. There was no substantial exposure evident in the CTP exam.

There was considerable duplication in the Periodontics, Prosthodontics and Medical Considerations Exam (PPMC). Cases A, O and Q in the current exam were substantially exposed as far back as 1995-97. The details of the case problems as well as the questions were identical in many instances. Through subsequent discussions with Dr. Guy Shampaine, it was learned that a copy of the DSCE had been released on or about 1996; this information had never been previously provided to CRDTS. It is of concern that in the past 13 years, these released cases are still in use and derivatives or totally new cases have not been developed. One would think that there would be a large bank of case problems that would have been developed and field tested throughout these intervening years. This is of particular interest to CRDTS because the PPMC is an examination that was developed by CRDTS.

- In the early 1980's CRDTS developed an exam of medical considerations at the behest of Dr. Jim Swenson from Wyoming.
- In the mid 80's, CRDTS began developing and administering a Prosthodontics exam under contract with Drs. Tom Taft and Glen McGiveny from Marquette University. The exam covered complete and partial removable prosthodontics and fixed prosthodontics. At that time, many CRDTS' examiners believed it was important to have prosthodontics in a clinical exam because of the prevalent problem of denturists in many states.
- In 1988, CRDTS contracted with Dr. Mike Loupe of the University of Minnesota for the development of a Periodontal Diagnosis Exam. It was a case-based examination with patient histories, periodontal charts, clinical picture and radiographs.

In 1995 when CRDTS was in CORE, the Prosthodontics Exam was converted into a case-based examination, and these three examinations were combined into the PPMC and substituted for NERB's existing Periodontal Examination. The pictures, case details and questions for Case Q are identical to the 1997 version of the CRDTS exam. There were six periodontal cases and four prosthodontic cases in the test bank. It appears those cases were substantially compromised between 1995 and 1997 after

CRDTS withdrew from CORE. CRDTS discontinued the administration of written exams in 1996 when National Boards started using case-based exams. NERB has continued to use the PPMC since 1995.

It would be naïve to think that "brain dumping" and more innovative, high-tech forms of test pirating has ceased since 1997. Clearly, more exhaustive investigation is warranted to determine the extent to which the DSCE may be compromised in 2008. In addition, research should be done about electronic security methodologies that might be employed to ensure the confidentiality and validity of the examination.

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October 13, 2008

Bruce Barrette, D.D.S.
CRDTS President
1710 Cleveland Ave.
Marinette, WI 54143-3925

RE: Defensibility of CRDTS Dental Hygiene Licensure Exam

Dear Dr. Barrette,

You have asked us to research the defensibility of the Dental Hygiene Exam as adopted by ADEX in 2006 and administered by CRDTS since its adoption, hereinafter referred to as ADHLEX.

Legal Standard: Rational Relationship

Legal challenges to the validity of professional examinations are typically couched in terms of constitutional due process rights. *See Schware v. Bd. of Examiners*, 353 U.S. 232, 238-239 (1957); *U.S. v. State of North Carolina*, 400 F. Supp. 343 (E.D.N.C. 1975); *Dilulio v. Bd. of Fire and Police Commrs*, 682 F.2d 666, 670 (7th Cir. 1982); *Corsello v. Pennsylvania*, 460 A.2d 1226 (Pa. Cmwlth. 1983). In his analysis of ADA Resolution 64H Mr. Stan Ingram points out that the legal standard for upholding the test-takers due process rights is a "rational relationship" between the examination requirements and job requirements. This standard has been repeatedly upheld. See *Id.*; *See also Baji v. Northeast Regional Bd. of Dental Examiners, Inc.*, 2001 WL 111646.

In *Tyler v. Vickery*, the Georgia court of appeals held "the focus of the rational relationship test is not whether the state has superior means available to accomplish its objectives, but whether the means it has chosen is a reasonable one." *Tyler v. Vickery*, 517 F.2d 1089, 1101-1102 (C.A.Ga. 1975). The courts have given deference to licensing boards holding "It is not the province of this court to order an examinee certified when in the judgment of the certifying board his performance does not meet the standard for the profession. Nor can this court sit as a super-examining board." *Wilner v. State Dept. Of Licensing and Regulation*, 285 N.W.2d 432, 435 (Mich. Ct. App. 1979).

Test Validation

In determining whether a professional examination will meet the rational relationship test, a court will consider test validity "to justify or support its relationship to what it is intended to measure." *U.S. v. New York; William G. Connellie, et. al.*, 77-CV-343 (N.D.N.Y. 1973). According to the American Psychological Association, validity is "the most fundamental consideration in developing and evaluating tests." APA, Standards for Educational and Psychological Testing, 9 (1999). "Test validation is the process by which a test developer collects evidence to support the types of inferences that are to be drawn from test scores." (Schroeder Management Technologies, Inc. available at http://www.smttest.com/web/resources/articles/Legal%20defensibility.pdf (last viewed 10/9/08)). The three common methods of accumulating validity evidence are; Construct-Related Evidence, Content-Related Evidence, and Criterion-Related Evidence. APA, Standards, 9 (1985); *See also* APA Standards (1999)(Glossary).

Criterion-related evidence seeks to establish a positive correlation between test outcomes and on-the-job performance. See APA Standards 14(1999). The two types of criterion-related evidence are (1) predictive and (2) concurrent. Predictive validation "is a procedure which tests individuals when they are hired, and then statistically compares the test results, after a certain time, to on-the-job performance. A successful comparison or correlation suggests that the test is predictive of on-the-job success." *See* www.waldentesting.com/backup/services/validation.htm. Predictive validity is not feasible in the licensing context since participants who fail the exam are not allowed to practice in the field. Concurrent validation on the other hand "is a procedure which tests individuals currently in the position, and then statistically compares their test results with their current performance." *Id.* Dr. Littlefield recommended such a "contrasting groups" method for determining the minimum passing score to be used on the current CRDTS exam. See John Littlefield, PhD, Psychometric Recommendations for the American Dental Hygiene Licensure Exam, 5, Jan. 30, 2008.

Construct-related evidence "focuses primarily on the test score as a measure of the psychological characteristics of interest." APA Standards, 9 (1985). Put another way, if it certain skills are deemed necessary for successful job performance, the exam should be designed to measure the degree to which an examinee possess those skills. In Douglass v. Hampton, the court held that "[i]n light of the strong preference expressed in reported opinions for empirical validity and the greater reliability of empirical validity, we think construct validity may be considered, if at all, only in certain circumstances." *Douglas v. Hampton*, 512 F.2d 976, 986 (C.A.D.C. 1975).

Content-validity evidence "demonstrates the degree to which the sample of items, tasks, or questions on a test are representative of some defined universe or domain of content." APA Standards, 9 (1985); *See also* APA Standards (1999)(Glossary). Put another way content-validity measures the correlation between tasks on the exam to tasks regularly performed on the job. In that

sense, content-validity is the strongest indicator that the patient-based clinical exam is rationally related to the CRDTS administered licensure exam. Considering content-validity, the court in *Corsello v Pennsylvania* held

> "[t]here is no doubt that the petitioner has failed to complete the restorative portion of the clinical examination successfully. This clearly has a substantial and reasonable relationship to his ability to practice dentistry successfully, and is a prerequisite to obtaining licensure."

Corsello v. Pennsylvania, 460 A.2d 1226, (Pa. Cmwlth. 1983). According to the APA, "[v]alidation of credentialing tests depends mainly on content related evidence, often in the form of judgments that the test adequately represents the content domain of the occupation or specialty being considered." APA Standards, 157 (1999).

Analysis

There is ample evidence to establish the content-validity of the ADHLEX. Drs. Littlefield and Wallace have reviewed the ADHLEX and made conclusions as to its validity and psychometric recommendations to improve the test. The Littlefield/Wallace study concluded that "ADHLEX Patient-based exam content is a representative sample of Dental Hygiene professional skills required by CODA and AHDA standards and, therefore, content validity is excellent. Score reliability is as high as possible given the constraints of only one patient per each candidate." In addition, 4 of the 7 conclusions in the Littlefield/Williams report recommended maintaining the current operation of the test, and the only recommended change for the patient-based exam was to consider using a concurrent validation method, discussed above, to establish score standards. See John Littlefield, PhD, Psychometric Recommendations for the American Dental Hygiene Licensure Exam, 7.

Dr. Klein's "Technical Report on the ADEX/CRDTS Dental Hygiene Licensing Examination" discusses validity of the patient-based exam portions in great detail. Dr. Klein opines that

> "Test validity is in part a function of how many of the important KSAJs [knowledge, skills, abilities and judgments] and tasks the test measures. In general, tests that measure many of a job's most important (i.e. frequent and critical tasks are more valid than tests that cover only a few of these tasks ... Some of the other factors that affect validity are the appropriateness of the weight attached to the different test sections."

Klein, Technical Report on the ADEX/CRDTS Dental Hygiene Licensing Examination, 18 (May 11, 2008). Dr. Klein also mentions that

> "in 2004, the ADEX Hygiene Committee began its task of developing content specification for the current ADEX Hygiene examination. This committee of subject matter experts consisted of representative from the four regional testing agencies (CRDTS, NERB, SRTA, and WREB) and from Hawaii, North Carolina, Florida, and Mississippi (the latter participant also represented Alabama, Louisiana and Puerto Rico)."

Id. 19 (emphasis added). However Dr. Klein focuses on the fact that the oral evaluation section "tests the candidate's ability to recognize whether their own patients have one or more of the specified conditions. It does not assess a candidate's ability to recognize those that might be encountered in a practice environment." Id. 21. The crux of this argument is the fact that CRDTS, WREB and CITA place the oral evaluation test in the performance test while NERB and SRTA do not. Further, inclusion of this portion on a CSCE will only identify a candidate's ability to identify a given condition by picture or verbal description, not by palpation or other sensation. Extra-oral evaluation is a common and critical skill used regularly in a dental hygienist's practice and its inclusion in the performance test is related to on-the-job requirements. *See* Buros Study, Klein Technical Report Appendix A.

Attached to the Klein report as Appendix A is an Occupational Analysis for Hygienists created by the Buros Institute for Assessment Consultation and Outreach at the University of Nebraska. That study was performed to assess the "judgments, skills, and procedures that an entry-level dental hygienist is likely to encounter in practice." Klein, Technical Report, 29. Skills rated in the Buros study included soft tissue management, extra-oral examination, aseptic technique, periodontal probing, scaling, periodontal debridement, deep scaling, and calculus removal. Id. 34. Procedure frequency and criticality were rated on the on 4-point scales (1= never to 4= daily), with all of the above categories rated at 3.40 or higher – meaning these skills were utilized virtually every day. See Id. Table A.3, 34. In addition the above skills were rated for mouth criticality with each receiving a rating of 3.11 to 3.96 rating. Id.

The Buros study was then reviewed by a panel consisting of two experienced dentists and two experienced hygienist (one each from CRDTS and NERB) to ensure that each of the identified criteria was addressed in the Computer Simulated Clinical Exam or the ADEX performance tests. "This 'cross-walk' between the ADEX/CRDTS examination and the occupational analysis found that all of the important and/or critical tasks were covered by the CSCE and/or the performance test." Klein, Technical Report, 21.

Dr. Klein's only real issue with the ADHLEX becomes truly apparent in Chapter 7, "Statistical Analysis Results." It is here that Dr. Klein compared the statistical reliability of particular test sections with their overall weighted score. He concludes that "the only sections that have a real impact on pass/fail decisions are calculus removal (which by far carries the most weight) and oral evaluation. The disproportional weight attached to the oral evaluation section is of concern given the problems with this section that were discussed in Chapter 6." Klein, Technical

Report, 24. The calculus removal section contains 56 of 100 points and the oral evaluation 14 of 100. In this instance it is particularly important to remember the legal standard by which a test will be measured by a court of law. Under the rational relationship test, "the focus ... is not whether the state has superior means available to accomplish its objectives, but whether the means it has chosen is a reasonable one." *Tyler*, 517 F.2d at 1101-1102. And again, "it is not the province of this Court to order an examinee certified when in the judgment of the certifying board his performance does not meet the standard of the profession." *Wilner*, 285 N.W.2d 435 (quoted in *Baji*, 2001 WL 111646).

Conclusion

When a state licensing board has adopted a licensing examination, unless upon review that examination is found to be facially discriminatory, the test is subject to the rational relationship standard. Here, the state boards of licensing of more than 20 states have accepted the ADHLEX. This acceptance is based on the extensive research and content validity that has been a part of the test since its inception. ADHLEX have continued to improve the test based on the available data and input from content experts in the field. The question to be answered is not whether the test is perfect, but whether "the means chosen is a reasonable one." *Id.*

Therefore, for the reasons stated above, in our opinion, the ADHLEX is both valid and reliable and therefore the results of the examination can be relied upon by State Boards of dental examiners in making their licensure decisions. Though there can be no guarantee of the outcome of any particular lawsuit, as each case will be decided on its own facts, (which may include factors peculiar to a particular examination site, the conduct of the examiners, or the candidate during the course of the examination, etc.); nonetheless, it is reasonable to expect that the results of the ADHLEX can be successfully defended and licensure decisions made based upon the ADHLEX examination, as administered by CRDTS, will be upheld.

Very truly yours,

H. Philip Elwood

HPE/ag
cc: CRDTS Steering Committee Members
CRDTS Executive Committee Members
Jerry Holley, Executive Director
Lynn Ray, Director of Data Processing and Analysis
Kimber Cobb, Director of Dental Exams, Development & Administration
Kim Laudenslager, Director of Dental Hygiene Exams, Development & Administration

A170018

Cone Beam Computed Tomography (CBCT)

1. Who can own a CBCT unit in your state? Is it considered a dental or medical device?

From VDH's Certificate of Public Need (COPN) Program- A determination was made that the use of CT (cone beam or otherwise) in a dentist's office for dental imaging was not subject to COPN. If, however, they use the equipment for other facial or cranial imaging (like other CTs) then they have to comply with the same rules as the other CT providers, meaning, they need a COPN.

From VDH's Division of Radiological Health perspective anyone may own an X-ray machine, but see Question 2 for usage.

The U.S. Food and Drug Administration FDA)regulates the manufacture of medical devices and diagnostic radiation producing machines. It appears the manufactures for several of devices are certified for use as both medical use and dental use.

The states have authority for the use radiation producing machines (VDH) and licensure of health professionals using these devices (Department of Health Professions).

VDH classifies these devices based on the type of practice the machine is installed, i.e. dental facilities.

2. Who can operate the CBCT unit in your state? What qualification must these individuals possess.

The applicable regulations VDH has promulgated follows:

12VAC5-481-1590 General and administrative requirements

Section A item 14

14. The registrant shall maintain a list of X-ray machine operators for each facility. The following information will be maintained on the list:

The name of the X-ray machine operator. Operators must be licensed by the Department of Health Professions where X-rays are used within the scope of practice or be certified by the ARRT, or an individual enrolled in an accredited program for radiologic technology and under the supervision of a licensed or certified radiological technologist, and if a dental assistant, comply with the Board of Dentistry's radiation certification requirements in 18VAC60-20-195.

12VAC5-481-1640 Computed tomography X-ray systems

Section D Surveys, calibrations, spot checks and operating procedures. Item 4

4. Operating procedures.

a. The CT X-ray system shall not be operated except by an individual who has been specifically trained in its operation.

In addition to VDH regulations, the various licensing boards define the scope of practice with respect to use of various technologies and whether the practitioner is providing the standards of care.

3.Who can interpret the scan and write a report accompanying the imaging study?

Defined by the scope of practice by the appropriate licensing board in Department of Health Professions.

4.Who can bill for the scans?

This could be re-worded to " To whom will insurance carriers reimburse?"

This could also be a two part question. It is possible that services for providing the exam and interpreting the examination could be separate charges.

The State Medical Assistance Services may be of assistance with questions on Medicaid reimbursements.

Regarding regulations, VDH requires registration, periodic inspection and certification of CBCT units. The X-ray machine radiation safety and performance regulations are based on the *Suggested State Regulations* published by the Conference of Radiation Control Program Directors, Inc. Although the regulations do not specifically address some of the evolving technology, the regulations do address items that are generally applicable to all machines. The is a section specific to CT units, 12VAC5-481-1640. In some cases we do reply on the manufacturer's specifications as submitted to the FDA to ensure compliance with the performance standards.

There are 23 dental CT units in Virginia. A list will be provided separately.

Reen, Sandra

From: Cindy Durley [cdurley@danb.org]
Sent: Monday, February 02, 2009 2:36 PM
To: Reen, Sandra
Subject: Digital Impression Technology

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Board Information

Digital Impression Technology

From: **Cindy Durley** 02/02/09
To: **All** 01:36:23 PM
Attachments: **None** 2KO09O9PA

Hi, all-

I apologize in advance for the length of this post! DANB submits an article to be published each month in PennWell's online newsletter, Dental Assisting Digest (DAD). In exchange, PennWell has agreed to allow DANB staff to pre-view the articles shortly before publication, primarily to make sure that no one is calling themselves a CDA who is not (or otherwise misusing DANB trademarks). However we also make comment on article content if it appears to be appropriate. Our comments are taken under advisement by PennWell - they are not considered binding directives.

The DAD issue that was just published contains an article touting Lava COS - technology that allows for digital impression taking. My understanding is that this could be considered analogous to taking a final impression, because it is used to make final impressions. Not all states allow dental assistants to take final impressions, and those that do, require some advanced education/exam/credential to do so, and usually under some specific level of dentist supervision.

If you are interested in receiving a pdf of this article, let me know because I don't know how to attach one here. Based on my comment, the publisher indicated that since some states may not allow dental assistants to use this technology, the reader should check with their state's dental board. Therefore, you may be receiving some calls or emails from dentists and assistants.

At first I contacted our fellow AADA members in MN, MA, and WA because the three dental assistants quoted in the article are from those three states. However, last week I received a call from Kevin Thomas of 3M ESPE, manufacturer of this product, wondering if DANB knew if dental assistants could use it. I told him this would be a state by state decision, but I would posts the question on the AADA listserv. 3m ESPE's logic is this: Since the Lava COS system is an intraoral camera, if dental assistants can take intraoral photos in a given state, can they be delegated the use of this technology? Another question is this: Must the dentist first review the diagnostic quality of the intraoral image before it is digitally transmitted to the lab to make final impressions?

Please understand that DANB has no vested interest in whether or not your state allows use of this technology. What we do care about is whether or not it is considered taking final impressions vs taking intraoral photos, because we have test questions and are developing test questions for various states on final impression taking, and would like to know if DANB should be testing on this technology in general.

In addition, staff from ADA's Council on Dental Practice called me last week to see if I knew anything about the legality of delegating use of this technology to dental assistants in any given state, so I told that Council's manager I would reach out to each of you.

Again, let me know if you want a pdf of the article.

Cindy Durley
DANB Executive Director
cdurley@danb.org

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Reen, Sandra

From: Dematteo, Rose
Sent: Monday, November 17, 2008 4:10 PM
To: Reen, Sandra; Heaberlin, Alan
Subject: FW: Board Requirements

FYI below

R. E. DeMatteo
Compliance Case Manager
804-367-4500
Board of Dentistry
Department of Health Professions
9960 Mayland Dr, Suite 300
Richmond, VA 23233-1463

From: [redacted]
Sent: Monday, November 17, 2008 4:03 PM
To: Dematteo, Rose
Subject: Board Requirements

Ms. Dematteo,

Today I faxed you the results of the PSI VA Dental Law Exam which should be the final requirements for me from the Virginia Dental Board.

I would like to personally thank you for your help in this matter.

Actually, I would like to also thank the members of the Board for forcing me to update my record keeping practices. Although I had made many improvements over the 39 years in practice, my record keeping did need improvement, especially in the type of practice that I have. No one likes to be called before the Board, especially with only a couple of years left to practice, but I feel, now that my requirements are fulfilled, it was probably a blessing that I was and was required to take the risk management course and a test on VA Law. So sincerely thank the Board for their dedication to Dentistry and the important work that they do in my behalf.

Sincerely,

[redacted]D.D.S.

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