Friday, November 17, 2017

Dental Hygiene Committee of California

Full Committee

Agenda

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815
P (916) 263-1978 | **F** (916) 263-2688 | **www.dhcc.ca.gov**

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

DHCC MEETING AGENDA

The DHCC welcomes and encourages public participation in its meetings. The public may take appropriate opportunities to comment on any issue before the Committee at the time the item is heard.

Friday, November 17, 2017
DHCC Headquarters Building
2005 Evergreen Street, 1st Floor
Hearing Room
Sacramento, CA 95815
9:00 am until adjournment

AGENDA

1. Roll Call & Establishment of Quorum

2. Public Comment for Items Not on the Agenda

[The DHCC may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 & 11125.7(a)]

3. President's Report

4. Approval of the June 10, 2017, Full Committee Meeting Minutes

5. Interim Executive Officer's Report
- Personnel
- DCA Reporting Year – Mandatory Staff Trainings
- Office Location
- Sunset Review
- IEO Activities

6. Update from the Dental Board of California

7. Budget Report – DCA Budget Office to Provide Report

8. Presentation from the Office of Statewide Health Planning and Development on Underserved Areas of California

9. Update and Presentation from the Central Regional Dental Testing Services

10. Discussion and Possible Action on Final Revisions to Adopt the 2017 DHCC Sunset Review Report to the Legislature

Recess to Convene Subcommittee Meetings of the Dental Hygiene Committee of California

Subcommittee Meetings for Friday, November 17, 2017 – See Attached Agendas for Subcommittee Items

11. Education Subcommittee:
See Attached Agenda

12. Enforcement Subcommittee:
See Attached Agenda

13. Licensing and Examination Subcommittee:
See Attached Agenda

14. Legislative and Regulatory Subcommittee:
See Attached Agenda

Recess to Reconvene the Full Committee

15. Closed Session – Full Committee

The DHCC may meet in closed session to deliberate on disciplinary matters pursuant to Government Code §11126 (c)(3)

Return to Open Session

16. Recess until Saturday, November 18, 2017 at 9:00 am

Public comments will be taken on agenda items at the time the specific item is raised. The DHCC may take action on any item listed on the agenda including informational only items. All times are approximate and subject to change. Agenda items may be taken out of order to accommodate speakers and to maintain a quorum. The meeting may be cancelled without notice. For verification of the meeting, call (916) 263-1978 or access DHCC's Web Site at **www.dhcc.ca.gov**.

The meeting facilities are accessible to individuals with physical disabilities. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Brittany Alicia at (916) 576-5001, via e-mail at: brittany.alicia@dca.ca.gov or send a written request to DHCC at 2005 Evergreen Street, Ste. 2050, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation.

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 2

Public Comment for Items Not on the Agenda

[The DHCC may not discuss or take action on any matter raised during the Public Comment section that is not included on this agenda, except whether to decide to place the matter on the agenda of a future meeting (Government Code §§ 11125 & 11125.7(a)]

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 3

President's Report
- **Activities**

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 4

Approval of the June 10, 2017 Full Committee Meeting Minutes

Dental Hygiene Committee of California Meeting Minutes

Saturday, June 10, 2017

Embassy Suites Irvine
2120 Main Street
Irvine, CA 92614

Dental Hygiene Committee of California (DHCC) Members Present:
Noel Kelsch, Registered Dental Hygienist (RDH)
Susan Good, Vice President, Public Member
Evangeline Ward, Secretary, RDH
Michelle Hurlbutt, RDH Educator
Timothy Martinez, Public Health Dentist
Nicolette Moultrie, RDH
Edcelyn Pujol, Public Member
Garry Shay, Public Member

DHCC Member Absent:
Sandra Klein, Public Member

DHCC Staff Present:
Anthony Lum, Interim Executive Officer
Estelle Champlain, Legislative and Regulatory Analyst
Adina Pineschi-Petty, Doctor of Dental Surgery (DDS), Education Specialist
Norine Marks, Department of Consumer Affairs (DCA) Legal Counsel for the DHCC

Public Present:
Ana Garcia Brady, Student , Taft College Dental Hygiene Program (TCDH)
Diana Champion, Faculty Member, TCDH
Yvonne Chavez, Student, TCDH
Edward Cramp, Legal Counsel for Concorde Career College – Garden Grove (CCC-GG)
Debra Daniels, President, Taft College
Kelly Donovan, Faculty, TCDH
Nicholas Ewell, President, CCC-GG
Natalie Ferrigno, West Los Angeles College
Glenda Flora
JoAnn Galliano, RDH, Education Consultant
Arezou Goshtasbi, DDS, Program Director, CCC-GG
Jeanice Howard, California Dental Hygiene Educators' Association (CDHEA)
Sandra Jennings, TCDH
Vickie Kimbrough, California Dental Hygienists' Association (CDHA)
Michelle Matthews, Clinic Technician, TCDH
Mary McCune, California Dental Association (CDA)
Aubree Often, TCDH

Arlene Parker, RDH, CDHA,
Maryann Pedersen, CDHA
Kathy Royce, Dean Health Sciences, Shasta College
Kelly Reich, Western Regional Examining Board (WREB)
Annette Stelter, Orange County Dental Hygienists' Society (OCDHS)
Klara Studer, Student, TCD

Call and Establishment of a Quorum

Noel Kelsch, President of the Dental Hygiene Committee of California (DHCC), called the meeting to order at 3:18 p.m. She took roll call and a quorum was established with eight members present. Sandra Klein was absent and excused.

President Kelsch reminded the DHCC and the public that the mission of the DHCC was consumer protection. She thanked all attendees for taking the time to participate.

President's Report

President Kelsch stated that there would be no President's Report for this meeting.

Public Comments for Items Not on the Agenda

There were no comments from the public.

Education Subcommittee Report – Discussion and Possible Action Regarding Continued Approval of the Registered Dental Hygiene Education Program at Concorde Career College-Garden Grove & Substantial Changes to their Program

Michelle Hurlbutt, Chairperson of the Education Subcommittee, reported that the Subcommittee recommended that the DHCC withdraw its approval of the Registered Dental Hygienist (RDH) Education Program at Concorde Career College-Garden Grove (CCC-GG) due to the program's continued noncompliance. Chair Hurlbutt asked if any of the DHCC members would like to make comments.

Garry Shay requested that the representatives from CCC-GG be given the floor so that they could make statements, if they would like, prior to the DHCC's discussion on the matter.

Nicholas Ewell, Campus President of CCC-GG; Arezou Goshtasbi, DDS, Program Director at CCC-GG; and Edward Cramp, Legal Counsel for CCC-GG, came forward to present comments.

Public Comment: Mr. Ewell apologized for the errors of the program and requested that the RDH Education Program at CCC-GG could move forward without conditions, but he added that he would be willing to work with the DHCC on the program moving forward with reasonable conditions, should that be the DHCC's decision. He also stated that he and his colleagues would be happy to answer any questions the DHCC may wish to ask.

Mr. Shay stated that he had heard, during the testimony given to the Education Subcommittee, that administrators at CCC-GG had taken measures to come into compliance. He stated that he would like to know more specifically what those measures consisted of. He asked Mr. Ewell to provide concrete examples.

Mr. Ewell replied that he had hired a new staff member with a working title of "Regional Accreditation Manager" (RAM). The RAM was tasked specifically with monitoring the school's compliance with California's laws. He clarified that the initial responsibility for compliance with laws would remain in the hands of the program director on campus; however, the RAM was added to provide support.

President Kelsch asked when the RAM was hired and whether this position had already existed or whether it was newly created.

Mr. Ewell replied that it had been about a month-and-a-half since the RAM for California was hired. He stated that the company had already retained a person responsible for accreditation across the states, but the new RAM position was different in that the role was specific to a region.

Mr. Shay requested that Mr. Ewell provide the job description of the RAM to the DHCC. Mr. Ewell agreed to do so.

Mr. Shay posited that instead of the DHCC provisionally approving CCC-GG with conditions, perhaps it would be better for the DHCC to withdraw approval, conditionally suspend the withdrawal of approval, and monitor to see whether the conditions were satisfactorily met. If the conditions were satisfactorily met, then the DHCC could move forward with approval of the program. But if the conditions were not met, the decision to withdraw approval would stand.

Norine Marks, Legal Counsel for the DHCC, stated that while California's regulations did not specifically state that this option existed, the regulations did state that the DHCC had the authority to grant approval or to withdraw approval. She continues to state that it would be reasonable to assume that the DHCC could apply conditions to its approval or withdrawal of approval.

Nicolette Moultrie asked whether Dr. Goshtasbi's biosketch had been submitted to the DHCC's staff and whether the staff had verified Dr. Goshtasbi's qualifications. She also asked if CCC-GG had timely notified the Commission on Dental Accreditation (CODA) of the hire.

Dr. Pinseshi-Petty, Education Specialist for the DHCC, answered that Dr. Goshtasbi's biosketch had been submitted, reviewed, and she was found to be qualified. Mr. Ewell answered that CODA was notified less than three days from the date of Dr. Goshtasbi's appointment.

Ms. Moultrie asked whether CCC-GGG had notified CODA of Dr. Roling's appointment. [Dr. Roling was the program director at CCC-GG prior to Dr. Goshtasbi.]

Public Comment: Mr. Ewell admitted that although CCC-GG did notify CODA, the notification to DHCC was missed.

Ms. Moutrie asked if CCC-GG had a new Advisory Committee, whether the Advisory Committee had been informed about CODAs and DHCCs recommendations to CCC-GG, and whether Mr. Ewell would be willing to provide the DHCC with minutes from the Advisory Committee meetings.

Public Comment: Dr. Goshtasbi stated that she believed CCC-GG had notified the Advisory Committee of the recommendations. Mr. Ewell replied that he would provide the Advisory Committee meeting minutes to DHCC.

Susan Good, Vice President of the DHCC, reminded Mr. Ewell that during the Education Subcommittee meeting there were comments from the public regarding lack of communication between CCC-GG and its Advisory Committee. She asked Mr. Ewell if the person making those comments was a member of the Advisory Committee and if not, had CCC-GG notified that person that she was no longer a member of the Advisory Committee. She also asked for an explanation of how Advisory Committee members were selected.

Public Comment: Mr. Ewell replied that CCC-GG's policy was for the program director to recruit and retain the Advisory Committee members. He stated that around two years ago, when he first came to work at CCC-GG, the program director in place at that time, Dr. Bina, had made the decision to recruit some new Advisory Committee members. He stated that since Advisory Committee personnel were handled by the program director, he was not aware of how or if Dr. Bina had notified the Advisory Committee of changes.

Public Comment: Glenda Flora stated that she had never been notified that she was no longer a member of CCC-GG's Advisory Committee and she had attended Advisory Committee meeting even after Dr. Bina was let go. She said she hoped the new members would be vigilant, as she had tried to be.

Chair Hurlbutt asked if there were any other comments or questions from the DHCC.

Mr. Shay stated that he would like to make a substitute motion to the Education Subcommittees' motion:

Substitute Motion: Garry Shay moved to withdraw approval of Dental Hygiene Education Program at Concorde Career College – Garden Grove (CCC-GG); and to stay the withdrawal

of approval for a twelve month period; contingent upon CCC-GG keeping in continuous compliance with all laws, regulations, and CODA Standards; with quarterly reporting to the DHCC of the same.

Chair Hurlbutt stated that she supported Mr. Shay's proposition.

Ms. Marks advised that it would be cleaner to vote on the Education Subcommittee's recommendation first, and only then consider Mr. Shay's proposed substitute.

Vote: The motion from the Education Subcommittee to withdraw approval of the Registered Dental Hygienist Education Program at CCC-GG due to the program's continued noncompliance passed 5:3.

Ms. Marks suggested the DHCC should make a separate motion to add an effective date of withdrawal.

The DHCC expressed concern for CCC-GG's graduating class. They discussed that due to procedural requirements within the regulations, the effective date of withdrawal could not possibly take place before the class of 2017's scheduled graduation; therefore, if graduation were to take place on the date scheduled for the class of 2017, the students would be graduating from an approved program and would be eligible to apply for licensure in California.

Garry Shay moved to stay the withdrawal of approval of the Registered Dental Hygienists Education Program at Concorde Career College-Garden Grove (CCC-GG) for a twelve month period; contingent upon CCC-GG keeping in continuous compliance with all laws, regulations, and CODA Standards; with quarterly reporting to the DHCC of the same.

Second: Nicolette Moultrie

Vice President Good asked whether this would mean the DHCC would have to send subject matter experts to verify the quarterly reports.

Mr. Shay stated that he might support accepting the reports as self-certification since the nature of the current violation was a matter of not timely submitting paperwork. He stated that there were much more egregious violations that would be before the Committee that day and that he would advise keeping things in perspective.

Evangeline Ward stated that from her point of view, the matter of CCC-GG's late filing of paperwork (that was required by law) did warrant more than a "slap on the wrist." She explained that CCC-GG had a history of violations ranging from serious to minor, and that their continued pattern of operating in a state of non-compliance, especially when all they had to do in this instance was file papers on time, was a serious matter indeed. She added that students were required to adhere to rules at CCC-GG, so it would be inconsistent for their administrators to be held to a lower standard. Additionally, she stated that it was unfair that students and their families who had payed tuition and fees and placed their trust in CCC-GG were now facing the program being in jeopardy. She noted that the repeat violations, including easily avoidable violations such as timely filing paperwork, had cost these students, their families, and DHCC's time and resources.

President Kelsch stated that she appreciated Mr. Shay's suggestion but she had reservations. She stated that CCC-GG's administrators had a responsibility to know the California Dental Practice Act and to stay abreast of any changes and updates. She noted that if they had fulfilled this basic responsibility they would not be before the DHCC.

Edcelyn Pujol stated that she based her decision to vote in favor of withdrawing approval because that the violations were continuous, not because of a specific violation.

Ms. Moultrie stated that she recognized there was a pattern of non-compliance, but there was also another pattern in that CCC-GG had made significant progress to come into compliance on the most egregious violations. She viewed the most recent violation (failing to timely notify the DHCC of an appointment of a new program director) in the context of the ongoing process. She added that if conditions, such as those proposed by Mr. Shay, were implemented, this could allow CCC-GG to continue to improve, but if CCC-GG did not do its part, there would be a consequence: namely, DHCC would end the stay and impose withdrawal.

JoAnn Galliano stated that quarterly reports may not be adequate to ensure that CCC-GG was meeting all laws, regulations, and standards. She suggested adding biannual site visits to the conditions.

Mr. Shay replied that he would consider the addition of site visits acceptable. He added that it would be prudent to specify that the DHCC was entitled to conduct unannounced site visits.

There were no statements in opposition.

Mr. Shay amended his motion to read: Motion to stay the withdrawal of approval of the Registered Dental Hygienists Education Program at Concorde Career College-Garden Grove (CCC-GG) for a twelve month period; contingent upon CCC-GG keeping in continuous compliance with all laws, regulations, and CODA Standards; with CCC-GG being required to submit quarterly written reports to the DHCC of the same; and with the DHCC being authorized to conduct unannounced site visits to CCC-GG at the DHCC's discretion.

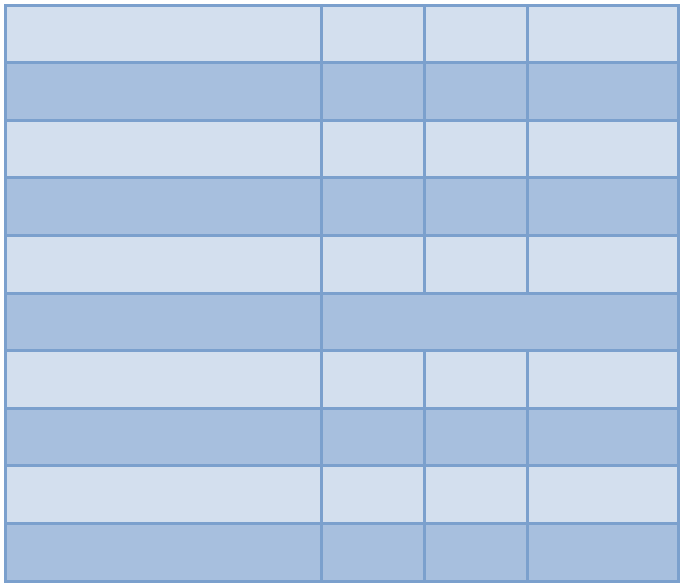
Ms. Marks stated that she would interpret that to mean if the DHCC's site visit resulted in evidence that CCC-GG was not in compliance then the decision to withdraw approval would come back before the DHCC rather than being applied administratively.

No DHCC members objected to Ms. Marks' clarification.

Second: Nicolette Moultrie

Chair Hurlbutt asked if any member of the public would like to make comments. There were none.

Vote: The motion to stay the withdrawal of approval of the Registered Dental Hygienists Education Program at Concorde Career College-Garden Grove (CCC-GG) for a twelve month period; contingent upon CCC-GG keeping in continuous compliance with all laws, regulations, and CODA Standards; with CCC-GG being required to submit quarterly written reports to the DHCC of the same; and with the DHCC being authorized to conduct unannounced site visits to CCC-GG at the DHCC's discretion passed 5:3.



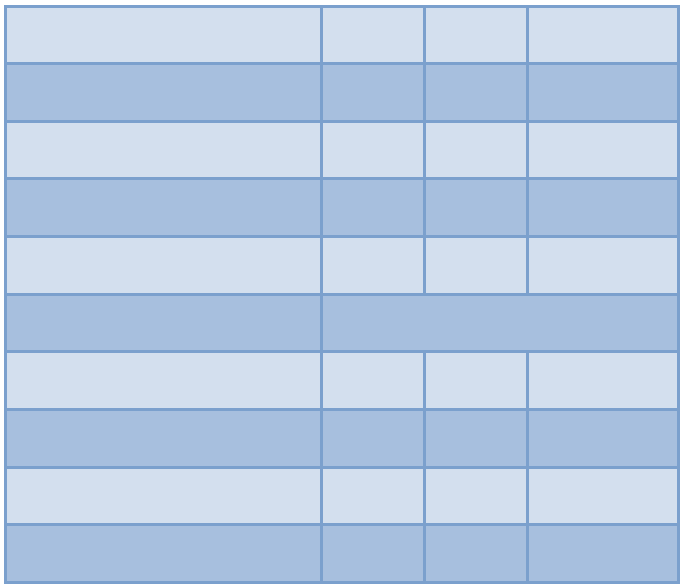
Ms. Marks advised the DHCC to set an effective date.

Motion: Noel Kelsch moved to set the effective date of the withdrawal of DHCC's approval and stay of withdrawal of DHCC's approval of the Registered Dental Hygienist Education Program at Concorde Career College-Garden Grove (CCC-GG) for thirty days from the date the DHCC serves administrators at CCC-GG written notice.

Second: Nicolette Moultrie

Chair Hurlbutt asked if any member of the Committee or public would like to make comments. There were none.

Vote: The motion set the effective date of the withdrawal of DHCC's approval and stay of withdrawal of DHCC's approval of the Registered Dental Hygienist Education Program at Concorde Career College-Garden Grove (CCC-GG) for thirty days from the date the DHCC serves administrators at CCC-GG written notice passed 6:2.



Education Subcommittee Report – Discussion and Possible Action Regarding Shasta College's RDH Education Program Faculty Requirements to Maintain Approval

Chair Hurlbutt reported that the Education Subcommittee did not take any action on the agenda item regarding Shasta College.

She asked if any member of the DHCC would like to discuss the Registered Dental Hygienist Education Program at Shasta College in relation to their faculty requirements to maintain the DHCC's approval. There were no comments.

Chair Hurlbutt asked if any member of the public would like to make comments regarding the Registered Dental Hygienist Education Program at Shasta College. There were no comments.

Education Subcommittee Report – Discussion and Possible Action Regarding Taft College RDH Education Program Requirements to Maintain Approval

Chair Hurlbutt announced that Noel Kelsch had recused herself from the discussion regarding the Registered Dental Hygienist Education Program at Taft College, so for the reminder of the discussion Vice President Good would preside.

Chair Hurlbutt reported that the Education Subcommittee recommended that the DHCC withdraw approval of the Registered Dental Hygienist Education Program at Taft College (TCDH) based on deficiencies in the areas of program completion, grading policies, administrative involvement, documentation integrity, sufficiency of patient pool, and the class of 2017's clinical requirements status.

Chair Hurlbutt asked if any DHCC member would like to make comments. There were none.

Vice President Good asked if anyone from the public, or specifically anyone from TCDH, would like to make comments.

Public Comment: Debra Daniels, President of Taft College, stated that although she had only been with Taft College for 11 months, she had 38 years' experience working in higher education and that she felt it was important for the DHCC to know that so they would understand that she understood the gravity of the situation at TCDH.

Dr. Daniels continued to explain that once she learned of the deficiencies at TCDH, she had worked tirelessly to correct them. She added that her board, advisory committee, faculty, and staff were behind her, and that together they would continue to make corrections until the program was in full compliance. She thanked the DHCC for helping her to identify the discrepancies and stated that she and her team at TCDH would like to work in partnership with the DHCC through the improvement process. She reminded the DHCC that Taft College was an important feature in its small, rural community because it provided members of that community with opportunities that they may not otherwise have by affording them the chance to pursue a college education.

Anthony Lum, Interim Executive Officer for the DHCC, stated that he was curious how this could have happened in the first place if the program was such an important part of the community. He told Dr. Daniels that he had been getting calls from past graduates telling him that the program had been that way for some time. He said that these calls made him

wonder that if TCDH was so important in the community, how would the school be in this situation?

Dr. Daniels stated that the program director, who recently resigned from her position at TCDH, had been in that position for 17 years. Dr. Daniels stated that when she came to work for Taft College it appeared to her that the program director was respected, so she expected her to competently fulfill her responsibilities. She stated that in retrospect, it appeared that the program director had become complacent in her duties.

Public Comment: Kelly Donovan identified herself as a faculty member at TCDH. She stated that she had worked at TCDH for ten years. She directed her reply at Mr. Lum and stated that in answer to his question, the problem was the leadership on campus and that since the leadership had changed, the faculty was rededicated to bringing back professionalism in their program. She noted that the drive from Taft to the present meeting site was over three hours one way - yet there were three faculty members, two support staff members, plus several current and past students in attendance. She stated that they had all come to show their support for Dr. Daniels and their willingness to get their program back on track.

Chair Hurlbutt replied that as a program director herself, she understood that leadership is critical; nonetheless, the evidence showed that at least some faculty members participated in behavior such as signing off on things they did not see students actually do. She stated that such acts could be seen as breaching standards of professional ethics. She stated that she was concerned that TCDH was retaining faculty who had been part of that problem.

Dr. Daniels replied that it would be difficult for her to answer for specific incidences since she was not there at the time of the violations, but she believed that the complacency in enforcing stricter standards was a product of a complacent program director. She admitted that changing this culture within the school would take some effort but that she was committed to making it right.

Ms. Ward stated that her concern was that the unprofessional training environment may result in RDHs who think it is normal and acceptable to take the act of signing off on patient records lightly. She said this may create a situation where those RDHs would find themselves personally before the DHCC having to explain their conduct, and they may potentially end up losing their licenses. She noted that this would be unfortunate if they were only behaving how they were trained to behave. She warned that it may be advisable for TCDH to "weed out" the offending faculty members.

Ms. Donovan stated that there were faculty members at TCDH who spoke out against those practices, but during the time the former leadership was in place, the faculty's complaints were not addressed in a serious manner.

Public Comment: Ana Garcia Brady stated that as a student she was troubled that every time students filed complaints with the Office of Student Services or the Vice President, the students' concerns were not heard. She stated that she and others had repeatedly talked to school officials "asking for help, somebody's got to help us." She explained that it was

frustrating for her because she had "followed the chain of command" and "gone where they were directing you to go" but when she went through the established grievance process, she realized that there was "nowhere to go because they don't hear you."

Chair Hurlbutt asked Ms. Brady if she had confidence in Dr. Daniels and with the current leadership at the school.

Ms. Brady replied that she thought Dr. Daniels was doing the best she could. She noted that she had emailed Dr. Daniels several times and Dr. Daniels always responded and seemed open. She also mentioned that it was encouraging for her to see that the faculty and staff were making changes to the clinics and they seemed to be fixing problems.

Ms. Brady continued to explain that one significant problem remained, and that problem was that students needed answers. She explained that for the graduating class it was hard to not know what to expect in terms of a graduation date. She said she and several others had to commute to school and there was an expense involved. She also stated that she and others needed to be able to start working full time because families depended on their income and budgets had been planned for a certain gradation date - but now that date was changing and uncertain.

Chair Hurlbutt stated that she would like to remind those present that regulations required that prior to the effective date of DHCC's withdrawal of approval of an RDH education program, that program's administrators must be given the opportunity to attend an informal conference with the DHCC's executive officer. During that meeting, the executive officer may consider further evidence and make a determination of whether or not to uphold the DHCC's withdrawal of approval.

She continued to explain that if the DHCC were to decide to withdraw approval of TCDH, since there was evidence that remediation efforts were underway at TCDH, it may be worthwhile for the DHCC to consider adopting a withdrawal of approval date set for far enough into the future to allow TCDH to make measurable headway on their remediation so that they could have the opportunity to present evidence to the Executive Officer during their informal hearing.

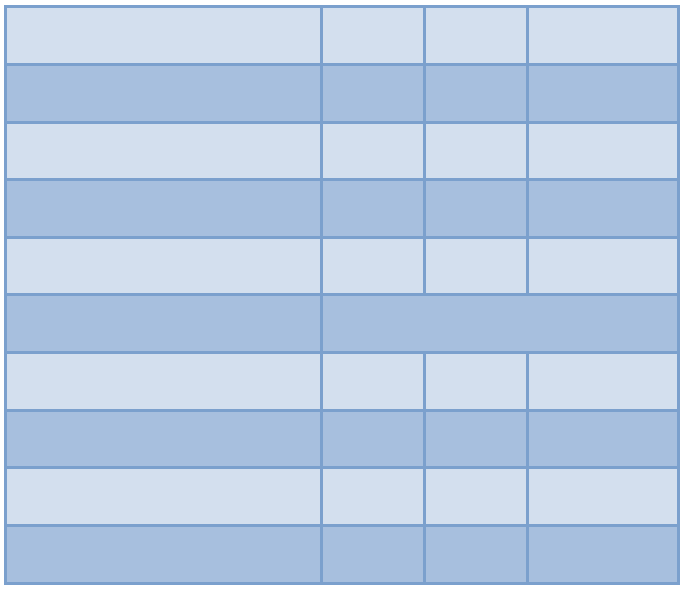
DHCC members and Ms. Marks discussed timing possibilities and determined that it would be best to first vote on the motion, then to sort out details as needed.

Vice President Good asked if any other DHCC members or members of the public would like to make comments. There were none.

President Kelsch asked if any member of the public would like to comment on the motion. There were no public comments.

Vote: The motion to withdraw approval of the Registered Dental Hygienist Education Program at Taft College based on deficiencies in the areas of program completion,

grading policies, administrative involvement, documentation integrity, sufficiency of patient pool, and the class of 2017's clinical requirements status passed 7:0.



Vice President Good stated that the DHCC would entertain any motions on timelines and details for the withdrawal of approval.

Motion: Nicolette Moultrie moved to set the date of DHCC's withdrawal of approval for October 1, 2017.

Second: Garry Shay.

Vice President Good asked if any DHCC member would like to comment.

The DHCC discussed the merits of setting the withdrawal in terms of a number of days as opposed to a specific date. Ms. Marks recommended setting the withdrawal's effective date as a number of days from the date on which DHCC serves TCDH with written notice of the action.

Ms. Moutrie withdrew her motion.

Mr. Shay withdrew his second to the motion.

Motion: Nicolette Moultrie moved to set the date of DHCC's withdrawal of approval of the Registered Dental Hygiene Education Program at Taft College (TCDH) for 30 days from the date the DHCC serves administrators at TCDH with written notice of the same.

Second: Garry Shay.

Vice President Good asked if any DHCC member would like to comment.

Chair Hurlbutt stated that she was concerned that 30 days may not be enough time.

Ms. Marks explained that the event that would determine how much time TCDH has to correct their deficiencies is the service of notice. She explained that it may take the Executive Officer any number of days to prepare the notice and to serve it to the administrators at the school.

Chair Hurlbutt reminded her fellow members that in the past, that there had been an occasion in which another RDH education program in California was served with a notice of intent to withdraw approval, and when that happened the school was given around 90 days. She requested that her fellow members would consider whether it would be fair to give TCDH any less time.

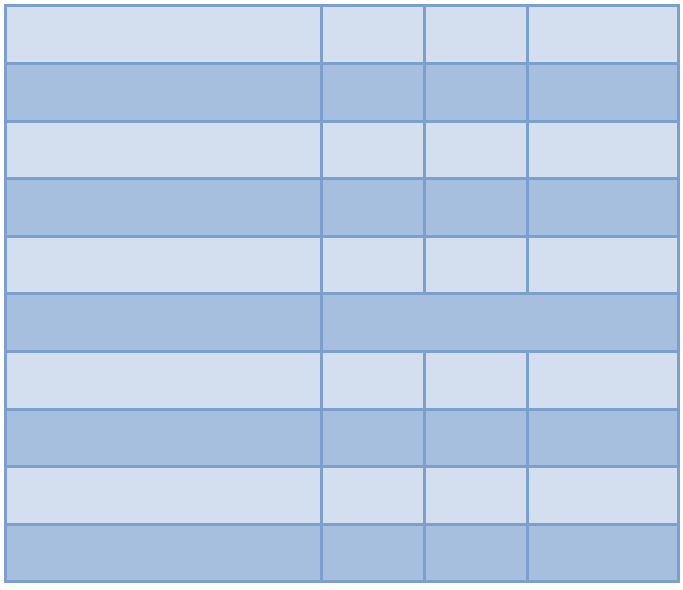
Vice President Good asked if any member of the public would like to comment on the motion.

Public Comment: JoAnn Galliano, Education Specialist for the DHCC, stated that she shared Chair Hurlbutt's concern.

Ms. Marks advised that the law did not preclude the Executive Officer from exercising judgement on scheduling the date of the informal conference.

There were no further comments.

Vote: The motion to set the date of DHCC's withdrawal of approval of the Registered Dental Hygiene Education Program at Taft College (TCDH) for 30 days from the date the DHCC serves administrators at TCDH with written notice of the same passed 7:0.



Ms. Moultrie asked that students who were concerned should contact Anthony Lum, DHCC's Interim Executive Officer, at his office so that he could explain the procedures for withdrawal of approval and appeals directly to them. Chair Hurlbutt stated that Mr. Lum should also post information on the DHCC's website regarding the withdrawal of approval and appeals process.

Chair Hurlbutt concluded the Education Subcommittee's report, and then President Kelsch rejoined the meeting.

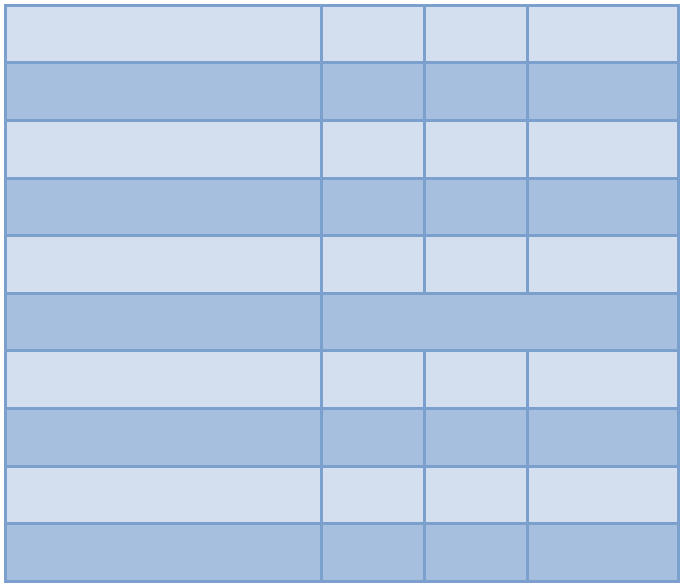
Approval of the May 6-7, 2017, Full Committee Minutes

Motion: Garry Shay moved to approve the May 6-7, 2017, Full Committee Meeting Minutes.

Second: Nicolette Moultrie.

President Kelsch asked if any member of the DHCC or the public would like to comment. There were no comments.

Vote: The motion to approve the May 6-7, 2017, Full Committee Meeting Minutes passed 7:0.



Discussion and Possible Action on the Revised Duty Statement for the Executive Officer

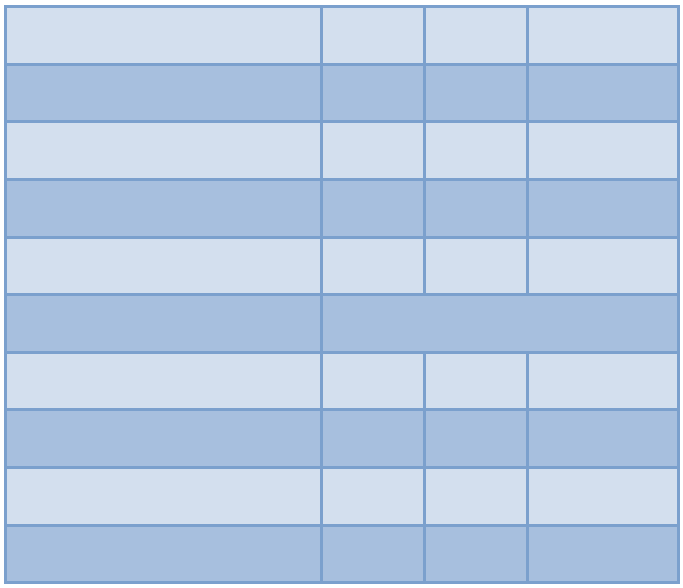
President Kelsch reported that she and Sandra Klein worked with the Department of Consumer Affairs' Chief of Human Resources on the document.

Motion: Garry Shay moved to adopt the Revised Duty Statement for the Executive Officer.

Second: Evangeline Ward.

President Kelsch asked if any member of the public or the Subcommittee would like to comment. There were no comments.

Vote: The motion to the Revised Duty Statement for the Interim Executive Officer passed 8:0.



Future Agenda Items

President Kelsch asked if any member of the DHCC or the public would like to suggest future agenda items. There were none.

President Kelsch adjourned the DHCC meeting at 5:00 p.m.

DHCC
Dental Hygiene
Committee
of California

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 5

Interim Executive Officer's Report:

- **Personnel**
- **DCA Reporting Year: Mandatory Staff Trainings**
- **Office Location**
- **Sunset Review**
- **Activities**

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 6

Update from Dental Board of California (DBC)

A Verbal Report Will Be Provided

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 7

Budget Report:

DCA Budget Office to Provide Report

DENTAL HYGIENE COMMITTEE - FUND 3140
BUDGET REPORT

OBJECT DESCRIPTION	FY 2016-17 ACTUAL EXPENDITURES (MONTH 13)	FY 2017-18 2017 BUDGET ACT
PERSONNEL SERVICES		
Salary & Wages (Staff)	391,591	**489,000**
Statutory Exempt (EO)	87,156	**82,000**
Temp Help Reg (907)	96,293	**57,000**
Temp Help (Exam Proctors)	0	**2,000**
Committee Spc 911 Per Diem	7,100	**0**
Committee Spc 961 Special Per Diem	0	**24,000**
Overtime	9,132	**0**
Staff Benefits	238,222	**276,000**
TOTALS, PERSONNEL SVC	829,494	**930,000**
OPERATING EXPENSE AND EQUIPMENT		
General Expense	6,146	**13,000**
Fingerprint Reports	0	**3,000**
Minor Equipment	1,690	**0**
Printing	32,514	**6,000**
Communication	3,677	**7,000**
Postage	5,411	**16,000**
Insurance	10	**0**
Travel In State	29,951	**14,000**
Training	453	**3,000**
Facilities Operations	55,989	**30,000**
Utilities	0	**1,000**
C & P Services - Interdept.	0	**24,000**
C & P Services - External	15,421	**37,000**
DEPARTMENTAL SERVICES:		
OIS Pro Rata	328,663	**326,000**
Admin/Exec	128,500	**137,000**
Interagency Services	0	**30,000**
IA w/ OPES	5,372	**0**
DOI-ProRata Internal	2,760	**4,000**
Communications Div	14,446	**9,000**
PPRD Pro Rata	654	**8,000**
INTERAGENCY SERVICES:		
Consolidated Data Center	3	**4,000**
DP Maintenance & Supply	0	**3,000**
EXAMS EXPENSES:		
Exam Supplies	0	**8,000**
Exam Site Rental-Non State	0	**24,000**
C/P Svcs-External Expert Administration	4,137	**254,000**
C/P Svcs-External Expert Examiners	0	**25,000**
ENFORCEMENT:		
Attorney General	86,463	**47,000**
Office Admin. Hearings	8,458	**3,000**
Court Reporters	175	**0**
Vehicle Operations	0	**8,000**
Major Equipment	25,685	**25,000**
TOTALS, OE&E	756,578	**1,069,000**
TOTAL EXPENSE	1,586,072	**1,999,000**
Sched. Reimb. - Fingerprints	0	**(5,000)**
Sched. Reimb. - External/Private/Grant	(1,410)	**(1,000)**
Unsched. Reimb. - Probation Monitoring Fee	(12,924)	**0**
Unsched. Reimb. - Investigative Cost Recover	(6,250)	**0**
Unsched. - DOI ICR Civil Case Only	(360)	**0**
NET APPROPRIATION	1,565,128	**1,993,000**

*2018-19 Governor's Budget will be released on January 10, 2018.

3140 - State Dental Hygiene Fund
Analysis of Fund Condition

9/18/2017

(Dollars in Thousands)

2017 Budget Act
w/ FM 13

		Actual 2016-17	CY 2017-18	BY 2018-19
BEGINNING BALANCE		$ 1,844	$ 2,014	$ 1,488
Prior Year Adjustments		$ 2	$ -	$ -
Adjusted Beginning Balance		$ 1,846	$ 2,014	$ 1,488
REVENUES, TRANSFERS, AND OTHER ADJUSTMENTS				
Revenues:				
125600	Other regulatory fees	$ 15	$ 13	$ 13
125700	Other regulatory licenses and permits	$ 185	$ 165	$ 165
125800	Renewal fees	$ 1,557	$ 1,391	$ 1,391
125900	Delinquent fees	$ 27	$ 18	$ 18
142500	Miscellaneous services to the public	$ 2	$ -	$ -
150300	Income from surplus money investments	$ 15	$ 3	$ 3
161400	Miscellaneous revenue	$ 20	$ 4	$ 4
Total Revenues		$ 1,821	$ 1,594	$ 1,594
Total Revenues, Transfers, and Other Adjustments		$ 1,821	$ 1,594	$ 1,594
Total Resources		$ 3,667	$ 3,608	$ 3,082
EXPENDITURES				
Disbursements:				
8880	Financial Information System for CA (State Operations)	$ 3	$ 2	$ 2
1111	Program Expenditures (State Operations)	$ 1,565	$ 1,993	$ 2,033
9900	Statewide General Administrative Expenditures (State Pro Rata)	$ 85	$ 125	$ 125
Total Disbursements		$ 1,653	$ 2,120	$ 2,160
FUND BALANCE				
Reserve for economic uncertainties		$ 2,014	$ 1,488	$ 922
Months in Reserve		11.4	8.3	5.0

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED IN BY+1 AND ON-GOING.

B. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR BEGINNING IN BY+1.

C. ASSUMES INTEREST RATE AT 0.3%.

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 8

Presentation from the Office of Statewide Health Planning and Development (OSHPD):

Underserved Areas of California

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 9

Update and Presentation from the Central Regional Testing Services (CRDTS):

Examination Status and Information

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 10

Discussion and Possible Action on Final Revisions to Adopt the 2017/18 DHCC Sunset Review Report to the Legislature

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
2005 Evergreen Street, Suite 2050 Sacramento, CA 95815
P (916) 263-1978 | F (916) 263-2688 | www.dhcc.ca.gov

MEMORANDUM

DATE	November 17, 2017
TO	DHCC Full Committee
FROM	Anthony Lum, Interim Executive Officer
SUBJECT	FULL 10 - Discussion and Possible Action on Final Revisions to Adopt the 2018 DHCC Sunset Review Report to the Legislature

Background

2017 is the year that the DHCC must work on a Sunset Review Report to submit to the Joint Legislative Sunset Review Committee (JLSRC) by the December 1, 2017 deadline. The DHCC President appointed the Sunset Review Subcommittee at the May 7, 2017 meetings to address the 2018 DHCC Sunset Review Report workload that will be sent to the JLSRC. After receiving the report template questions at the beginning of September, the subcommittee was able to meet for the first time on September 6, 2017. A follow-up teleconference was conducted on October 12, 2017 to continue the work on areas that were not addressed in the prior meeting. In the meantime, and over several months, staff worked diligently to accumulate all of the data that is presented in the draft report.

In lieu of conducting an additional meeting to solely address sunset, the draft Sunset Review Report was sent to the members on November 7, 2017 and the subsequent attachments on November 9, 2017 for review. Instructions to all of the members were provided to review the draft report and bring any suggestions or revisions to the November open meeting for discussion and action.

Committee Action Requested

□ Staff requests the Full Committee to approve the draft 2017/18 Sunset Review Report and attachments and authorize the Interim Executive Officer to make any technical and non-substantive changes to the language and move forward with the report for submission to the JLSRC.

DENTAL HYGIENE COMMITTEE OF CALIFORNIA
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of December 1, 2017

Section 1 – Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.[1] Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

In 2002, the Joint Legislative Sunset Review Committee (JLSRC) agreed that "dental hygienists had reached the point where their responsibilities warranted a regulatory body, separate from Dental Board of California (DBC)." The Dental Hygiene Committee of California (DHCCC) was created in fiscal year (FY) 2009/10 as result of the passage of Senate Bill (SB) 853 (Ch. 31, Statutes of 2008) in 2008.

As an independent committee, the DHCC represents the only self-regulating dental hygiene agency of its kind in the United States. The DHCC has the authority regarding all aspects of the licensing, enforcement, and investigation authority regarding all dental hygienists, and the approval of dental hygiene educational programs in California that provide the prerequisite education to become a licensed dental hygienist. According to the Business and Professions Code (BPC), Section 1900, the purpose of the DHCC is "to permit the full utilization of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions in order to meet the dental care needs of all of the state's citizens."

The DHCC is responsible for overseeing three categories of dental hygienists: registered dental hygienist (RDH), registered dental hygienist in alternative practice (RDHAP), and registered dental hygienist in extended functions (RDHEF). As a self-regulating agency, the DHCC develops and administers written licensing examinations, conducts occupational analyses of the various professional categories, evaluates educational courses, pursues legislation, establishes regulations, approves educational programs, and has licensing and enforcement responsibilities of the profession. The DHCC also participates in outreach and support of the dental and dental hygiene community with the goal of ensuring the highest quality of oral healthcare for all Californians. The DHCC regulates the dental hygiene profession by the guidance of its statutes contained in the BPC §§ 1900 – 1967.4 (cf., Section 12, Attachment B).

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

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

The make-up of the DHCC consists of nine members (four dental hygienists, four public members, and one practicing dentist) appointed by the Governor. The function of the DHCC is to discuss, deliberate, address, hear public comment, and possibly act upon any programmatic, legislative, or other issue(s) that may affect its professional population, interested stakeholders, but most of all, the consumers of California.

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

a) Education Subcommittee –
The purpose of the Education Subcommittee is to oversee the dental hygiene educational programs and make recommendation to the DHCC on policy matters related to curriculum, faculty, administration, and approval. The oversight includes enforcing dental hygiene program standards to increase consistency, safety, and quality. May also aid in the development of informational brochures and other publications; planning of outreach events for consumers, applicants, and licensees.

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

c) Legislative and Regulatory Subcommittee –
The purpose of the Legislative and Regulatory Subcommittee is to advocate for statutes, promulgate regulations, and adopt policies and procedures that strengthen and support its mandate, mission, and vision. The subcommittee reviews and tracks legislation and makes recommendations to the DHCC. It also creates regulations that govern the profession which affects licensees and enhances consumer protection.

d) Licensing and Examination Subcommittee –
The purpose of the Licensing and Examination Subcommittee is to advise the DHCC on policy matters relating to the examining and licensing of individuals who want to practice dental hygiene in California. This subcommittee maintains licensing standards and the Law and Ethics examination(s) to protect consumers while allowing reasonable access to the profession.

Susan Good, Vice President, Public Member			
Date Appointed: 04/05/2013	Reappointed: 01/17/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Legislative and Regulatory Subcommittee	12/6/2013	Sacramento	No
Education Subcommittee	12/6/2013	Sacramento	No
Full Committee	12/7/2013	Sacramento	No
Full Committee	03/05/2014	Teleconference	Yes

Legislative and Regulatory Subcommittee	05/02/2014	Pomona	Yes
Education Subcommittee	05/02/2014	Pomona	Yes
Full Committee	05/03/2014	Pomona	Yes
Legislative and Regulatory Subcommittee	12/05/2014	Sacramento	Yes
Education Subcommittee	12/05/2014	Sacramento	Yes
Full Committee	12/05/2014	Sacramento	Yes
Full Committee	12/06/2014	Sacramento	Yes
Full Committee	03/02/2015	Teleconference	Yes
Legislative and Regulatory Subcommittee	05/02/2015	Orange	Yes
Education Subcommittee	05/02/2015	Orange	Yes
Full Committee	05/02/2015	Orange	Yes
Full Committee	05/03/2015	Orange	Yes
Full Committee	09/25/2015	Teleconference	Yes
Full Committee	12/05/2015	Sacramento	No
Full Committee	05/06/2016	Los Angeles	No
Legislative and Regulatory Subcommittee	05/06/2016	Los Angeles	No
Education Subcommittee	05/06/2016	Los Angeles	No
Full Committee	05/07/2016	Los Angeles	No
Full Committee	08/20/2016	Sacramento	Yes
Education Subcommittee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference Locations	Yes
Full Committee	05/06/2017	Teleconference (S. Good only) and Irvine	Yes
Legislative and Regulatory Subcommittee	05/06/2017	Teleconference (S. Good only) and Irvine	Yes
Education Subcommittee	05/06/2017	Teleconference (S. Good only) and Irvine	Yes
Full Committee	05/07/2017	Irvine	No
Full Committee	06/10/2017	Irvine	Yes
Education Subcommittee (Taft College)	06/10/2017	Irvine	Yes
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Table 1a. Attendance			
Dr. Michelle Hurlbutt, Dental Hygiene Educator Member			
Date Appointed: 10/21/2009	Reappointed: 08/23/2012, 01/06/2016		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Legislative and Regulatory Subcommittee	12/06/2013	Sacramento	Yes
Licensing Subcommittee	12/06/2013	Sacramento	Yes
Full Committee	12/07/2013	Sacramento	Yes
Full Committee	03/05/2014	Teleconference	Yes
Education Subcommittee	05/02/2014	Pomona	Yes
Legislative and Regulatory Subcommittee	05/02/2014	Pomona	Yes
Full Committee	05/03/2014	Pomona	Yes
Education Subcommittee	12/05/2014	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/05/2014	Sacramento	Yes
Licensing Subcommittee	12/05/2014	Sacramento	Yes
Full Committee	12/05/2014	Sacramento	Yes
Full Committee	12/06/2014	Sacramento	Yes
Full Committee	03/02/2015	Teleconference	Yes
Education Subcommittee	05/02/2015	Orange	Yes
Legislative and Regulatory Subcommittee	05/02/2015	Orange	Yes
Full Committee	05/02/2015	Orange	Yes
Full Committee	05/03/2015	Orange	Yes
Full Committee	09/25/2015	Teleconference	Yes
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Education Subcommittee	05/06/2016	Los Angeles	Yes
Legislative and Regulatory Subcommittee	05/06/2016	Los Angeles	Yes
Licensing Subcommittee	05/06/2016	Los Angeles	Yes
Full Committee	05/07/2016	Los Angeles	Yes
Full Committee	08/20/2016	Sacramento	No
Education Subcommittee (Concorde Career College -Garden Grove)	08/20/2016	Sacramento	No
Full Committee – Strategic Planning	09/24/2016	Sacramento	No
Full Committee	12/03/2016	Sacramento	Yes
Education Subcommittee	12/03/2016	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/03/2016	Sacramento	
Full Committee	12/17/2016	Sacramento and Teleconference Locations	Yes
Full Committee	05/06/2017	Irvine	Yes
Education Subcommittee	05/06/2017	Irvine	Yes
Legislative and Regulatory Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee	06/10/2017	Irvine	Yes

Education Subcommittee (Taft College)	06/10/2017	Irvine	Yes
Sunset Subcommittee Meeting	09/06/2017	Sacramento	Yes
Sunset Subcommittee Meeting 2	10/12/2017	Teleconference	Yes
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Noel Kelsch, President, RDHAP Member			
Date Appointed: 08/23/2012	Reappointed: 01/06/2016		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Enforcement Subcommittee	12/06/2013	Sacramento	Yes
Licensing Subcommittee	12/06/2013	Sacramento	Yes
Full Committee	12/07/2013	Sacramento	Yes
Full Committee	03/05/2014	Teleconference	Yes
Education Subcommittee	05/02/2014	Pomona	Yes
Legislative and Regulatory Subcommittee	05/02/2014	Pomona	Yes
Licensing Subcommittee	05/02/2014	Pomona	Yes
Full Committee	05/03/2014	Pomona	Yes
Legislative and Regulatory Subcommittee	12/05/2014	Sacramento	No
Licensing Subcommittee	12/05/2014	Sacramento	No
Full Committee	12/05/2014	Sacramento	No
	12/06/2015	Sacramento	No
Full Committee	03/02/2015	Teleconference	Yes
Full Committee	05/02/2015	Orange	Yes
Legislative and Regulatory Subcommittee	05/02/2015	Orange	Yes
Licensing Subcommittee	05/02/2015	Orange	Yes
Full Committee	05/03/2015	Orange	Yes
Full Committee	09/25/2015	Teleconference	Yes
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Legislative and Regulatory Subcommittee	05/06/2016	Los Angeles	Yes
Full Committee	05/07/2016	Los Angeles	Yes
Full Committee	08/20/2016	Sacramento	Yes
Education Subcommittee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference	Yes

		Locations	
Full Committee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee (Taft College)	06/10/2017	Irvine	Yes
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Sandra Klein, Public Member			
Date Appointed: 10/25/2015	Reappointed: 01/06/2016		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Education Subcommittee	05/06/2016	Los Angeles	Yes
Legislative and Regulatory Subcommittee	05/06/2016	Los Angeles	Yes
Licensing Subcommittee	05/06/2016	Los Angeles	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Full Committee	08/20/2016	Sacramento	No
Education Subcommittee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	No
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference Locations	Yes
Full Committee	05/06/2017	Irvine	Yes
Education Subcommittee	05/06/2017	Irvine	Yes
Licensing Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee	06/10/2017	Irvine	No
Education Subcommittee	06/10/2017	Irvine	No
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Dr. Timothy Martinez, Dentist Member, Public Health

Date Appointed: 08/23/2012	Reappointed: 01/17/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Education Subcommittee	12/06/2013	Sacramento	Yes
Licensing Subcommittee	12/06/2013	Sacramento	Yes
Full Committee	12/07/2013	Sacramento	Yes
Full Committee	03/05/2014	Teleconference	Yes
Education Subcommittee	05/02/2014	Pomona	No
Enforcement Subcommittee	05/02/2014	Pomona	No
Licensing Subcommittee	05/02/2014	Pomona	No
Full Committee	05/03/2014	Pomona	Yes
Enforcement Subcommittee	12/05/2014	Sacramento	Yes
Licensing Subcommittee	12/05/2014	Sacramento	Yes
Full Committee	12/05/2014	Sacramento	Yes
Full Committee	12/06/2014	Sacramento	Yes
Full Committee	03/02/2015	Teleconference	Yes
Education Subcommittee	05/02/2015	Orange	No
Enforcement Subcommittee	05/02/2015	Orange	No
Full Committee	05/02/2015	Orange	No
Full Committee	05/03/2015	Orange	Yes
Full Committee	09/25/2015	Teleconference	Yes
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Education Subcommittee	05/06/2016	Los Angeles	Yes
Enforcement Subcommittee	05/06/2016	Los Angeles	Yes
Licensing Subcommittee	05/06/2016	Los Angeles	Yes
Full Committee	05/07/2016	Los Angeles	Yes
Full Committee	08/20/2016	Sacramento	Yes
Education Subcommittee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	No
Full Committee	12/03/2016	Sacramento	No
Full Committee	12/17/2016	Sacramento and Teleconference Locations	No
Full Committee	05/06/2017	Irvine	Yes
Education Subcommittee	05/06/2017	Irvine	Yes
Enforcement Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee	06/10/2017	Irvine	Yes
Education Subcommittee (Taft College)	06/10/2017	Irvine	Yes
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Nicolette Moultrie, RDH Member			
Date Appointed:08/23/2012	Reappointed: 01/17/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Enforcement Subcommittee	12/06/2013	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/06/2013	Sacramento	Yes
Full Committee	12/07/2013	Sacramento	Yes
Full Committee	03/05/2014	Teleconference	Yes
Education Subcommittee	05/02/2014	Pomona	Yes
Legislative and Regulatory Subcommittee	05/02/2014	Pomona	Yes
Full Committee	05/03/2014	Pomona	Yes
Education Subcommittee	12/05/2014	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/05/2014	Sacramento	Yes
Full Committee	12/05/2014	Sacramento	Yes
Full Committee	12/06/2014	Sacramento	Yes
Full Committee	03/02/2015	Teleconference	Yes
Enforcement Subcommittee	05/02/2015	Orange	Yes
Legislative and Regulatory Subcommittee	05/02/2015	Orange	Yes
Licensing Subcommittee	05/02/2015	Orange	Yes
Full Committee	05/02/2015	Orange	Yes
Full Committee	05/03/2015	Orange	Yes
Full Committee	09/25/2015	Teleconference	Yes
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	No
Legislative and Regulatory Subcommittee	05/06/2016	Los Angeles	No
Licensing Subcommittee	05/06/2016	Los Angeles	No
Full Committee	05/07/2016	Los Angeles	No
Full Committee	08/20/2016	Sacramento	Yes
Education Subcommittee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference Locations	Yes
Full Committee	05/06/2017	Irvine	Yes
Legislative and Regulatory Subcommittee	05/06/2017	Irvine	Yes
Licensing Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/06/2017	Irvine	Yes
Full Committee (Taft College)	06/10/2017	Irvine	Yes

Sunset Review Subcommittee	09/06/2017	Sacramento	Yes
Sunset Review Subcommittee 2	10/12/2017	Teleconference	No
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Edcelyn Pujol, Public Member			
Date Appointed:01/25/2016	Reappointed: N/A		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Full Committee	05/06/2016	Los Angeles	Yes
Enforcement Subcommittee	05/06/2016	Los Angeles	Yes
Full Committee	05/07/2016	Los Angeles	Yes
Full Committee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference Locations	Yes
Full Committee	05/06/2017	Irvine	Yes
Enforcement Subcommittee	05/06/2017	Irvine	Yes
Licensing Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee (Taft College)	06/10/2017	Irvine	Yes
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Garry Shay, Public Member			
Date Appointed: 04/05/2013	Reappointed: 01/17/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Enforcement Subcommittee	12/06/2013	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/06/2013	Sacramento	Yes
Full Committee	12/07/2013	Sacramento	Yes
Full Committee	03/05/2014	Teleconference	No
Education Subcommittee	05/02/2014	Pomona	Yes

Enforcement Subcommittee	05/02/2014	Pomona	Yes
Licensing Subcommittee	05/02/2014	Pomona	Yes
Full Committee	05/03/2014	Pomona	Yes
Enforcement Subcommittee	12/05/2014	Sacramento	Yes
Full Committee	12/05/2014	Sacramento	Yes
Full Committee	12/06/2014	Sacramento	Yes
Full Committee	03/02/2015	Teleconference	No
Enforcement Subcommittee	05/02/2015	Orange	No
Licensing Subcommittee	05/02/2015	Orange	No
Full Committee	05/02/2015	Orange	No
Full Committee	05/03/2015	Orange	No
Full Committee	09/25/2015	Teleconference	No
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	Yes
Enforcement Subcommittee	05/06/2016	Los Angeles	Yes
Legislative and Regulatory Subcommittee	05/06/2016	Los Angeles	Yes
Full Committee	05/07/2016	Los Angeles	Yes
Full Committee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Legislative and Regulatory Subcommittee	12/03/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference Locations	No
Full Committee	05/06/2017	Irvine	Yes
Enforcement Subcommittee	05/06/2017	Irvine	Yes
Legislative and Regulatory Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee (Taft College)	06/10/2017	Irvine	Yes
	11/17/2017	Sacramento	No
	11/17/2017	Sacramento	No
	11/17/2017	Sacramento	No
	11/18/2017	Sacramento	No

Evangeline Ward, Secretary, RDH Member			
Date Appointed: 02/12/2012	Reappointed: 01/17/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Education Subcommittee	12/06/2013	Sacramento	Yes
Licensing Subcommittee	12/06/2013	Sacramento	Yes
Full Committee	12/07/2013	Sacramento	Yes

Full Committee	03/05/2014	Teleconference	Yes
Education Subcommittee	05/02/2014	Pomona	Yes
Enforcement Subcommittee	05/02/2014	Pomona	Yes
Licensing Subcommittee	05/02/2014	Pomona	Yes
Full Committee	05/03/2014	Pomona	Yes
Education Subcommittee	12/05/2014	Sacramento	Yes
Enforcement Subcommittee	12/05/2014	Sacramento	Yes
Licensing Subcommittee	12/05/2014	Sacramento	Yes
Full Committee	12/05/2014	Sacramento	Yes
Full Committee	12/06/2014	Sacramento	Yes
Full Committee	03/02/2015	Teleconference	Yes
Enforcement Subcommittee	05/02/2015	Orange	Yes
Licensing Subcommittee	05/02/2015	Orange	Yes
Full Committee	05/02/2015	Orange	Yes
Full Committee	05/03/2015	Orange	Yes
Full Committee	09/25/2015	Teleconference	Yes
Full Committee	12/05/2015	Sacramento	Yes
Full Committee	05/06/2016	Los Angeles	No
Enforcement Subcommittee	05/06/2016	Los Angeles	No
Licensing Subcommittee	05/06/2016	Los Angeles	No
Full Committee	05/07/2016	Los Angeles	No
Full Committee (Concorde Career College – Garden Grove)	08/20/2016	Sacramento	Yes
Full Committee – Strategic Planning	09/24/2016	Sacramento	Yes
Full Committee	12/03/2016	Sacramento	Yes
Full Committee	12/17/2016	Sacramento and Teleconference Locations	No
Full Committee	05/06/2017	Irvine	Yes
Enforcement Subcommittee	05/06/2017	Irvine	Yes
Licensing Subcommittee	05/06/2017	Irvine	Yes
Full Committee	05/07/2017	Irvine	Yes
Full Committee (Taft College)	06/10/2017	Irvine	Yes
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/17/2017	Sacramento	
	11/18/2017	Sacramento	

Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)

Susan Good*	04/05/13	01/17/14	01/01/18	Governor	Public
Michelle Hurlbutt	10/21/09	08/23/12, 01/06/16	01/01/20	Governor	Professional
Noel Kelsch	08/22/12	01/06/16	01/01/20	Governor	Professional
Sandra Klein	10/25/15	01/06/16	01/01/20	Governor	Public
Timothy Martinez*	08/23/12	01/17/14	01/01/18	Governor	Professional
Nicolette Moultrie*	08/23/12	01/17/14	01/01/18	Governor	Professional
Edcelyn Pujol	01/25/16	N/A	01/01/20	Governor	Public
Garry Shay*	04/05/13	01/17/14	01/01/18	Governor	Public
Evangeline Ward*	02/12/12	01/17/14	01/01/18	Governor	Professional

**DHCC members whose term expires on January 1, 2018. Unless reappointed, there is still a 1-year grace period in which these members can continue to serve the DHCC.*

2. In the past four years, was the board unable to hold any meetings due to lack of quorum?

   If so, please describe. Why? When? How did it impact operations?

   The DHCC has been privileged to have dedicated and engaged members (both currently and in the past) that participate in the DHCC meetings and activities. Whenever there has been a scheduled meeting, the number of members participating has either met or exceeded the minimum number (e.g., five members required to establish a quorum) required to vote and act upon an issue presented at a meeting. To date, the DHCC has not been unable to conduct its meetings due to a lack of a quorum.

3. Describe any major changes to the board since the last Sunset Review, including, but not limited to:

   - Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)
   - All legislation sponsored by the board and affecting the board since the last sunset review.
   - All regulation changes approved by the board the last sunset review. Include the status of each regulatory change approved by the board.

   Since the DHCC's last Sunset Review in 2014, the Education/Outreach Subcommittee has been reorganized to the Education Subcommittee due to the promulgation of regulations related to educational programs, faculty and curriculum. Outreach activities continue as a responsibility of this subcommittee, but the title was renamed to indicate its primary focus.

   The DHCC's office was relocated to a larger suite in the same building. Although larger, the suite is a temporary solution to accommodate staff, files, equipment, and supplies until a larger, more permanent location is found. Space is limited in the current office, so the DHCC may seek a new office location or expansion of the existing office space in the future.

   The DHCC had an internal leadership change as the Executive Officer (EO), who had been in place since the DHCC's inception, retired as of December 31, 2016. Currently, there is an Interim EO and the DHCC is in the process of hiring a permanent EO to oversee operations.

   Also in 2016, the DHCC created and adopted a new 5-year Strategic Plan to reaffirm its mission of licensing, enforcing, and regulating dental hygiene professionals to protect the public and meet

the oral hygiene needs of all Californians. Strategic goal areas include licensing and law and ethics examination; enforcement; legislation and regulation; educational program oversight; and organizational development.

The DHCC has not sponsored any legislation since the last Sunset Review, but has had several bills that affected its operations and dental hygiene scope of practice. These include:

- Approval of Assembly Bill (AB) 1174 (Ch. 662, Statutes of 2014) - Interim Therapeutic Restorations and Diagnosis of Radiographs. This allowed dental hygienists to perform a new function.
- Approval of AB 502 (Ch. 516, Statutes of 2015) – Incorporation of RDHAPs. Allowed RDHAPs to incorporate for their businesses.
- Approval of AB 2859 (Ch. 473, Statutes of 2016) – Retired Category of Licenses. Provided the authority for licensees to place their license into a retired status after they decide to end their careers.
- Approval of Senate Bill (SB) 1039 (Ch. 799, Statutes of 2016) – Biennial License Renewal Fee Ceiling Increase. Increased the License Renewal Fee ceiling to $500 to provide some flexibility for the DHCC to generate additional revenue when needed from its primary revenue source to address the cost of doing business.
- Military Legislation – Legislation approved to provide special provisions for military personnel and their spouses to apply and qualify for licensure:
    - AB 1904 (Ch. 399, Statutes of 2013) – Expedited Licensure Process for Military Members and their Spouses
    - SB 1226 (Ch 657, Statutes of 2015) – Licensure Process Expedited for Honorably Discharged Veterans

  Both of these bills provided the authority to expedite the processing of applications for dental hygiene licensure from military, ex-military members and their spouses.

All regulatory changes approved by the DHCC, including the status of each regulatory change, since the last sunset review report. These changes include (list individual regulations).

Regulations approved:

- Approval of RDH Educational Programs (operative 10/1/2016) – the regulation provides the authority required to properly oversee and review the state's dental hygiene educational programs.
- Remedial Education (operative 2/18/2016) – the regulation provides the requirements for dental hygiene educational programs to establish remedial education courses for applicants who have failed to pass the required clinical examination after three attempts or as a single incidence of imposing gross trauma on a patient.
- Definitions (operative 4/20/16) – the regulation provides additional clarity and meaning to frequently used dental hygiene terms used in the profession.
- SLN Course Approval (operative 8/4/2014) – the regulation provides the course content details and requirements to establish a training course in Soft Tissue Curettage, Local Anesthesia, and Nitrous Oxide and Oxygen administration.
- Dental Hygiene Written Examinations (operative 10/1/2016) – the regulation provides additional clarity for issues addressed at written examinations.

- Infection Control Standards (operative 10/1/2016) – DHCC regulation that references the infection control standards as stated in 16 CCR § 1005.
- Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (operative 1/16/2014) – the regulation provides the policies and standards used when addressing licensees who may deviate from the standard of care, unprofessional conduct found, or has issues with substance and alcohol misuse.

Regulations pending approval:

- Retired Licenses – Draft regulatory language to implement a retired license ending their dental hygiene careers. The regulatory package status is that it has been approved by the DHCC and submitted to DCA for review as part of the regulatory process.
- ITR – DHCC staff are working to draft language to address this new function for dental hygienists.
- Sponsored Free Health Care Events – Name Badge – Draft regulatory language has been approved by the DHCC to require dental hygienists from out-of-state that have not completed the SLN requirement to wear a name badge showing that they cannot perform these functions to inform the patient. The regulatory package has been submitted to DCA for review as part of the regulatory process.
- Dental Hygiene Educational Programs Continued Approval – Draft regulatory language has been approved by the DHCC to allow staff to perform announced and unannounced site visits for improved oversight of the dental hygiene educational programs.

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

Due to the lack of staffing resources, the DHCC has not conducted any major studies but has an ongoing workforce survey where all licensees are required to disclose with their renewal applications their practice and employment status. Information is also collected regarding their cultural background and foreign language proficiency. This information is shared with the Healthcare Workforce Clearing House so that an occupational fact sheet can be produced.

The DHCC is also scheduled to conduct an Occupational Analysis in FY 2018/19, if warranted.

5. List the status of all national associations to which the board belongs.
   - Does the board's membership include voting privileges?
   - List committees, workshops, working groups, task forces, etc., on which board participates.
   - How many meetings did board representative(s) attend? When and where?
   - If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

Currently, the DHCC is a member state for the Central Regional Dental Testing Services (CRDTS), Inc. which provides regional testing for dental hygiene licensee applicants. The DHCC does not belong to any national, regional, or local associations.

The DHCC requires licensee candidates to pass the dental hygiene national examination to be eligible for licensure. The National Dental Hygiene Board Exam (NDHBE) fulfills the written examination requirement needed for a dental hygiene student to successfully complete an

accredited dental hygiene program. Proof of graduation from a dental hygiene program that has been accredited by CODA and approved by the DHCC in California is required for licensure.

The Joint Commission on National Dental Examinations (JCNDE) is the agency responsible for the development and administration of the NDHBE. The 15-member commission includes representatives from dental and dental hygiene schools, dental practices, state dental examining boards, dentists, dental hygienists, dental students, and the public. A standing committee of the JCNDE includes dental hygienists who serve as consultants regarding the NDHBE examination.

Section 2 – Performance Measures and Customer Satisfaction Surveys

6. Provide each quarterly and annual performance measure report for the board as published on the DCA website

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

7. Provide results for each question in the board's customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys. (Note: the data is presented by calendar year, as that is the methodology used to collect the data by the contracted vendor. However, no data is available for years 2015, 2016, & 2017 because the survey vendor contract expired at the end of 2014 and was not renewed unbeknownst to DHCC staff. As such, data for these years was not maintained by the survey vendor. The contract has been renewed as of November 2017 and the DHCC will monitor and maintain it going forward).

1. During the past 12 months, how often have you contacted the Dental Hygiene Committee of California?				
• 1-5 Times	70	N/A	N/A	N/A
• 6-10 Times	13	N/A	N/A	N/A
• More than 10 times	14	N/A	N/A	N/A
• Skipped Question	-	N/A	N/A	N/A
2. Which of the following best describes you?				
• Current Licensee	56	N/A	N/A	N/A
• Applicant for Licensure	28	N/A	N/A	N/A
• Consumer of Dental Hygiene Services	5	N/A	N/A	N/A
• Educator	10	N/A	N/A	N/A
• Employer	1	N/A	N/A	N/A
• Other (please specify)	13	N/A	N/A	N/A
• Skipped Question	-	N/A	N/A	N/A
3. Did you receive the service/assistance you requested?				
• Yes	54	N/A	N/A	N/A

• No	-	N/A	N/A	N/A
• Skipped Question	-	N/A	N/A	N/A
4. Please rate the Dental Hygiene Committee of California's staff in the following				
• Accessibility				
Excellent	30	N/A	N/A	N/A
Good	15	N/A	N/A	N/A
Fair	14	N/A	N/A	N/A
Poor	8	N/A	N/A	N/A
Unsatisfied	23	N/A	N/A	N/A
• Courtesy/Helpfulness				
Excellent	38	N/A	N/A	N/A
Good	9	N/A	N/A	N/A
Fair	11	N/A	N/A	N/A
Poor	7	N/A	N/A	N/A
Unsatisfied	24	N/A	N/A	N/A
• Knowledge/Expertise				
Excellent	36	N/A	N/A	N/A
Good	10	N/A	N/A	N/A
Fair	15	N/A	N/A	N/A
Poor	4	N/A	N/A	N/A
Unsatisfied	24	N/A	N/A	N/A
• Successful Resolution				
Excellent	36	N/A	N/A	N/A
Good	8	N/A	N/A	N/A
Fair	7	N/A	N/A	N/A
Poor	6	N/A	N/A	N/A
Unsatisfied	33	N/A	N/A	N/A
• Overall Satisfaction				
Excellent	35	N/A	N/A	N/A
Good	9	N/A	N/A	N/A
Fair	6	N/A	N/A	N/A
Poor	5	N/A	N/A	N/A
Unsatisfied	36	N/A	N/A	N/A
• Skipped Question	-	N/A	N/A	N/A
5. Do you find the Dental Hygiene Committee of California's Website useful?				
• Yes	67	N/A	N/A	N/A
• No	-	N/A	N/A	N/A
• Skipped Question	-	N/A	N/A	N/A

N/A – No Data Available for 2015, 2016, & 2017. The contract with the survey vendor expired at the end of 2014 unbeknownst to DHCC staff, but renewed as of November 2017. The vendor did not maintain or track any data for the DHCC after the contract expired in 2014.

The 2014 survey data above indicates that compared to the number of individuals who utilize the DHCC's website each day, only a fraction of the users participate in the satisfaction survey. Many of the individuals who participated in the survey were licensees and applicants for licensure who were satisfied with the website's ease of use and found it helpful with the information it contains. Individuals who completed the survey and were unsatisfied provided reasons such as non-qualification for an exam, inadequate information to renew a license, and additional information required to issue a license for their dissatisfaction. Many of the dissatisfied users received information that would delay the issuance or renewal of a license.

The DHCC staff continually directs applicants, individuals, licensees, and the public to the DHCC website to obtain answers to their inquiries. If any questions remain, the DHCC staff is readily available to provide further assistance for clarity by contacting us by phone or email. The information on the DHCC website is continually updated to provide licensees, interested stakeholders, and the public the most current and accurate information as possible.

The DHCC receives many comments through its online survey; however, there are no discernable trends on the specific issues identified. Some examples of the topics received in the survey comments range from great to poor DHCC customer service, suggestions to change the DHCC procedures or forms, and make the navigation of the site easier or more user friendly. Most of the survey users elected to leave the comment section of the survey blank with no response.

The DHCC takes these comments and suggestions seriously and is in the process of working with the Department of Consumer Affairs (DCA) to update its website in the near-future. With the implementation of the BreEZe computer system, many of the forms and applications that were only available previously in hard copy are now available to be completed electronically through the BreEZe website. BreEZe users can also fulfill their requests by paying the fees with a credit card in real time.

Section 3 – Fiscal and Staff

Fiscal Issues

8. Is the board's fund continuously appropriated? If yes, please cite the statute outlining this continuous appropriation.

   The DHCC's fund is not continuously appropriated. Each year, the Dental Hygiene Fund is appropriated when the State's budget is approved by the Legislature and signed by the Governor.

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

   The DHCC's current fund reserve is projected to remain solvent through FY 2019/20 barring any new or unexpected expenses. For the current year, the DHCC's fund has a reserve of $1.48 million which is equivalent to about 8.3 months of a reserve. The DHCC currently spends about $125,000 to $135,000 per month on expenditures, depending upon the month. This includes personnel services and operating expenses and equipment (OE&E). The funding is used to run its programs of licensing, enforcement, educational program review, examinations, education/outreach, and administration, including legislation and regulation. A decrease in the fund reserve over time is considered a normal occurrence resulting from the increased cost of doing business with no additional revenue being added to the fund.

The DHCC's statutory fund reserve limit is 24 months as per BPC § 128.5, and with the current 8.3 months reserve this year and projecting to maintain fund solvency until the end of FY 2019/20 barring any unforeseen expenditures, it is well within the reserve limit.

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

The DHCC is projected to experience a fund reserve deficiency by the end of FY 2019/20 if no extensive new expenses arise and no additional revenue is generated. Before that time, options will be determined to analyze whether a fee increase is warranted to raise revenue and replenish the fund. The reasons for the decrease in the fund reserve are:

- The cost of doing business continually increases over time as contracted services, rent, equipment and supplies, travel, and salary and wages, progressively increase each year.
- The DHCC recently initiated the active oversight of all the approved dental hygiene educational programs in California. This oversight will increase the expenditures expected to properly review and inspect the programs for compliance with the law and the accrediting body standards. The enhanced oversight will require an increase in travel expenses and staff time for them to visit the school locations throughout California.
- The DHCC needs additional staff to address existing as well as an ever-growing workload to properly oversee the dental hygiene profession and educational programs. Additional DHCC staff are expensive, but a necessity in order to carry out its mission of consumer protection.

To avoid insolvency of its fund, fee increases to collect additional revenue is anticipated by the end of FY 2019/20, but preliminary projections over the next two years will provide more details to determine whether fee increases are necessary. The last fee increases in 2014 was projected to maintain fund solvency for five years, but now it is projected to last for six years. The primary revenue generating fees that have a substantial effect on the fund balance to avoid insolvency are the biennial license renewal and delinquent renewal fees for each of the licensure categories of RDH, RDHAP, and RDHEF.

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

(Dollars in Thousands)	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19
Beginning Balance	587	843	1,285	1,846	2,014	1,488
Revenues and Transfers	1,513	1,757	1,870	1,821	1,594	1,594
Total Revenue	$2,100	$2,600	$3,155	$3,667	$3,608	$3,082
Budget Authority	1,507	1,637	1,871	1,996	1,993	2,033
Expenditures	1,274	1,321	1,311	1,653	1,993	2,033
Loans to General Fund	N/A	N/A	N/A	N/A	N/A	N/A
Accrued Interest, Loans to General Fund	N/A	N/A	N/A	N/A	N/A	N/A
Loans Repaid from General Fund	N/A	N/A	N/A	N/A	N/A	N/A
Fund Balance	$826	$1,279	$1,844	$2,014	$1,488	$922

Months in Reserve	7.5	11.7	13.4	11.4	8.3	5.0

11. Describe the history of general fund loans. When were the loans made? When have payments been made to the board? Has interest been paid? What is the remaining balance?

    The DHCC does not have a history nor has it ever requested any general fund loans.

12. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

	FY 2013/14			FY 2014/15			FY 2015/16			FY 2016/17		
	Personnel Services	OE&E	%	Personnel Services	OE&E	%	Personnel Services	OE&E	%	Personnel Services	OE&E	%
Enforcement	57	139	15	40	177	16	21	156	13	64	256	20
Examination	72	249	25	40	167	15	0	6	0.5	0	4	0.5
Licensing	95	140	18	81	157	18	63	288	26	92	229	20
Admin.*	180	140	25	188	196	29	143	240	29	196	268	29
DCA Pro Rata	207	0	16	282	0	21	414	0	31	475	0	30
Diversion (if applicable)	5	7	1	4	8	1	2	0	0.5	2	0	0.5
TOTALS	$616	$675	100	$635	$705	100	$643	$690	100	$829	$757	100

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

13. Describe the amount the board has contributed to the BreEZe program. What are the anticipated BreEZe costs the board has received from DCA?

    The DHCC has contributed $399,903 from fiscal year FY 2009/10 thru FY 2016/17. Going forward, the projected BreEZe costs anticipated for program maintenance for the DHCC is $387,000 for the next two fiscal years thru FY 2018/19. The original budgeted amount for BreEZe through FY 2016/17 was $548,297, and the actual expended amount through FY 2016/17 is $537,312. The chart below shows the budgeted and actual expenditure totals for each fiscal year.

DHCC BreEZe Costs	**FY 2013-14**	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**
Budget Amount	$48,045	$97,162	$206,045	$197,045	$198,000
Actual Expenditures	$48,045	$94,468	$204,644	$190,155	TBD

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

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

The license renewal cycle is on a biennial basis where the license expires on the last day of a licensee's birth month depending upon whether they were born in an even or odd year. An example is that if a licensee is born in July of an even year and they renewed the license at the end of July 2016, their license would need to be renewed prior to July 31, 2018 (two years later) for them to continue practicing on a valid and current license. If it is a licensee's first renewal, the duration they have an active license is normally less than 24 months, then, once renewed, the license will be on a biennial cycle to expire every 24 months.

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

The DHCC has only raised its fees a few times since inception when it was evident that the fund was going insolvent. The DHCC raised the following fees in the past seven years:

1) Biennial License Renewal Fee for RDH, RDHAP, and RDHEF – This fee was increased on January 1, 2014 from $80 to $160.
2) License Renewal Delinquency Fee for RDH, RDHAP, and RDHEF – This fee was increased concurrently with the Biennial License Renewal Fee. It increased from $40 to $80.
3) RDHAP Fictitious Name Permit (FNP) Fee – This fee ties statutorily with the rate charged for the RDHAP License Renewal Fees. If the License Renewal Fee increases, so does the FNP fees. The FNP fee increased from $80 to $160 as well.
4) RDHAP FNP ½ Initial License Fee – This fee ties statutorily with the rate charged for the RDHAP License Renewal Fees effective January 1, 2014. The ½ FP fee increased from $40 to $80.
5) Application for Licensure Fee – This fee was increased from $50 to $100 on May 3, 2015 to cover the increase in cost to process applications for licensure.

Fee	Current Fee Amount	Statutory Limit	FY 2013/14 Revenue	FY 2014/15 Revenue	FY 2015/16 Revenue	FY 2016/17 Revenue	% of Total Revenue
Application Fees							
RDH Clinical Exam Fee ($525)	N/A	N/A	$254	$32	$0	$0	8%
RDH Application Fee ($50)	N/A	N/A	$51	$39	$30	$0	2%
RDH Application Fee	$100	$250	$0	$0	$23	$86	3%
RDH Original Licensure Fee	$100	$250	$98	$75	$83	$85	5%
RDHAP License Fee	$250	$250	$14	$13	$13	$9	>1%

RDHAP Application Fee ($50)	N/A	$250	$3	$3	$2	$0	>1%
RDHAP Fictitious Name Permit (FNP) Fee ($80)	N/A	$80	$4	$1	$0	$0	>1%
RDHAP ½ FNP Fee ($40)	N/A	$40	$0	$0	$0	$0	0%
RDHAP FNP Fee	$160	$160	$0	$0	$1	$6	>1%
RDHAP ½ FNP Fee	$80	$80	$0	$0	$0	$0	0%
Extramural Dental Facility Fee	$200	$250	$0	$0	$0	$0	0%
Mobile Dental Hygiene Unit Permit Fee	$100	$150	$0	$0	$0	$0	0%
Additional Office Permit Fee	$100	$250	$0	$0	$0	$0	0%
Additional Office Permit Renewal Fee	$100	$250	$0	$0	$0	$0	0%
Special Permit (Teaching) Fee	$160	$160	$0	$0	$0	$0	0%
Renewal Fees							
Mobile Dental Hygiene Unit Permit Biennial Renewal Fee	$100	$250	$0	$0	$0	$0	0%
Additional Office Permit Biennial Renewal Fee	$100	$250	$0	$0	$0	$0	0%
Special Permit (Teaching) Biennial Renewal Fee	$160	$160	$0	$0	$0	$0	0%
RDH Biennial Renewal Fee ($80)	N/A	$80	$408	$1	$0	$1	6%
RDHAP Biennial Renewal Fee ($80)	N/A	$80	$11	$0	$0	$0	>1%
RDHEF Biennial Renewal Fee ($80)	N/A	$80	$1	$0	$0	$0	>1%
RDHAP FNP Biennial Renewal Fee ($80)	N/A	$80	$3	$0	$0	$0	>1%
RDHAP ½ FNP Biennial Renewal Fee ($40)	N/A	$80	$0	$0	$0	$0	0%
RDH Biennial Renewal Fee	$160	$500	$618	$1,486	$1,572	$1,507	75%
RDHAP Biennial Renewal Fee	$160	$500	16	38	49	$40	2%
RDHEF Biennial Renewal Fee	$160	$500	$1	$1	$3	$2	>1%
Delinquency Fees							
RDH Delinquent License Renewal Fee ($40)	N/A	$40	$8	$1	$0	$0	>1%
RDHAP Delinquent License Renewal Fee ($40)	N/A	$40	$0	$0	$0	$0	0%
RDHEF Delinquent License Renewal Fee ($40)	N/A	$40	$0	$0	$0	$0	0%
RDHAP FNP Delinquent License Renewal Fee ($40)	N/A	$40	$0	$0	$0	$0	0%
RDH Delinquent License Renewal Fee ($80)	$80	$80	$0	$20	$24	$26	1%
RDHAP Delinquent License Renewal Fee ($80)	$80	$80	$0	$0	$0	$0	>1%
RDHEF Delinquent License	$80	$80	$0	$0	$0	$0	0%

Renewal Fee ($80)							
RDH FNP Delinquent License Renewal Fee ($80)	$80	$80	$0	$1	$0	$0	>1%
Other DHCC Program FEES							
Duplicate License Fee	$25	$25	$12	$11	$13	$14	>1%
Continuing Education Course Review Fee	$300	$300	$0	$0	$2	$1	>1%
*Current Fees are Listed; N/A = Prior, inactive fee							

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

The DHCC has worked diligently to maximize its resources while staying within budget parameters set by the Governor's Office, Department of Finance, and the DCA. However, the inability to successfully obtain positions through BCPs has meant that the DHCC cannot meet many of its targeted Strategic Plan goals or to address existing workload that current staff cannot absorb. Table 5 displays the BCPs presented to address programmatic issues and their results since the last Sunset Review.

BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
1110-030-BCP-BR-2015-GB	2015/16	Dental Hygiene Educational Program Reviews	1.0 – Staff Services Analyst	1.0 – Staff Services Analyst	$71	$71	$7	$7
1111-013-BCP-BR-2016-GB	2016/17	Probation Monitoring (Enforcement)	1.0 – Staff Services Analyst	1.0 – Staff Services Analyst	$82	$82	$7	$7
1111-005-BCP-BR-2017-GB	2017/18	Licensing Program	0.8 Office Technician (to be combined with a 0.2 Special Investigator to create 1.0 position)	0	$54	$0	$5	$0

None Issued (Denied)	2018/19	Licensing – Continuing Education Audits	1.0 Staff Services Analyst	0	$0 (no funding requested; only position authority)	$0	$0 (no funding requested; only position authority)	$0

Staffing Issues

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

The DHCC's vacancy rate is roughly 10% - 20% which equals to about one or two vacant position per year out of the ten positions the DHCC is currently authorized. Staff naturally want to advance in their careers and leave if an opportunity arises for advancement. The main challenge for the DHCC has been to acquire additional positions to address current workloads that need to be addressed such as CE review and audits, enforcement, licensing, and administration, but not place the dental hygiene fund in a position of possible insolvency. The DHCC's expenditure budget is not large at approximately $2 million per year and for a program with roughly 22,000 active licensees, there is not a lot of funds available to pay for additional positions, so they are requested as the DHCC can afford them. A comparison of the DHCC with similarly sized boards within DCA by licensee population (between 20,000 – 25,000) show that they average over 20 staff positions per board to address their workloads versus the ten that the DHCC currently has.

The DHCC has requested additional staff positions through the BCP process to address licensing and the CE review and audit programmatic workloads. However, due to the parameters in existence to approve additional positions within the state, the requests were denied even though the DHCC was willing to absorb the cost for the 2018/19 position request. The DCA has recommended to gather data to help support the next BCP request; however, DHCC staff already have full time assigned duties and do not have the time or capability to absorb more workload to gather data. The current workloads to be addressed are primarily from existing mandates that the DHCC never had staff opportunities to address from the beginning.

The DHCC also needs additional staff for growing workloads in several program areas and succession planning as some staff are becoming of retirement age and have voiced that they plan to continue to work for only a short time, then retire. If the DHCC is not allowed to hire staff for succession planning prior to the existing staff leaving for retirement, there will be a substantial institutional memory loss, as these are specialized positions in Licensing and Enforcement and take years to learn the program and their functions. Some of the areas that need to be addressed are:

- The Continuing Education Review and Audit Program workload to ensure that the licensees who have had their licenses renewed remain compliant with the license renewal law (BPC § 1936.1).
- Enforcement – complaint receipt, processing, and analyzing of the case to be referred to a subject matter expert, investigator, possibly the Attorney General's Office, or closed.

- Licensing – processing of hundreds of applications annually for licensure for registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions. Also processes many special permits and fictitious name permits for licensees.
- Dental Hygiene Educational Programs - For the DHCC approved dental hygiene educational programs, the plan is to review all 27 approved programs at the time of their reaffirmation of accreditation unless a complaint has been filed against the program in which we would review them sooner. However, the DHCC only has a single staff person to conduct site visits, review the program curriculum, faculty qualifications, and extensive documentation, and to write up complex reports for the DHCC to review. In a short amount of time, the DHCC has realized that the workload for this program is considerably more complex and time consuming than what a single person should be expected to handle. The review of dental hygiene programs is extensive and a very laborious process to ensure they are complying with the law.

  Four out of the six dental hygiene educational programs that have been reviewed were found to have multiple deficiencies of the law including infection control and failure to meet accreditation standards. Decades of minimal to no oversight of these programs has proven to be a challenge to bring them into compliance of the law and a single analyst cannot address this enormous workload.

The DHCC has been involved with the DCA's master succession plan and will continue to participate in its development. With some staff becoming of retirement age, it is crucial that the DHCC obtain additional staff to learn from these individuals so it does not lose the institutional memory that many veteran staff will leave with upon retirement. Other staff simply have too great of a workload for a single person to address and need more staff to address it.

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

The DHCC is fortunate to be a part of the Department of Consumer Affairs (DCA), who provide a plethora of educational and training courses for all staff to participate in at minimal or no cost to the programs. The DCA training program is called SOLID Training Solutions and are funded through the departmental costs. They provide the majority of education and training courses in topics such as contracts, project management, purchasing, job growth skills, sexual harassment, business writing, upward mobility, and many other topics that apply to the state's work environment and careers. As such, the DHCC has budgeted to spend approximately $500 - $1,000 each year for training staff utilizing external vendors, but most of the needed training topics that are used daily are covered by SOLID. Management is also very flexible in approving training courses or new project opportunities for staff, so long as there is adequate coverage in the office to maintain operations.

Section 4 – Licensing Program

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

- Central Regional Dental Testing Services (CRDTS), Inc. examination;
- Western Regional Examination Board (WREB) examination; and

- Licensure by Credential (LBC) pathway to licensure.

18. What are the board's performance targets/expectations for its licensing[2] program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

The DHCC's performance targets/expectations for its licensing program meets the guidelines as presented in California Code of Regulations (CCR) § 1069 Permit Reform Act of 1981, pertaining to application processing times. This regulation provides a detailed timeline for the processing of permits, applications, certifications, registrations, or other form of authorization required by a state agency to engage in a particular activity or act. The DHCC follows these timelines to process its applications and maintains a processing period that is less than the maximum.

As stated in the regulation, the maximum period of time allotted to notify an applicant that their application is complete or deficient is 90 days. The DHCC is currently processing applications within 30 business days, which is well within the specified timeframe of 120 days.

Is the board meeting those expectations?

The DHCC is not only meeting, but exceeding its expectations and takes an average of 30 business days to process a completed application or at least notify the applicant of a deficiency. If an application is incomplete or deficient, the processing time increases to an average of 58 days to complete an application, which is still within the allotted timeline of 120 days. However, with the new BreEZe computer system, the completeness of applications is heavily dependent on how quickly the applicant submits the required documentation and fees to properly process the application. If there is a delay in the receipt of the required application and documentation from the applicant, there will be a longer delay in the issuance of a license. This changed the DHCC application practices before the BreEZe system, as incomplete applications were previously returned to the applicant for resubmission with the deficient items.

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

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

19. Describe any increase or decrease in the board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

There has not been any significant increase or decrease in the average time to process applications for licensure or issuance of a license. The application processing time remains

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

constant and well within the allotted time frame to complete the processing of an application. By law, the DHCC is allowed to receive and process an application for licensure and notify the applicant of whether it is complete or deficient within 90 days of receipt. The DHCC continues to exceed this expectation by notifying an applicant for licensure of their application status within 30 business days from the date of receipt.

The DHCC is experiencing an increase in the number of pending applications for processing with the implementation of the BreEZe computer system. Before, hardcopy applications for licensure were only accepted in their entirety where they could be processed quickly without waiting for additional documentation. If the application was incomplete it was returned to the applicant to resubmit with the missing item(s) to then be fully processed. Now with the BreEZe system, online applications can be submitted in pieces with heavy reliance on the applicant to submit all of the documents required to process the application. The applicant can submit the application and payment and gradually submit the other required documentation on a flow basis. The process is still new, but could lead to eventual slowdowns in the application approval process due to the reliance on the applicant to submit all of the required documentation while the file is pending.

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

The DHCC has not experienced a growth rate in pending applications that exceeds the completed applications yet. In time, this may occur as more applications pend within the BreEZe computer system and wait for the applicant to submit any missing documentation or items.

If so, what has been done to address them?

The DHCC will address this issue when it arises.

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

The DHCC is not experiencing any performance barriers to complete the processing of its examination, licensure, and permit applications.

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

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

20. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

The DHCC issues approximately 800 licenses and completes approximately 8,500 - 9,000 renewals per year, depending upon the year.

The DHCC is responsible for the license renewal and oversight of approximately 22,000 active licentiates and over 30,000 licenses issued inclusive of those licenses on an inactive status. Table 6 displays the breakdown of each license category and the number of active licenses. With 27 dental hygiene programs now operating in the state, the number of new graduates is over 800 per year.

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

		FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Registered Dental Hygienist (RDH)	Active	18,817	19,118	19,407	17,369
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	2,326	2,602	2,700	2,940
Registered Dental Hygienist in Alternative Practice (RDHAP)	Active	496	540	562	543
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	18	19	28	52
Registered Dental Hygienist in Extended Functions (RDHEF)	Active	31	29	29	25
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	1	3	3	4
Fictitious Name Permits (FNP)	Active	121	152	160	135
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	17	17	17	50

	FY 2014/15	FY 2015/16	FY 2016/17
Initial License/Initial Exam Applications Received RDH	1,456	1,043	1,248
Initial License/Initial Exam Applications Approved RDH	744	832	855
Initial License/Initial Exam Applications Closed RDH	0	45	137
License Issued RDH	744	832	855
Initial License/Initial Exam Applications Received RDHAP	51	78	57
Initial License/Initial Exam Applications Approved RDHAP	47	52	51
Initial License/Initial Exam Applications Closed RDHAP	0	0	0
License Issued RDHAP	47	52	51
Initial License/Initial Exam Applications Received RDHEF	0	0	0
Initial License/Initial Exam Applications Approved RDHEF	0	0	0
Initial License/Initial Exam Applications Closed RDHEF	0	0	0
License Issued RDHEF	0	0	0
Initial License/Initial Exam Applications Received FNP	33	10	15
Initial License/Initial Exam Applications Approved FNP	32	9	10
Initial License/Initial Exam Applications Closed FNP	0	5	0

License Issued FNP	34	21	9
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY) RDH	36	390	249
Pending Applications (outside of board control)* RDH	0	0	3
Pending Applications (within the board control)* RDH	0	0	0
Pending Applications (total at close of FY) RDHAP	51	32	30
Pending Applications (outside of board control)* RDHAP	51	0	0
Pending Applications (within the board control)* RDHAP	0	0	0
Pending Applications (total at close of FY) RDHEF	0	0	0
Pending Applications (outside of board control)* RDHEF	0	0	0
Pending Applications (within the board control)* RDHEF	0	0	0
Pending Applications (total at close of FY) FNP	0	3	8
Pending Applications (outside of board control)* FNP	0	3	0
Pending Applications (within the board control)* FNP	0	0	0
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)	52	45	22
Average Days to Application Approval (incomplete applications)*	48	42	19
Average Days to Application Approval (complete applications)*	52	30	22
License Renewal Data:			
License Renewed	9,802	9,705	9,810
* Optional. List if tracked by the board.			

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2014/15	Exam (RDH)	1,456	811	0	-	3	-	-	-	-	-
	License	-	811	-	811	0	-	-	82	-	82
	Renewal	9,791	9,483	-	-	17	-	-	78	-	78
	Exam (RDHAP)	51	47	0	-	0	-	-	183	-	183
	License	-	47	-	47	0	-	-			
	Renewal	250	245	0	-	0	-	-	86	-	86
	RDHEF Renewal	16	9	0	-	0	-	-	313	-	313
	FNP	33	32	0	34	0	-	-	2	-	2
	License	-	34	0	-	0	-	-	-	-	-
	Renewal	73	65	-	-	0	-	-	132	-	132
FY 2015/16	Exam (RDH)	1,043	-	45	-	82	-	-	2,931	12	2,918
	License	762	797	97	796	0	-	-	50	-	50
	Renewal	8,820	9,324	245	-	15	-	-	48	-	48

	Exam (RDHAP)	78	-	1	-	0	-	-	1,928	35	1,925
	License	52	52	1	52	0	-	-	113	-	113
	Renewal	272	288	0	-	1	-	-	57	-	57
	RDHEF Renewal	15	18	0	-	1	-	-	72	-	72
	FNP	10	9	5	-	0	-	-	267	-	267
	Renewal	75	75	1	21	0	-	-	49	-	49
FY 2016/17	Exam (RDH)	1,248	1,191	137	-	134	-	-	14	19	17
	License	825	868	12	866	115	-	-	67	26	33
	Renewal	10,476	9,553	597	-	4,334	-	-	10	-	10
	Exam (RDHAP)	57	51	4	-	4	-	-	13	33	24
	License	35	34	1	34	26	-	-	222	106	160
	Renewal	288	262	5	-	104	-	-	17	-	17
	RDHEF Renewal	11	10	0	-	10	-	-	8	-	8
	FNP	15	10	0	-	8	-	-	14	-	14
	License	-	-	-	9	-	-	-	-	-	-
	Renewal	78	45	4	-	74	-	-	23	-	23
* Optional. List if tracked by the board.											

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

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

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

    b. Does the board fingerprint all applicants?

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

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

    The DHCC promulgated regulations requiring all active licensees to be electronically fingerprinted. The DHCC has completed the fingerprinting of approximately 90-95% of the dental hygiene licensing population. The remaining 5-10% are either in an inactive license status, making them exempt from the fingerprinting requirement, or reside outside of California. Many licensees reside outside of California or elect to place their license on an inactive status, exempting them from the fingerprint requirement because they are not practicing in the state. If the licensees that reside out of state ever choose to return to California to practice dental hygiene, they will be required to obtain fingerprint clearances if they do not have them on record. The BreEZe computer system will not allow a licensee without fingerprint clearances on file renew the license at its next expiration. Inactive licensees without fingerprint clearances on record will be required to obtain clearances prior to the reactivation of the dental hygiene license.

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

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

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

The DHCC checks this databank prior to issuing a license.

Renewing a license?

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

e. Does the board require primary source documentation?

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

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

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

The DHCC does not differentiate between out-of-state, out-of-country, and in-state applicants. The legal requirements and process for licensure for all applicants are the same pursuant to BPC §§ 1917 and 1917.1. The only exception is the implementation of BPC § 115.5 whereby these individuals are granted priority during the application process due to their spouse or domestic partner's military status.

23. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

a. Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?

Yes, the DHCC identifies applicants who are veterans in compliance with BPC § 114.5.

b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?

There have been no applicants who offered military education, training or experience towards meeting licensing or credentialing requirements.

c. What regulatory changes has the board made to bring it into conformance with BPC § 35?

To date, no regulatory changes have been proposed due to the existing statutory requirements required for licensure as a dental hygienist.

d. How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?

No licensees have requested to waive renewal fees or continuing education requirements to date.

e. How many applications has the board expedited pursuant to BPC § 115.5?

The DHCC has expedited the licensure process for 6 applicants to comply with this section of law.

24. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

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

Is this done electronically?

The DHCC sends No Longer Interested notifications to the DOJ by BreEZe computer system electronically.

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

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

Examinations

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

California Examination (include multiple language) if any:				
	License Type	Registered Dental Hygienist (RDH)	Registered Dental Hygienist (RDH)	Registered Dental Hygienist in Alternative Practice (RDHAP)
	Exam Title	DHCC Clinical Examination	Law & Ethics	Law & Ethics
FY 2013/14	# of 1st Time Candidates	311	520	42
	Pass %	90%	99%	92%
FY 2014/15	# of 1st Time Candidates	208	529	38
	Pass %	89%	98%	97%
FY 2015/16	# of 1st Time Candidates	N/A	831	53
	Pass %	N/A	67%	66%
FY 2016/17	# of 1st time Candidates	N/A	832	41
	Pass %	N/A	68%	71%
	Date of Last OA	1998	2010	2010
	Name of OA Developer	DCA/OPES*	DCA/OPES	DCA/OPES

	Target OA Date	N/A	2019	2019
National Examination (include multiple language) if any:				
	License Type	RDH	RDH	RDH
	Exam Title	NDHBE**	NDHBE	NDHBE
FY 2013/14	# of 1st Time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
FY 2014/15	# of 1st Time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
FY 2015/16	# of 1st Time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
FY 2016/17	# of 1st time Candidates	N/A	N/A	N/A
	Pass %	N/A	N/A	N/A
	Date of Last OA	N/A	N/A	N/A
	Name of OA Developer	N/A	N/A	N/A
	Target OA Date	N/A	N/A	N/A

Notes: *DCA/OPES = Dept. of Consumer Affairs Office of Professional Examination Services

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

25. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required? Are examinations offered in a language other than English?

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

The purpose of the NDHBE is to ensure that each examination candidate and applicant for licensure has achieved the level of knowledge, skill, and judgment necessary to practice in a safe and responsible manner. Accordingly, all candidates are expected to pass the examination on their own merit without assistance, and are expected to maintain the confidentiality of the examination. Members of the public who entrust dental hygienists with their well-being expect that they are trustworthy and competent individuals.

The NDHBE is a comprehensive examination consisting of 350 multiple-choice examination items. The examination has two components; a discipline based component and a case based component. The discipline-based component includes 200 items addressing three major areas: 1) Scientific Basis for Dental Hygiene Practice; 2) Provision of Clinical Dental Hygiene Services; and 3) Community Health/Research Principles.

The case-based component includes 150 case-based items that refer to 12 to 15 dental hygiene patient cases. These cases presented in this component contain information dealing with adult and child patients by means of patient histories, dental charts, radiographs, and clinical photographs. Information about the American Dental Association NDHBE is available in their 2017 Guide on their website at: www.ada.org under the Education/Careers tab.

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

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

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

Prior to issuance of a license, an applicant for licensure as a RDH shall successfully complete a supplemental written examination in the DHCC Law and Ethics. The DHCC Law and Ethics Examination, as stated in CCR § 1082.3, requires:

(a) The examination shall test the applicant's knowledge of California Law as it relates to the practice of dental hygiene.

(b) The examination on ethics shall test the applicant's ability to recognize and apply ethical principles as they relate to the practice of dental hygiene.

(c) An examinee shall be deemed to have passed the examination if his/her score is at least 75% in each examination.

Are examinations offered in a language other than English?

No, both the national and state examination are only offered in English. However, both the national and state examination provide reasonable and appropriate accommodations in accordance with the Americans with Disabilities Act.

26. What are pass rates for first time vs. retakes in the past 4 fiscal years? *(Refer to Table 8: Examination Data)* Are pass rates collected for examinations offered in a language other than English?

The DHCC only administers the California Law and Ethics Examination for RDH and RDHAPs. The pass rates for first time takers over the past four years is:

Pass Rates for First Time Takers of the CA Law and Ethics Examination*				
	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
RDH	99%	98%	67%	68%
RDHAP	92%	97%	66%	71%

*Examination Retake Statistics are unavailable.

There are several unverified reasons as to why the CA Law and Ethics examination results decreased drastically in FY 2015/16 and FY 2016/17. The first is that it could be caused by new examinations being introduced and used during this time. The DCA Office of Professional Examination Services indicates that they structure the exam to target a pass rate of 75%, but that goal may not always be met. Another is the examinees and whether they have properly prepared themselves through the amount of studies and training they experience in preparing for the examination. The DHCC believes that there is not one single factor that can be identified as the

root cause of the decline in the pass rates for first time exam takers; however, the issue will be reviewed by the DHCC's Licensing and Examination Subcommittee to find a cause.

Are pass rates collected for examinations offered in a language other than English?

No, the DHCC does not offer examinations in a language other than English.

27. Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

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

28. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

Currently, there are no existing statutes that hinder the efficiency of processing the DHCC license applications.

School approvals

29. Describe legal requirements regarding school approval.

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

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

New educational programs must submit an application and feasibility study demonstrating the need for a new educational program and apply for approval prior to seeking initial accreditation from the national accrediting body, CODA. The program must also be provided by a college or institution of higher education accredited by a regional agency recognized by the United States Department of Education. The DHCC has the authority to approve, provisionally approve, or deny approval of a new dental hygiene educational program.

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

Who approves your schools?

The California dental hygiene schools are approved by the DHCC and accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association.

What role does BPPE have in approving schools?

BPPE does not have any active role in approving any California dental hygiene programs. However, if there is an issue with a dental hygiene program that is affiliated with a private postsecondary entity, the DHCC works closely and collaboratively with BPPE on any issues within each respective program's jurisdictions in the interest of the students as consumers.

How does the board work with BPPE in the school approval process?

BPPE does not have an active role in the approval of California's dental hygiene educational programs. However, the DHCC occasionally does contact BPPE as a resource to assist with issues concerning the school and its students that could affect its DHCC approval.

30. How many schools are approved by the board?

Currently, there are 27 dental hygiene educational programs approved by the DHCC.

How often are approved schools reviewed?

The DHCC began reviewing California's dental hygiene educational programs as of 2016 when new regulations went into effect regarding requirements for approval of educational programs. The plan is to review all 27 approved programs at the time of their reaffirmation of national accreditation unless a complaint has been filed against a program or there are noted deficiencies of the law or CODA standards discovered. To date, six programs have been reviewed of which four have been found to have major deficiencies in compliance with the law or CODA standards. The remaining schools had minor correctable deficiencies that have since been fixed. All 27 schools had their faculty qualifications and documented coursework reviewed.

Can the board remove its approval of a school?

Yes, the DHCC can withdraw its approval for a dental hygiene program. The school may continue to teach the dental hygiene education curriculum if the approval is withdrawn; however, the students graduating from a program whose approval has been withdrawn will not be able to qualify for licensure in California.

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

At this time, the DHCC does not have authority to review or approve any international schools.

Continuing Education/Competency Requirements

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

The continuing education (CE) requirements for the DHCC's licensees are as follows:

1) Registered Dental Hygienist (RDH) = 25 units every 2 years;
2) Registered Dental Hygienist in Extended Functions (RDHEF) = 25 units every 2 years; and
3) Registered Dental Hygienist in Alternative Practice (RDHAP) = 35 units every 2 years.

There have been no changes to the CE requirements for licensees since the last Sunset Review.

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

Licensees sign an affidavit that the number of CE units (hours) have been met as well as the mandatory courses have been completed.

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

The DHCC currently conducts CE audits in conjunction with any enforcement or educational program review (i.e., review of educational requirements and qualifications for faculty at dental hygiene educational programs) activity because there is no other staff to conduct audits. The DHCC's plan is to obtain additional staff to conduct CE audits on a continuous basis of up to 10% of the licensee population each year to ensure that they adhere to the license renewal requirements in the interest of consumer protection.

What are consequences for failing a CE audit?

If a licensee fails a CE audit, the licensee must complete the number of CE hours deficient and pay any citation and/or fine for non-compliance of the license renewal. If the audit is completed in conjunction with an enforcement issue, the licensee could pay additional charges and late fees for an incomplete license renewal.

c. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?

The DHCC has conducted 47 CE audits in the past four fiscal years between our Enforcement Unit and Educational Program. Of the 47 CE audits completed, 10 licensees failed their audit. The percentage of CE failure is 21%. This shows that there are a high number of licensees that are not completing the number of CE hours required by law to renew their license. The CE audit workload cannot be absorbed within existing staff and additional staff is needed to address it.

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

The DHCC has the authority to approve CE courses; however, it does not have enough staff to address the CE course and provider approval workload. Once the DHCC obtains additional staff, the plan is to promulgate regulations to clarify and strengthen the CE approval policy.

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

The DHCC is authorized to approve CE providers, but currently utilizes and accepts the Dental Board of California's (DBC) approved providers by BPC § 1936.1(c) due to staffing issues. The DHCC currently utilizes CCR § 1016 for its CE provider approvals; however, once adequate staffing is obtained, the DHCC plans to approve its own CE providers.

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

The DHCC has the authority to approve CE courses, but currently utilizes and accepts the DBC approved courses until additional staffing is obtained to address this workload as it cannot be absorbed within existing staff resources. Once that is done, the DHCC will promulgate regulations to clarify, detail, and strengthen the CE course approval and review process.

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

Due to the DHCC being in the process of promulgating regulations to approve CE providers and courses, there have been no applications received to date. However, there has been several communications to the DHCC from potential CE providers who are interested in

offering CE courses. Once regulations are promulgated, the DHCC will process all of the CE provider and CE course applications received.

How many were approved?

None due to the response above.

g. Does the board audit CE providers? If so, describe the board's policy and process.

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

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

Once implemented, the DHCC plans to conduct a random audit on a certain percentage of CE providers on a biennial basis. The exact process in which the DHCC will audit CE providers will be determined during the creation of the new regulations. The issue has not been addressed because this is a pending workload until the DHCC obtains staff to address it.

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

The DHCC will continue its efforts to implement statutory language for continued competency. The DHCC submitted statutory language in SB 1202 (Ch. 331, Statutes of 2012); however, it was stricken during the legislative process. This may be an issue the DHCC decides to address at a future date.

Section 5 – Enforcement Program

33. What are the board's performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?

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

1. Intake of Investigations within 30 days.
2. Intake and Investigation within 270 days.

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

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

The DHCC's statistics show that the DCA Performance Measurement expectations are being met. For example, in Quarter 3 of 2017, our average for the intake of complaint receipt to the date the complaint was closed or assigned to an investigator was fifteen (15) days. The target average to intake complaints to the date the complaint was closed or assigned to an investigator is 30 days. The DHCC Enforcement program is exceeding its expectations in processing its enforcement cases and, as such, will monitor its current efficiencies and modify them as needed to improve performance.

34. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

In the last two years, the DHCC has seen an increase in the number of investigations first assigned. For example, in FY 2013/14 and FY 2014/15, the DHCC's average number of investigations first assigned was 153. In FY 2015/16 and FY 2016/17, the DHCC's average number of investigations first assigned was 186, which is a 22% increase from the previous two fiscal year average. Concurrently, the DHCC has seen a slight increase in the number of investigations closed. For example, in FY 2013/14 and FY 2014/15, the DHCC's average number of investigations closed was 130. In FY 2015/16 and FY 2016/17, the DHCC's average number of investigations closed was 136, which is about a 5% increase from the previous two fiscal year average.

The DHCC has seen a (previously) increasing number of pending investigation cases come to a plateau. For example, In FY 2013/14, FY 2014/15 and FY 2015/16 the number of pending investigation cases were 31, 76, and 98 respectively. In FY 2016/17, the number of pending investigation cases was 102. The minimal increase in the amount of pending cases from FY 2015/16 to FY 2016/17 is attributed to the DHCC's concerted effort to close aging investigations from previous fiscal years.

In the last year, the DHCC has seen an increase in the number of new probationers. For example, in FY 2013/14, FY 2014/15 and FY 2015/16 the average number of new probationers per fiscal year was 10. In FY 2016/17 the number of new probationers was 18, which is an 80% increase from the previous three fiscal year average. Over the last four years, the DHCC has also seen a steady increase in the number of licensees on probation at the end of each fiscal year. For example, in FY 2013/14, FY 2014/15, FY 2015/16 and FY 2016/17 there were 18, 29, 33 and 43 probationers at the end of each year respectively.

What are the performance barriers?

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

A second barrier is that DHCC staff are at the breaking point where additional staff are needed to address the continually increasing enforcement workload. The DHCC was granted one additional enforcement position to address the probation monitoring workload; however, additional staff is still needed to review and investigate enforcement cases and prepare for succession planning, as the current Enforcement Analyst is on the verge of retirement and the number of cases is continuing to grow.

What improvement plans are in place?

The DHCC enforcement staff regularly communicates with the AG's Office regarding the status of its cases; however, because the AG's Office has such a heavy workload and is understaffed, the DHCC can only request a quicker processing of its cases and frequent follow-up to reduce the time to complete accusations or statement of issues. Whether the DHCC's request is fulfilled is dependent upon the current caseload at the AG's Office. The DHCC is also working to increase the number of enforcement staff to review and process enforcement cases so there is minimal delay within the DHCC business practices.

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

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

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

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

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

	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Intake				
Received	66	78	51	57
Closed	1	32	23	2
Referred to INV	65	46	31	55
Average Time to Close	43	71	55	32
Pending (close of FY)	1	20	42	1
Source of Complaint				
Public	14	8	32	33
Licensee/Professional Groups	12	4	4	1
Governmental Agencies	131	193	148	145
Other	11	6	4	5
Conviction / Arrest				
CONV Received	102	133	137	127
CONV Closed	133	133	96	126
Average Time to Close	28	28	55	144
CONV Pending (close of FY)	1	0	56	22
License Applications Denied	0	0	1	0

SOIs Filed	2	2	2	6
SOIs Withdrawn	0	1	0	0
SOIs Dismissed	0	0	0	0
SOIs Declined	0	0	0	0
Average Days SOI	84	44	79	335
Accusations Filed	7	15	8	9
Accusations Withdrawn	0	0	0	0
Accusations Dismissed	0	0	0	0
Accusations Declined	0	0	0	0
Average Days Accusations	678	273	649	693
Pending (close of FY)	8	11	13	12

	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Disciplinary Actions				
Proposed/Default Decisions	2	1	2	3
Stipulations	6	3	6	10
Average Days to Complete	305	312	412	483
AG Cases Initiated	18	18	17	16
AG Cases Pending (close of FY)	8	11	10	13
Disciplinary Outcomes				
Revocation	3	1	2	1
Voluntary Surrender	5	2	4	0
Suspension	0	0	0	0
Probation with Suspension	0	0	0	0
Probation	4	8	3	12
Probationary License Issued	7	3	4	6
Other	0	0	0	0
New Probationers	11	11	7	18
Probations Successfully Completed	1	0	3	3
Probationers (close of FY)	18	29	33	43
Petitions to Revoke Probation	0	0	0	0
Probations Revoked	0	0	0	0
Probations Modified	1	0	3	0
Probations Extended	0	0	0	0
Probationers Subject to Drug Testing	9	18	19	22
Drug Tests Ordered	0	0	0	0
Positive Drug Tests	0	0	0	0
Petition for Reinstatement Granted	0	1	0	1
New Participants	0	0	0	0
Successful Completions	0	0	0	0
Participants (close of FY)	0	0	0	0
Terminations	0	0	0	0
Terminations for Public Threat	0	0	0	0

Drug Tests Ordered	0	0	0	0
Positive Drug Tests	0	0	0	0

	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
All Investigations				
First Assigned	166	140	188	183
Closed	1	32	119	109
Average days to close	43	71	55	144
Pending (close of FY)	31	76	98	102
Desk Investigations				
Closed	154	105	119	109
Average days to close	43	71	55	56
Pending (close of FY)	31	28	56	68
Non-Sworn Investigation				
Closed	0	0	16	27
Average days to close	0	0	55	233
Pending (close of FY)	31	48	42	34
Sworn Investigation				
Closed	0	0	1	0
Average days to close	0	0	227	777
Pending (close of FY)	0	0	1	0
ISO & TRO Issued	0	0	0	0
PC 23 Orders Requested	0	0	1	0
Other Suspension Orders	0	0	0	0
Public Letter of Reprimand	0	0	0	0
Cease & Desist/Warning	0	0	0	0
Referred for Diversion	0	0	0	0
Compel Examination	0	0	0	0
Citations Issued	68	85	29	35
Average Days to Complete	65	53	132	72
Amount of Fines Assessed	13,700	17,550	19,250	22,200
Reduced, Withdrawn, Dismissed	500	1	0	0
Amount Collected	7,500	17,550	14,050	15,458
CRIMINAL ACTION				
Referred for Criminal Prosecution	0	0	0	0

	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	Cases Closed	Average %
Closed Within:							
1 Year	2	0	5	5	7	19	40%
2 Years	2	5	3	2	4	16	34%
3 Years	1	1	3	2	1	8	17%
4 Years	1	1	0	1	1	4	9%
Over 4 Years	0	0	0	0	0	0	0%
Total Cases Closed	6	7	11	10	13	47	100%
Closed Within:							
90 Days	156	124	99	80	128	587	76%
180 Days	21	14	7	3	12	57	7%
1 Year	17	10	13	6	21	67	9%
2 Years	1	5	6	4	26	42	5%
3 Years	2	1	3	0	8	14	2%
Over 3 Years	1	0	0	1	2	4	1%
Total Cases Closed	198	154	128	94	197	771	100%

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

The overall statistics since the DHCC's last Sunset Review in 2014 show an increase in disciplinary action. In the DHCC's last review FY 2009/10 through FY 2012/13, the average number of cases referred to the AG's office was 7 per FY. However, for this review FY 2013/14 through FY 2016/17, the average number of cases referred to the AG's office was 17.5 per FY, which is a 150% increase since last review.

36. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.

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

The DHCC follows the case prioritization guidelines set forth in the DCA's August 31, 2009 memorandum Complaint Prioritization for Health Care Agencies. These guidelines are used during the DHCC's complaint intake process as well as its investigation processes. However, the DHCC recognizes that these guidelines offer general parameters and do not apply uniformly to every case. The DHCC Enforcement Unit handles each case independently on a case-by-case basis for merit to pursue further action.

What is the board's complaint prioritization policy?

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

1. Urgent Priority - (requires immediate attention and has the highest priority) A case involving sexual misconduct, quality of care issues, arrest(s) or conviction(s), drug or alcohol abuse, or other serious offenses.
2. High Priority - (second highest priority type) A case involving unlicensed activity, negligence, or incompetence without serious bodily injury.
3. Routine Priority - (handled in the normal course of business) A case involving false or misleading advertising, fraud, or record keeping violations.

After the highest urgency cases are determined, the analyst or investigator who is reviewing the case prioritizes it within his/her existing caseload. Factors DHCC staff take into consideration include, but are not limited to actual or potential for consumer harm, and any applicable criminal and/or administrative statute of limitations.

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

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

If so, explain why.

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

37. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?

- Penal Code (PC) § 11105.2 – This section requires the DOJ to report to the DHCC whenever a licensee is arrested and convicted of crime(s).
- BPC § 803 – This section requires the clerk of a court that renders a judgment that a licensee has committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount of $30,000 caused by the licensee's negligence, error or omission in practice, or his or her rendering of unauthorized professional services, must report that judgment to the DHCC within 10 days after the judgment is entered.
- BPC § 1950.5(x) – This section requires the licensee to report to the DHCC in writing within seven days any death of his or her patient during the performance of any dental hygiene procedure or the discovery of the death of a patient which was related to a dental hygiene procedure performed by him or her.
- BPC § 1950.5(y) – This section requires the licensee to report to the DHCC all deaths occurring in his or her practice with a copy sent to the dental office.

- PC § 11164 et seq. – This section requires the licensee to report any child abuse and neglect.
- Welfare and Institutions Code § 15600 et seq. – This section requires the licensee to report elder abuse.

Are there problems with receiving the required reports?

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

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

Correcting the problems in obtaining required reports is difficult because the DHCC has had to rely on outside agencies to take the time to retrieve the record(s) requested and copy and mail them to the DHCC. If there is a payment involved for the record(s), the process could be delayed even longer, as requests for payments take time to process in addition to the delay in processing the record request by the outside agency.

The only options available to the DHCC to correct the problem is to consistently and frequently follow-up with the outside agency from where the record(s) are being requested. The payment to pay the fees for records could be expedited if a credit card or similar method of payment is used; however, the State would need to create such a system and its associated accountability aspects. The DHCC has no jurisdiction over the outside agencies where the information or report is requested and must rely on professional courtesy and cooperation to obtain the needed information.

a. What is the dollar threshold for settlement reports received by the board?

   BPC § 803 specifies that, after a judgement of more than $30,000 by a California court, the clerk of that court shall report the judgement to the DHCC within 10 days.

b. What is the average dollar amount of settlements reported to the board?

   To date, the DHCC has not received any settlement reports.

38. Describe settlements the board, and Office of the Attorney General on behalf of the board, enter into with licensees.

The DHCC uses its Disciplinary Guidelines and the Uniform Standards for Substance Abuse as the framework for determining the appropriate penalty for charges filed against a licensee. While the Disciplinary Guidelines and Uniform Standards from the recommended penalty, the facts of each individual case may support a deviation from the guidelines.

If a settlement agreement is reached, the settlement document must be approved by the DHCC members. The DHCC then may adopt the settlement as written, request changes to the settlement, or request the matter go to hearing before an Administrative Law Judge. The settlement recommendations stipulated by the DHCC must provide an appropriate level of public protection and rehabilitation.

Settling a case by stipulations that are agreed upon by both sides (licensee and DHCC) facilitates consumer protection by rehabilitating the license in a more expeditious manner. By entering into a stipulation, it places the licensee on probation quicker and the public is able to see the action taken by the DHCC sooner that if the matter went to hearing. In addition, the DHCC may obtain more terms and conditions through the settlement process than if the matter went to hearing.

a. What is the number of cases, pre-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?

*Pre-Statement of Issues Cases resulting in Settlement	7	3	4	6
**Pre-Accusation/Pre-Statement of Issues Cases resulting in a Hearing	N/A	N/A	N/A	N/A

Notes: *The DHCC only settles pre-statement of issues (applicant) matters. It does not settle matters prior to filing an accusation (licensees).

**No cases occurred because a hearing can only occur after the filing of an accusation or statement of issues.

b. What is the number of cases, post-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?

Post-Accusation/Post-Statement of Issues Cases resulting in Settlement	6	3	6	10
Post-Accusation/Post-Statement of Issues Cases resulting in a Hearing	2	1	2	3

c. What is the overall percentage of cases for the past four years that have been settled rather than resulted in a hearing?

The overall percentage of cases for the past four years that have been settled is 85%, and 15% resulted in a hearing. See the following chart for the breakout over the past four years.

Fiscal Year				
Percentage of Cases Resulting in a Settlement	87%	86%	83%	84%
Percentage of Cases Resulting in a Hearing	13%	14%	17%	16%

39. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

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

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

To date, one case has been lost due to the DHCC's statute of limitations.

As a safeguard, the DHCC uses the date the complaint is received as the initiation of the statute. However, until patient treatment records can be obtained, along with a subject response, and the case is reviewed by a dental hygiene expert consultant, the DHCC considers the dental hygiene expert consultant's opinion as the date of discovery.

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

To prevent unlicensed activity, information is presented to educate the public and all licensees on the DHCC's website, newsletter articles, and several outreach programs. In addition, a supplemental law and ethics examination is required for all applicants with an emphasis on personal ethics and morals. When renewing a license, a mandatory CE law and ethics course is required for the licensees pertaining to all applicable laws including professional misconduct that affect dental hygiene practice.

In the last four years, the DHCC received approximately 10 reports of unlicensed activity annually. In most instances, the allegations involve licensees who are practicing with an expired license. These cases are generally investigated during office visits and may result in the issuance of a citation and fine, or referral to the Attorney General's Office, depending on several factors such as the duration of the unlicensed activity. More precedent are the cases that are reported where truly unlicensed individuals are practicing dental hygiene. Although only comprising roughly 20% of the unlicensed activity reports, these cases involve individuals who have never been licensed in any

capacity or previously held a license. The DHCC works closely with the Dental Board of California on unlicensed activity cases as most dental hygienists are employed by a dentist in a dental office.

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

Cite and Fine

41. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the $5,000 statutory limit?

BPC § 125.9 authorizes the DHCC to issue citations and fines for violations of the Dental Practice Act. Over the past four years, the DHCC has used its authority for cite and fine extensively depending upon the cases that are eligible for a cite and fine. There have not been any changes to the cite and fine program since the last Sunset Review because at the time of the last review, the DHCC had recently obtained authority to issue citation and fines. The DHCC's citation and fine maximum is not to exceed $5,000.

BPC § 1955(a) authorizes the DHCC to issue administrative citations to licensees and healthcare facilities who fail to produce requested patient records within the mandated 15-day period. The DHCC may issue citations with a $250/day fine, up to a $5,000 maximum. To date, the DHCC has not needed to issue a citation for failure to produce patient records.

The DHCC has expanded the scope of its use of cite and fine (beyond record production) to address a wider range of violations that can be more efficiently and effectively addressed through the use of cite and fine process with abatement and/or remedial education outcomes. It is also being used to address licensees who do not complete the continuing education (CE) units required to renew a license. These individuals are discovered to be deficient after a CE audit.

There have been no changes to the DHCC's citation and fine program regulations since the last Sunset Review because at the time of the last review, the DHCC had recently obtained the authority and staff to issue citation and fines.

The DHCC's citation and fine authority is not to exceed $5,000, so if there is a case that is egregious enough to warrant a $5,000 citation and fine, the DHCC will impose its maximum charge as determined by the Executive Officer or his or her designee.

42. How is cite and fine used? What types of violations are the basis for citation and fine?

Citation and fines are used by the DHCC as a method to notify the licensee that a violation has occurred and that they are not in compliance with the law. In situations where the DHCC does not seek to suspend or revoke a license, a citation and fine may be issued to impose a monetary fine and/or order of abatement as an administrative action against a licensee. An example would be if a licensee is found to be practicing on an expired license. Another is if a licensee failed to complete all of the continuing education (CE) units required to renew a license and was found to be non-compliant after a CE audit.

Citations including remedial education may be used as abatement when patient harm is not found, but the quality of care provided to the consumer is substandard. Also taken into consideration is

the length of time needed to take administrative discipline. In some cases, an administrative citation is more appropriate to send a swift message regarding unprofessional conduct or to achieve prompt abatement.

When issuing citations, the DHCC's goal is to protect the California consumers by getting the licensee's attention, re-educating him/her on the applicable law, and to emphasize the importance of following the dental hygiene practices that fall within the profession's standard of care. Consideration when issuing a citation and fine include:

- Nature and severity of the violation;
- Length of time that has elapsed since the violation;
- Consequences of the violation – was there potential harm to the consumer;
- Licensee's history of previous violations: the number and types of violations in licensee's history;
- Evidence that the violation was willful.

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

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

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

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

In the last four (4) fiscal years, the DHCC held five (5) informal conferences. The DHCC has not had any Administrative appeals in the last four fiscal years.

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

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

1934	Change of address or Name: Failure to notify the Committee of an address change within 30 days and for a name change, it is within 10 days.
1950(a)	Consequences of conviction of crime substantially related to the licensee's qualifications, functions, or duties: DUI
1950.5(e)	The use of any false or fictitious name in advertising: False advertising on website and brochure.
1950.5(v)	Any action or conduct that would have warranted the denial of the license: False entry on a license renewal application.
1960(f)	Practicing with an expired license.

45. What is average fine pre- and post- appeal?

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

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

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

The DHCC has not used the Franchise Tax Board (FTB) intercept to collect any outstanding fines to date; however, the DHCC will review this method as an alternative to the traditional collection methods. If the DHCC implements this method, the procedure would be as follows:

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

Cost Recovery and Restitution

47. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

BPC § 125.3 authorizes the recovery of investigation costs that are associated with the formal discipline of a licensee. The DHCC's policy is to seek cost recovery in all cases where it is authorized. As a result, the DHCC's Disciplinary Guidelines lists the reimbursement of costs as a standard term of probation and is included when settling cases with a stipulated settlement, and most, but not all, administrative hearing decisions. When initially meeting with a probationer, the reimbursement of costs is discussed and an installment payment plan may be made at that time. In the order, the probationer must pay all cost recovery, whether in partial payments or a lump sum payment, within 6 months of the end of the term. Otherwise, the probationer is not in compliance with the terms of probation.

The DHCC's request for cost recovery is made to the presiding Administrative Law Judge (ALJ) who decides the amount of the DHCC's expenditures that will be compensated. The ALJ may award the DHCC full or partial cost recovery, or may reject the DHCC's request altogether.

Discuss any changes from the last review.

There have not been any changes since the last review.

48. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

In the last four years, the DHCC has ordered cost recovery in approximately 5 cases per year. Over that same period, the amount of cost recovery ordered by the DHCC was approximately $15,236 annually.

Typically, cost recovery is requested at the onset of administrative cases. The amount is determined by the investigation time and by costs incurred by the AG's Office. In the case of revocations or surrenders, the ordered costs are considered uncollectable until the licensee either petitions the DHCC for reinstatement or reapplies for licensure.

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

The DHCC's authority only allows for cost recovery to be imposed against licensees. Therefore, the DHCC is unable to seek cost recovery in Statement of Issues cases because these individuals are not yet licensed. A statement of issues case is initiated when the DHCC denies an applicant a license and the applicant appeals the denial pursuant to BPC § 485.

Why?

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

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

The DHCC has not used the FTB intercepts to collect outstanding cost recovery; however, the DHCC is currently working towards participation in this program and is identifying appropriate cases that can be enrolled. The process in which the DHCC would use the FTB intercepts to collect cost recovery is:

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

51. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

BPC § 129(c) provides the DHCC the ability to request appropriate relief for a complainant, including the ability to meet and confer to mediate a complaint. In some instances, an ALJ may impose restitution in addition to cost recovery and other conditions of a disciplinary order.

Obtaining restitution for individual consumers is an additional condition of probation in the DHCC's Disciplinary Guidelines and is included in stipulations or in an ALJ's decision after a hearing. To date, the DHCC has not had any reports of consumer harm to warrant a request for restitution for individual consumers; however, there has been a case where restitution was sought from a licensee for subversion of the DHCC Law and Ethics Examination.

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

	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Total Enforcement Expenditures					

Potential Cases for Recovery *	2	3	4	3	7
Cases Recovery Ordered	2	3	4	3	8
Amount of Cost Recovery Ordered	$13	$9	$19	$7	$12
Amount Collected	$5.5	$7	$10	$3	$3

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

DHCC Cost Recovery can occur over several fiscal years because the affected licensee has the option to make payments over the time that they are on probation rather than one lump sum payment. The Probation Order states, "Respondent shall be permitted to pay these costs in a payment plan approved by the Committee, with payments to be completed no later than 6 months prior to the end of the probationary term." With the DHCC placing more licensees on 5-year probation terms as compared to 3-year terms, the payments can be lengthened showing less cost recovery per year, but overall, recovering most of the amount ordered, as it is required to be paid in full no later than 6 months prior to the end of the probationary term.

	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Amount Ordered	10	0	0	0	0
Amount Collected	$3	$3.5	$3.2	$0.5	0

Section 6 – Public Information Policies

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

The DHCC uses its website to inform the public of any activities such as upcoming public meetings on its calendar, changes to laws or regulations, as well as general news pertaining to the dental hygiene profession and licensure. There are also frequent email blasts sent out to interested stakeholders who have subscribed to the DHCC's email list to be informed of any upcoming events or information.

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

The DHCC posts its meeting materials and agenda on its website/online within five to 10 calendar days prior to each meeting complying with the Bagley-Keene Open Meetings Act. The public meeting materials stay on the DHCC's website indefinitely, as older meeting materials are placed into an archive file where the public can continue to have access to them. A link is posted on the DHCC's meeting calendar to access the archived meeting materials at any time.

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

The draft meeting minutes for the prior meeting are contained in the materials for the next meeting to be approved and are posted five to 10 calendar days prior to the meeting. After the draft minutes from the prior meeting have been approved at the subsequent meeting, the final version of the minutes is posted on the website/internet meeting calendar under the same meeting date(s) and are available at any time. Eventually, the minutes will be moved into the archive file where the minutes remain indefinitely and are accessible on the website indefinitely.

53. Does the board webcast its meetings?

The DHCC fully supports webcasting and has webcast its meetings in the past. Unfortunately, the availability of a videographers and scheduling to webcast the meetings has been challenging.

What is the board's plan to webcast future board and committee meetings?

The DHCC plans to request webcasting for its future meetings.

How long to webcast meetings remain available online?

Webcasted meetings remain available online on the DCA website in the archives for a year. However, webcasts are available indefinitely on the YouTube webpage.

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

Yes. The DHCC's meeting calendar is posted on its website and updated as events arise so that the public is notified at a minimum within the legal time frame provided in the Open Meetings Act.

55. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

The DHCC uses the DCA's Recommended Minimum Standards for Consumer Complaint Disclosure.

Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

The DHCC posts accusations and disciplinary actions against its licensees in accordance with the DCA's Web Site Posting of Accusations and Disciplinary Actions through the biannual DHCC Newsletter. In addition, the BreEZe computer system does show any disciplinary action against a licensee to the public when an individual is queried through a license search.

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

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

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

The DHCC uses a variety of methods to provide consumer outreach and education to interested stakeholders. The DHCC has presented at student regional meetings, visited many of the dental hygiene schools throughout the state, attended both dental and dental hygiene association events and meetings, participated in health fairs, public health events, and educational institution outreach functions, issues email blasts to the DHCC email subscribers and educational program

directors, and has a newsletter that is readily available electronically or hardcopy to inform the public, students, associations, and educational institutions about the DHCC programs and authority.

Section 7–
Online Practice Issues

58. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate internet business practices or believe there is a need to do so?

The DHCC believes the prevalence of online practice is emerging and there have been no reports received of unlicensed dental hygiene activity. There are no legal prohibitions to using technology in the practice of dental hygiene, as long as the practice is done by a California licensed dental hygienist. Telehealth is not a telephone conversation, email/instant messaging conversation, or fax; it typically involves the application of videoconferencing or "store and forward" technology to provide or support health care delivery. Teledentistry is growing in popularity and is used more prevalently within the profession, especially for treatment centers in remote locations.

Section 8–
Workforce Development and Job Creation

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

The DHCC supported SB 850 and the decision of California Community Colleges to approve two colleges to develop bachelor's degree programs in dental hygiene. Selection was based on geographic distribution of the pilot programs and that the proposed programs will meet an unaddressed local or statewide workforce need. West Los Angeles College and Foothill College were chosen. This law was enacted to assist the State in meeting the need for individuals in high demand technical disciplines which are increasingly requiring baccalaureate degrees and to increase college participation rates and improve workforce training opportunities for local residents who are unable to relocate due to family or work commitments.

The DHCC supported SB 502 which amended the Moscone-Knox Professional Corporations Act of 1968 to include RDHAPs as one of the authorized health arts professionals to form a corporation.

The DHCC has been very proactive in seeking ways to implement BPC § 1900 which states:

"It is the intent of the Legislature by enactment of this article to permit the full utilization of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions in order to meet the dental care needs of all of the state's citizens."

The primary reasons that restrict full utilization of all categories of dental hygienists and decreases their ability to provide care for all of the state's citizens are restrictive supervision levels, scope of practice restrictions that limit the services that dental hygienists are allowed to provide, and the inability for dental hygiene practitioners such as the RDHAP to obtain payment for the services rendered.

Restrictive supervision levels have been removed for other dental healthcare providers. With the statutory revision of the dental practice act in recent years, determining the appropriate level of supervision for unlicensed dental assistants and registered dental assistants, language has been changed. Prior to the changes, the laws stipulated which services were to be completed under direct supervision (the dentist employer must be physically present in the office when the service is performed) and general supervision (the dentist employer need not be present when the services are performed). The new laws allow the dentist employer to determine the level of supervision necessary for the performance of the services that assistants are legally allowed to provide.

Although BPC §§ 1912 – 1914 allow for general supervision for most services performed by dental hygienists, some services are still only authorized under direct supervision which limits the full utilization of the dental hygienist services. The DHCC has approved to seek legislation to remove the direct supervision restrictions.

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

The DHCC is fortunate to not have experienced any licensing delays. The DHCC is currently issuing licenses within 30 business days of receipt of a complete application package which is well within the 120 days the DHCC is allowed to issue a license. The DHCC is also contacting applicants of any deficiencies in their application within 30 business days from the date of submission of the application to minimize any delays in the issuance of a license. Once contacted, it is the responsibility of the applicant to submit the missing item(s) to continue the processing of the application.

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

Through networking with professional organizations, CDHA, and the California Dental Hygiene Educator's Association (CDHEA), the DHCC has attended meetings for students and educators and presented information regarding licensing requirements and the licensing process. Additionally, the DHCC has participated in several class sessions in person and via online media and teleconference with educational programs to interact with dental hygiene students and explain the licensing requirements and process.

62. Describe any barriers to licensure and/or employment the board believes exist.

Currently, many dental insurance companies recognize dentists in a dental practice as the billable provider of dental hygiene services and even though RDHAPs provide the same billable services that an RDH provide, billed by the dentist, the insurance companies are denying RDHAP's reimbursement for services. In its 2014 Sunset Review Report, the DHCC identified as a barrier to RDHAP practice the inability for RDHAPs to collect payment for services rendered. The DHCC noted that RDHAPs have difficulty collecting payment for services from insurance companies based outside of California. This is because not all states have the RDHAP provider status making them ineligible for reimbursement. As a result, some patients who cannot easily access care in a traditional dental office are forced to pay out of pocket for the services of a RDHAP or not receive care due to financial constraints.

One of the requirements for licensure as an RDH is satisfactory completion of a practical examination given by either the Western Regional Examining Board (WREB) or Central Regional

Dental Testing Services (CRDTS). This method of testing has been proven that it is in no way testing for competence. Applicants seeking licensure as dentists have the option of completing a portfolio showcasing one's abilities. Additionally, applicants seeking licensure as a Registered Dental Assistant (RDA) only have to take a written exam and a law and ethics exam. The DHCC will continue to review alternative pathways to licensure in lieu of a practical examination.

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

a. Workforce shortages

The DHCC monitors reports from the Office of Statewide Health Planning and Development (OSHPD) and the industry on workforce shortages. Current data indicates there is no longer a shortage of dental hygienists in the state. There continues to be a mal-distribution of dental hygienists due to practice limitations that require dental hygienists to work for a dentist. The category RDHAP was enacted by the legislature to increase access to dental hygiene services in dental shortage areas. The number of RDHAP's has increased by 172% from 2009 (238 licensees) to 2016 (648 licensees). However, the requirement for a prescription from a dentist or physician has hindered the RDHAP's ability to provide dental hygiene services in some of these areas due to a lack of dentists and physicians in the area and/or the unwillingness of the dentist or physician to sign a prescription allowing the RDHAP to provide care.

b. Successful training programs.

The most successful training program has been offered to dental hygiene program educators on the placement of Interim Therapeutic Restorations (ITRs) and determination of radiographs to perform on patients utilizing teledentistry. The Health Workforce Pilot Project 172 was signed into Statute in 2015 and the DHCC requested each dental hygiene program send one faculty member and a supervising dentist to trainings offered in Northern and Southern California. To date, 16 dental hygiene programs have fully integrated ITRs and radiographic determination into their curriculums. The other programs are waiting for the regulations to be drafted and finalized by the DHCC before implementation.

The RDHAP training programs continue to successfully educate licensed RDHs to provide services in skilled nursing facilities, residences for the homebound, school-based oral health programs, residential care facilities, and dental health professional shortage areas. There are currently two RDHAP programs in the state. These programs are providing the necessary additional education to qualify an individual for licensure.

Section 9 – Current Issues

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

The DHCC has implemented CCR § 1138 to comply with the Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (dated April 2012) effective January 14, 2014. These standards provide the guidelines and structure for addressing licensee issues pertaining to substance abuse and disciplinary matters (cf., Section 12, Attachment F).

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

The DHCC has addressed some items through statute and some in both statute and Disciplinary Guidelines. The DHCC successfully sought legislation to require denial of a dental hygiene license to a registered sex offender and permanent revocation of a license for sexual misconduct. The DHCC pursued legislation that imposes substantial fines on licensees and health care facilities that fail to comply with a court order to provide documents and has proposed regulatory language within its Disciplinary Guidelines that specifies penalties for a licensee's failure to cooperate with an investigation. Regulatory language was approved in 2016 to specify the DHCC may delegate stipulated settlements to its EO and require a medical or psychological evaluation of an applicant. Although licensees are currently required to certify at the time of each license renewal, penalties for failure to report an arrest or conviction will be the subject of upcoming regulations, as will a prohibition of confidentiality agreements.

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

The DHCC has extensively participated in the development and implementation of the BreEZe computer system for DHCC use. DHCC staff has also participated in ongoing testing, updates, and training programs and exercises to identify programmatic issues. The DHCC will continue to test, evaluate, and communicate any issues or problems that arise to the DCA Office of Information Systems on an ongoing and as needed basis.

a. Is the board utilizing BreEZe?

Yes, the DHCC has been using the BreEZe computer system since the January 19, 2016 Release 2 date.

What Release was the board included in?

Release 2 (implemented on January 19, 2016).

What is the status of the board's change requests?

The DHCC is informed of the BreEZe change requests after submission through a list of release dates from the Office of Information Services at the Department of Consumer Affairs. The current change list has been consistent and updates occur about every month. The DHCC's specific change requests have been implemented on a fairly rapid pace and the cooperation between both parties on updates and any requested changes or information has been very good. There are still some ongoing issues, particularly with accurate licensing and enforcement data and information, but these issues should be corrected over time where correction patches or resolutions can be implemented to fix them.

b. If the board is not utilizing BreEZe, what is the board's plan for future IT needs? What discussions has the board had with DCA about IT needs and options? What is the board's understanding of Release 3 boards? Is the board currently using a bridge or workaround system?

N/A, as the DHCC has been on BreEZe since January 19, 2016.

Section 10 – Board Action and Response to Prior Sunset Issues

Include the following:

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

   A. The DHCC noted in their Sunset Review Report that problems have arisen when the shortage area in which an RDHAP sets up a practice is re-designated as a non-shortage area. Law requires the RDHAP to close the practice when this occurs. The DHCC views this as "counterproductive...as the closure of the practice would leave patients with no access to dental hygiene services."

   The DHCC attempted in Senate Bill 1202 in 2012 to amend BPC § 1926(d) to read:

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

   JLSRC Staff Recommendation: Based on the concerns raised regarding the re-designated shortage area, as well as the issues with reimbursement from insurance companies, the DHCC might consider seeking legislation to make the necessary changes to both BPC § 1926(d) and BPC § 1928.

   The DHCC supported SB 1202 sponsored by the California Dental Hygienists Association (CDHA) which included the proposed language. Due to opposition from the California Dental Association (CDA), who proposed that this language would only be acceptable if additional restrictions were placed on the RDHAPs requiring the RDHAPs limit the numbers of patients in their patient base who had insurance or were private pay, the language was removed. CDHA was in opposition to attempts by CDA to limit the types of patients seen by RDHAPs. A restriction that is not placed on dentists in these same areas.

   The DHCC supports the recommendation of the JLSRC that legislation should be sought to make changes to BPC § 1926(d) and BPC § 1928.

   B. CE requirements could be viewed as an avenue to ensure continued competence; however, it has been debated that CE does little to ensure that licensees remain competent and provide quality care.

   Continued competence moves beyond CE and speaks to the ongoing application of professional knowledge, skills and abilities, which relate to the occupational performance objectives in a range of possible encounters that is defined by the individual scope of practice and practice setting.

   As such, the DHCC desires to add the following to BPC § 1936.1:

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

   JLSRC Staff Recommendation: The DHCC should advise the Committees what the "measure of continued competency" would consist of. If the DHCC decides to expand its practice act to include measures of continued competency it will need to seek legislation to pursue this change.

The DHCC has begun discussions on seeking legislation and/or regulatory language to address the issue of continued competency.

C. In California, hygienists are required to be under direct supervision when administering soft tissue curettage, local anesthesia and nitrous oxide-oxygen analgesia.

Six states mandate general supervision for preventative tasks such as prophylaxis fluoride and sealants. Seven states allow hygienists to administer local anesthesia under general supervision.

There have been no reported incidents of consumer harm [for hygienists who administer soft tissue curettage, local anesthesia and nitrous oxide-oxygen analgesia]. Changing the supervision level from direct to general would allow dental hygienists to provide these services without the restriction of having the dentist in the office...but still under the direction of the supervising dentist. Soft tissue curettage is performed as an adjunct therapy to scaling and root planing which is performed under general supervision and therefore, should not require direct supervision.

JLSRC Staff Recommendation: The DHCC should consult with the Dental Board of California regarding the implications of adopting a general supervision model for the procedures. If the DHCC desires to amend its practice act to allow for a change in supervision model, it will need to seek legislation to pursue this change.

The California Dental Hygienists' Association (CDHA) has worked with the legislature to support legislation to make the needed statutory changes. CDHA sponsored SB 1202 which included this language and had the support of the DHCC. As with the language for allowing RDHAPs to retain their practices, due to opposition from CDA, the language was removed. The DHCC continues to support the removal of the direct supervision requirement and will continue to work with CDHA on legislation.

D. The DHCC has operated as an independent committee since its inception with Governor appointed committee members, the regulation of its licensees, the approval and oversight of the dental hygiene educational programs, and has its own enforcement staff to ensure compliance of the laws that govern the dental hygiene profession and in the interest of consumer protection.

The DHCC should be changed to an independent board. The use of language that states that the DHCC is under the jurisdiction of the Dental Board of California (DBC) has led to confusion in the profession and the public as to the authority of the DHCC to act as a self-regulating agency. Licentiates, the public, and other nationally recognized associations and governing entities view the jurisdiction language as restricting the ability of the DHCC to act independently in matters pertaining to the regulation of dental hygienists. Pursuant to the definition of the functions of an independent agency, the DHCC is not subject to restrictions set by the DBC and does act independently of the DBC. Furthermore, the DBC has no statutory authority to regulate the practice of dental hygiene.

JLSRC Staff Recommendation: Despite the DHCC's stated ability to operate independently from the DBC, it is important to note that this is only the first Sunset Review Hearing of the DHCC. As such, the Committee suggests that the DHCC undergo additional review(s) before seeking legislation to change their name to the Dental Hygiene Board of California.

The DHCC continues to operate as an independent program. The DHCC is requesting that the JLSRC recommend legislation to change the name of the DHCC to the DHBC (Dental Hygiene Board of California) after this sunset review is complete.

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

   Please see the DHCC responses in Question 1 (A),(B),(C),&(D) above.

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

   The DHCC recommends that the jurisdiction language in BPC § 1901 be removed. The DHCC has functioned as an independent agency since it was created in 2009.
   The JLSRC Background Paper for the Dental Board of California (DBC) Sunset Review dated March 14, 2011 (cf., Section 12, Attachment G) made the following recommendation:

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

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

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

   (b) This article may be hereby known as the Dental Hygiene Practice Act.

   ~~(b)~~ (c) This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2024, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the ~~committee~~ board subject to review by the appropriate policy committees of the Legislature.

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

   The DHCC also recommends that the language in BPC §§ 1905. (a)(8) and 1905.2 be removed. BPC § 1905 (a)(8) and § 1905.2 require the DHCC to make recommendations to the DBC regarding dental hygiene scope of practice issues. As an independent regulatory agency, the DHCC should not have to make recommendations to the DBC on issues that impact the practice of dental hygiene. In addition, the DBC has no authority over the dental hygiene scope of practice.

The DHCC has established a solid working relationship with the DBC in which the DBC and DHCC collaborate on issues that affect dental hygiene and dentistry. What has become problematic is the impact CDA has on the DBC decision making process. For example, the DHCC submitted a regulatory packet which included definitions for terms used in the statute pertaining to dental hygiene education and educational programs. The definitions coming from accepted dental and dental hygiene textbooks and/or research documents. The DBC did not consider the definitions to represent a scope of practice change. However, CDA threatened to take legal action with the DBC if the DBC did not review the definitions and make the changes proposed by CDA. The regulatory packet was pulled, edited, and resubmitted. This action was not instituted by the DBC, but was instituted by CDA using the scope of practice restriction. This was time consuming, postponing the approval for regulations providing definitions for over a year.

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

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

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

Section 11 – New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board’s recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, legislative changes) for each of the following:

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

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

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

   - Additional staff in the following areas:
     1. Continuing Education (CE) review, audit, and CE provider review programs to ensure that licensees who have had their license renewed remain in compliance with the license renewal law (BPC § 1936.1).
     2. Licensing – processing of hundreds of applications for licensure for registered dental hygienists, registered dental hygienist in alternative practice, and registered dental

hygienist in extended functions, plus special permits and fictitious name permits. The total active licensee population is close to 22,000 licensees and they all renew their licenses every 2 years.

3. Enforcement – consumer complaint receipt, review, and processing to be referred to an investigator, subject matter expert, or closed. The number of enforcement complaint cases has increase by 147% over the past four years.
4. Educational Programs – the DHCC began reviewing the dental hygiene educational programs in California and has discovered many programs are not in compliance of the law. Additional staff is needed to address the review of the program, faculty, infection control procedures, administrative functions, grading systems, write up of complex reports, and compliance with the law and Commission on Dental Accreditation (CODA) standards.

- Additional office space to accommodate more staff and resources to address an increased workload in support of the DHCC programs.

3. New issues not previously discussed in this report.

a) Remove practice restrictions for dental hygienists working without supervision in public health settings.

Amend BPC § 1911(c) to remove restrictions for dental hygienists working in any public health program to practice without supervision. This section currently allows for dental hygienists to practice without supervision only in public health programs created by federal, state, or local law or administered by a federal, state, or local government entities.

Foundations and other non-profit charity entities have need of the services that dental hygienists provide. Amending this section to remove the restrictions requiring that the program be created administered by federal, state, or local governmental entities would allow these other public health or community organizations to utilize the services of the dental hygienist without the supervision of a dentist.

Allow RDHAPs to provide dental hygiene services in dental and medical offices.

Amend BPC § 1926 RDHAP practice settings to include dental and medical offices.

RDHAPs must maintain both an RDH and RDHAP license to work in a traditional dental office. Due to RDHAPs being restricted from performing direct supervision duties, they must have two licenses to provide direct supervision duties in a dental office. This requires an additional licensure fee requiring them to pay double the cost for licensure.

RDHAPs have established relationships with physicians in areas where there may be few dental offices. Allowing the RDHAP to work in a medical office setting would increase patients access to dental hygiene services without having to seek the treatment elsewhere.

b) Remove the prescription requirement for the RDHAP.

Remove BPC § 1931: RDHAP requirement of a prescription from a dentist or physician and surgeon.

RDHAPs continually report the difficulty experienced when requesting a prescription from a dentist or physician. The dentist and/or physician is not providing the services and in many cases do not want to have an implied legal obligation to oversee care provided by an RDHAP. The intent of the prescription requirement was to ensure that patients received care from a dentist or physician at

least every 18 months. RDHAPs are required to have a dentist with who they collaborate with and refer to. Removing this restriction would not negate the need for the patient to have a dentist for needed dental care. Nor would it negate the patient's need to be under the care of a physician.

c) Provide statutory language for the DHCC to place dental hygiene programs on probation and/or cite and fine educational programs that are in violation of the state law, CODA accreditation standards, and/or infection control regulations.

Currently, the DHCC has statutory authority to either approve or withdraw the approval from a dental hygiene program that is in violation of the law. This has created problems for programs that are in violation who are working to be in compliance with the law once notified of the violations by the DHCC. Allowing the DHCC to place programs on probation and establish a time frame for coming into compliance gives the programs the opportunity and flexibility to correct deficiencies prior to approval being withdrawn where the program's students would be ineligible to obtain a California dental hygiene license.

The DHCC has no mechanism for cost recovery for the staff time and workload issues involved in the oversight of the dental hygiene educational programs. There is a huge commitment in DHCC resources with staff time and expenses in dealing with educational programs that are not compliant with the law. Allowing the DHCC to cite and fine programs for violating the law would allow for some cost recovery for overseeing the program's efforts to correct violations as well as provide a possible deterrent for programs that repeatedly violate the law.

d) Provide authority for the DHCC to repeal Business and Professions Code §§ 1966 – 1966.6 pertaining to a Diversion Program for licensees needing rehabilitation due to alcohol or substance misuse.

The DHCC has the statutory authority to provide a Diversion Program to its licensees who have misused alcohol or drugs to the extent where it may impair a licensee's competency. The DHCC is sensitive to the possible need for its licensees in these situations to seek assistance; however, the cost of the program is prohibitive for licensees especially when there are other affordable alternatives available to them. Through 2014, the DHCC has only had one licensee in the program who had already been accepted years before, but remained to graduate from the program. Since then, no new participants have come forward voluntarily or by order of the DHCC due to the aforementioned expense. The Diversion statutory language was a carry-over from the Dental Practice Act when the DHCC was created in FY 2009/10.

e) Payment for Services Rendered

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

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

"Contrary to original legislative intent, many recent proposals have sought to restrict RDHAPs from full independent practice, inevitably creating barriers to access. Policy-makers should instead focus on the purpose of the RDHAP profession – to improve access to dental care. The profession's capacity to improve access is inherently tied to reimbursement policies for treating

the underserved, including the elderly and developmentally disabled. Legislators may therefore want to consider expanding public financial support structures for RDHAPs" (Mertz, 2008, p. 14) (cf., Section 12, Attachment H).

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

BPC § 1928. Registered dental hygienist in alternative practice, submitting of insurance and reimbursement of providers:

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

- Whenever any such insurance policy or plan provides for reimbursement for any service which that may be lawfully performed by a person licensed in this state for the practice of dental hygiene, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed.

- Nothing in this article shall preclude an insurance company from setting different fee schedules in an insurance policy for different services performed by different professions, but the same fee schedule shall be used for those portions of health services which are substantially identical although performed by different professions.

f) Alternative licensure options

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

Although the use of patients as part of the examination process continues to be the pathway to licensure for all dental hygienists, there are several emerging alternative platforms in dentistry that do not include the use of human subjects. The DHCC has identified the need to explore alternative pathways for licensure. To that end, the DHCC will require statutory authority to implement any of these alternative pathways. This will require amending BPC § 1917 (b) to read:

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

4. New issues raised by the Committee.

The DHCC has worked extremely hard to validate its existence as the only government body in the United States that oversees dental hygienists. Other states use their dental board to oversee dental hygienists, but California is unique to have an autonomous body to oversee them. The DHCC requests the authority from the Legislature to change its nomenclature from a committee to a board since the DHCC functions as an autonomous, decision-making body the same as a board with its own set of laws and regulations. Some of the functions that the DHCC performs within the DCA and would justify a change to a board are:

1) The DHCC make up is nine individuals appointed by the Governor consisting of both professional and public members that will discuss, deliberate, and vote upon issues that affect the DHCC in the interest of consumer protection;
2) Create standing committees to deal with examinations, enforcement, licensing, and other subject matter the DHCC deems appropriate to complete business;
3) Possesses the authority to request regulatory and legislative changes;
4) Mandates that the protection of the public is the highest priority in exercising its licensing, regulatory, examination, and disciplinary functions;
5) Oversees the examination, licensing, enforcement, and administration programmatic functions for the dental hygiene profession including legislation and regulations.
6) Has oversight responsibility for the DHCC approved California dental hygiene educational programs including curriculum review, faculty qualifications, and administration of the program.
7) Is a special fund agency that generates its own revenue from its fees to conduct business and would have no impact on the State's General Fund; and
8) Been in existence for 8 years and completed the Sunset Review process in 2014 where no problematic issues were identified if the DHCC were changed from a committee to a board.

With the DHCC performing the functions listed above autonomously, it stands to reason that the nomenclature of the DHCC be changed from a committee to a board.

Section 12 – Attachments

Please provide the following attachments:

A. Board's administrative manual.
B. Business and Professions Code §§ 1900 – 1967.4
C. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).
D. Major studies, if any (cf., Section 1, Question 4).
E. Quarterly and Annual Performance Measures over the last 3 years
F. Uniform Standards Related to
G. JLSRC Background Paper for the Dental Board of California concerning the DHCC
H. RDHAP Article (Mertz, 2008)
I. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.).

Section 13 – Board Specific Issues

THIS SECTION ONLY APPLIES TO SPECIFIC BOARDS, AS INDICATED BELOW.

Diversion

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

Diversion Evaluation Committees (DEC) (for BRN and Osteo only)

1. DCA contracts with a vendor to perform probation monitoring services for licensees with substance abuse problems, why does the board use DEC? What is the value of a DEC?
2. What is the membership/makeup composition?
3. Did the board have any difficulties with scheduling DEC meetings? If so, describe why and how the difficulties were addressed.
4. Does the DEC comply with the Open Meetings Act?
5. How many meetings held in each of the last three fiscal years?
6. Who appoints the members?
7. How many cases (average) at each meeting?
8. How many pending? Are there backlogs?
9. What is the cost per meeting? Annual cost?
10. How is DEC used? What types of cases are seen by the DECs?
11. How many DEC recommendations have been rejected by the board in the past four fiscal years (broken down by year)?

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENTS

APPENDIX

Attachment A –
Board's Administrative Manual

Attachment B –
Business and Professions Code (BPC) Sections 1900 – 1967.4

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

Attachment D –
No Attachment D because there were no major studies completed since the last Sunset Review. Used as a placeholder only.

Attachment E –
DHCC Quarterly and Annual Performance Measures for the past 3 years

Attachment F –
Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (dated April 2012)

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

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

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

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT A:

DHCC Administrative Manual

DHCC
Dental Hygiene
Committee
of California

Member Guidelines & Procedure Manual

August 2016

CONTENTS

Chapter 1
INTRODUCTION

The Dental Hygiene Committee of California (DHCC) is the only self-regulating dental hygiene agency of its kind in the United States. The California Legislature established the DHCC in 2008 as an independent committee within the Department of Consumer Affairs (DCA). In California, the DHCC holds authority to regulate the dental hygiene profession under the guidance of statutes contained in the Business and Professions Code (B&P), Sections 1900 - 1967.4 and sections of the California Code of Regulations (CCR). The following is a summary of the DHCC's responsibilities:

- Pursue legislation;
- Author and enforce regulations;
- Grant, renew, and withdraw approval of dental hygiene educational programs;
- Conduct feasibility studies for new dental hygiene educational programs;
- Develop and maintain the dental hygiene Law and Ethics Examination in conjunction with the Office of Professional Examination Services;
- Issue, suspend, and revoke dental hygiene licenses and permits;
- Oversee licenses placed on probation;
- Conduct investigation of and administer enforcement for licensing violations; and
- Participate in outreach and support of the dental and dental hygiene community.

DHCC members are appointed by the Governor and serve at the pleasure of the Governor. A standard term of appointment is four years in duration. The Governor shall have the power to remove any member from the DHCC for neglect of duty required by law, for incompetence, or for unprofessional or dishonorable conduct. In the event that a member resigns, the resigning member shall send a letter to the Governor notifying the Governor of the member's resignation and effective last date of service. A copy of the letter of resignation shall be sent to the Director of DCA, the DHCC President, and the DHCC Executive Officer (EO).

This procedure manual is provided to guide members in the discharge of their duties and to ensure DHCC effectiveness and efficiency.

Chapter 2
COMPOSITION

Members - The DHCC shall consist of nine members. There shall be four public members, four registered dental hygienist (RDH) members, and one dentist member. Each licensed member shall possess, at the time of appointment and throughout the member's term on the DHCC, a valid California license in good standing to practice in the member's respective field of dentistry or dental hygiene.

- Public members - No public member shall have been licensed under this chapter within five years of the public member's date of appointment, nor shall the public member possess or acquire any financial interest in a business related to the practice of dentistry or dental hygiene during the public member's term on the DHCC.
- RDH members - Of the RDH members, one shall be licensed either in alternative practice or in extended functions; one shall be a dental hygiene educator; and two shall be RDHs.
- Dentist member - The dentist member shall be licensed either as a general dentist or a public health dentist.

Mid - term vacancies shall be filled by Governor appointment and the newly appointed member shall serve the remainder of his or her predecessor's unexpired term.

Member Officers - The DHCC shall elect a President, a Vice President, and a Secretary from its membership. The election shall be held at the final meeting of the calendar year. The newly elected member officers shall assume their respective offices on January 1st of the following year. Each term of service for a member officer position is one year. No person shall serve as a member officer for more than two consecutive terms unless extenuating circumstances prevail and unless the majority of the members vote in favor of an extension. If an office becomes vacant during the year, an election shall be held at the next meeting.

President - The President is the spokesperson for the DHCC. The President represents the DHCC by attending hearings and other meetings with legislators and stakeholders. The

President attends Dental Board of California meetings as necessary. The President may testify, sign letters, and address the media on behalf of the DHCC. The President shall copy the EO on all written communications made on behalf of the DHCC and the EO shall forward the communication to all members.

The President is the chief official responsible for DHCC business. The President chairs and facilitates DHCC meetings, approves DHCC meeting agendas, signs specified full committee enforcement orders, establishes subcommittees, appoints the Chairperson and members of each subcommittee, and when necessary, assigns members at large to serve in the absence of subcommittee members. The President may establish task forces to research policy questions as needed.

The President is the immediate supervisor of the EO. Specific instructions for work on policy matters by the EO from DHCC members shall be coordinated through the President. The President shall meet and communicates with the EO on a regular basis. The President holds approval authority for the EO's timesheets, travel expense claims, and leave requests. The President performs the following duties to lead the EO evaluation process:

- The President shall obtain an Executive Officer Performance Evaluation Guide from DCA Human Resources.
- The President shall distribute the Executive Officer Performance Evaluation Guide to DHCC members.
- The President shall collect each member's input and creates a draft EO Performance Appraisal and Salary Administration.
- The President shall present a draft EO Performance Appraisal and Salary Administration to the DHCC annually.
- The President shall ensure that discussion of EO Performance Appraisal and Salary Administration is noticed on the DHCC meeting agenda for which it will be deliberated. Deliberation on EO Performance Appraisal and Salary Administration shall be conducted annually. Deliberation on the EO Performance Appraisal and Salary Administration shall be conducted in closed session unless the EO requests to the President in writing that the matter be discussed in open session.

- Before the close of deliberations, the President shall ensure that the DHCC approves an EO Performance Appraisal and Salary Administration Report.
- The President shall provide the EO with a written EO Performance Appraisal and Salary Administration Report annually.

Vice President - The Vice President assists the President at the President's request and may assume the duties above in the President's absence.

Secretary - The Secretary calls the roll at each DHCC meeting and reports whether a quorum is established. The Secretary also calls the roll vote for each agendized action item voted upon and records the official vote results for the record.

Executive Officer - The EO is the chief administrative officer responsible for implementing the policies and directives of the DHCC.

- Recruitment and Selection - The DHCC shall institute an open recruitment plan to maintain a pool of qualified candidates. The DHCC shall also work with the DCA's Office of Human Resources for recruitment procedures. The selection of an EO shall be included as an item of business which must be noticed in a written agenda and transacted at a public meeting.
- Appointment - The appointed EO is exempt from civil service and serves at the pleasure of the DHCC. Appointment of the EO is subject to approval by the Director of the DCA.
- Supervision – The President is the direct supervisor of the EO. The EO, with the assistance of an Assistant EO, manages and supervises the staff.
- Vacancy – In the event the EO's position becomes vacant, the DHCC shall appoint the Assistant EO to serve as Interim EO until a permanent appointment can be made. The Interim EO's salary shall be set at an amount within the EO's salary range and the salary shall be applied to the first day of service as an Interim EO. The DHCC shall hold a special meeting within 30 days of the EO's vacancy to appoint an Interim EO, confirm the salary amount, and to initiate the selection process for a new EO.

Staff - Employees of the DHCC, with the exception of the EO, are civil service employees. Their conditions of employment (including pay, benefits, discipline, and evaluations) are governed by a myriad of civil service laws and regulations as well as collective bargaining labor agreements. Because of this complexity, it is appropriate that the DHCC delegate all authority and responsibility for managing the DHCC staff to the EO.

Chapter 3
TRAINING & CERTIFICATION REQUIREMENTS

DHCC members are required to complete the following training. Upon completion of each course, members shall send a copy of their Certificate of Completion to the EO. The EO shall retain a copy of each certificate in the member's personnel file and shall forward additional copies to the appropriate oversight agencies as required.

- Board Member Orientation
- California Ethics Training for State Officials
- Conflict of Interest Certification
- Defensive Driver Training
- Sexual Harassment Prevention

Board Member Orientation Training - Every newly appointed and/or reappointed member is required to complete a New Board Member Orientation training program presented by the DCA within one year of assuming office. The training covers functions, responsibilities, and obligations entailed in service as a DHCC member. For more information and assistance with scheduling, please contact:

SOLID Training Solutions
1747 Market Blvd., Ste. 270
Sacramento, CA 95834
(916) 574-8316
SOLID@dca.ca.gov

California Ethics Training for State Officials - Every newly appointed and/or reappointed member is required to complete the California Ethics Training for State Officials course within six months of appointment and every two years thereafter. The Attorney General's Website, http://oag.ca.gov/ethics, contains both an interactive version of the training as well as an accessible text-only version.

Conflict of Interest Certification - Every newly appointed and/or reappointed member is required to certify, within 10 days of appointment, and each year thereafter, specific documents to the general effect that he or she will perform all duties of a DHCC member in an impartial manner, free from bias caused by personal financial interests or the interest of persons who have supported the member. These documents, along with further explanation of conflict of interest restrictions and requirements, are available through the Board Member Resource Center on the DCA Website at:

http://www.dcaboardmembers.ca.gov/member_info/conflict_interest.shtml.

Defensive Driver Training - Each member who will drive a vehicle in the course of any official function as a DHCC member, including commuting to DHCC meetings, shall complete, within 10 days of appointment, and every four years thereafter, the Department of General Service's (DGS) Defensive Driver Training. This training can be accessed through the DGS Website at:

www.dgs.ca.gov/orim/Programs/DDTOnlineTraining.aspx.

Sexual Harassment Prevention - Every newly appointed and/or reappointed member is required to complete Sexual Harassment Prevention training within six months of appointment and every two years thereafter. DCA's Equal Opportunity Employment Office can provide instructions on how to obtain this training.

Equal Employment Opportunity Office
1625 N. Market Blvd., Ste. N330
Sacramento, CA 95834
(916) 574-8280

http://www.dcaboardmembers.ca.gov/training/harassment_prevention.shtml

Chapter 4
BAGLEY-KEENE OPEN MEETING ACT

Meetings are subject to all provisions of the Bagley-Keene Open Meeting Act. This act governs meetings of state regulatory boards and committee meetings of those boards when the committee consists of more than two members. The act specifies meeting notice and agenda requirements and prohibits discussing or taking action on items not included in the agenda.

All members are encouraged to read the entire Bagley-Keene Open Meeting Act guide prepared by DCA Legal Affairs and accessible through the DCA Internet Web Site at:

http://www.dca.ca.gov/publications/bagleykeene_meetingact.pdf.

Key points include the following:

- The DHCC shall post notice to the public on the Internet at least 10 calendar days before regular meetings are held. Alternate format notices shall be made available, upon request, for persons with disabilities.
- The notice shall include the agenda.
- During the meeting, the only items that shall be discussed are the items on the noticed agenda, with the exception that the public may raise issues during the Public Comment portion of the meeting.
- Issues raised during the meeting but not agenized may, at the discretion of the President, be placed on a future meeting's agenda for discussion.
- For all action items at DHCC meetings, as well as subcommittee meetings of three or more members, the law now requires the DHCC to conduct a roll call vote for each action item voted upon for the record including the abstention of each member present for that action item. The DHCC shall include this information in its meeting minutes.
- Provision is made to allow special meetings for certain circumstances in which adherence to the 10 day notice requirement would impose a substantial hardship on the state body or where immediate action is required to protect public interest.
- Members shall not contact other members in order to discuss, deliberate, or take action outside the meeting on a matter within the subject matter of the DHCC.

- Members are strongly discouraged from using cell phones during any meeting as this may give the impression of unlawful member-to-member communication.
- Members may seek further clarification and instruction from the EO.

Chapter 5
OPERATIONS

General Rules of Conduct -

- Members shall recognize the valuable contributions of all DHCC members.
- Members shall commit appropriate time and effort to DHCC responsibilities including reviewing meeting notes, administrative cases, and other materials provided by staff.
- Members shall adhere to the principles of fairness and impartiality in the discharge of their duty to protect the public, without bias, through the enforcement of DHCC laws and the creation of regulations to govern the practice of dental hygiene.
- Members shall conduct their business in an open manner so that the public may be both informed and involved in accordance with the Bagley-Keene Open Meeting Act.
- Members shall neither privately nor publicly lobby for, nor shall they publicly endorse, or otherwise engage in any personal efforts that would tend to promote their own personal or political views or goals when those views or goals are in opposition to a position adopted by the DHCC.
- Members shall never participate in making a governmental decision, or in any way attempt to use their official position to influence a governmental decision, in which there is a financial interest to the member or the potential of such. Any DHCC member who feels they are entering into a situation where there is a potential for a conflict of interest shall immediately consult the EO or DHCC's legal counsel.
- Members shall never accept gifts from applicants, licensees, or members of the profession while serving on the DHCC.
- Members shall not disclose or otherwise make known the contents or nature of sensitive, private, or confidential documents or information related to DHCC business.
- Members shall not speak or act on behalf of the DHCC without first notifying the EO and obtaining permission from the President.

Full Committee Meetings - The DHCC shall meet at least two times each calendar year and shall make a reasonable effort to vary the location of meetings, as economically feasible, to best serve the public and licensees.

Member attendance and active participation is critical to the success of DHCC meetings; therefore, if at any time a member cannot attend a meeting, it is imperative that the member notify the EO as soon as possible so that the EO can verify that a sufficient number of members will be present at the meeting to establish a quorum. To vote on an item of business, a quorum must be present. The presence of five members is necessary to establish a quorum. When a quorum is not present, but members are in attendance at a noticed meeting, members may discuss items of business but they may not take any action.

The President may ascertain from any member whose level of attendance and active participation at noticed meetings and whose timely submittal of mail votes is below standard whether or not the member is able or willing to continue to serve.

Agendas - Any member may submit items to the EO for consideration for future meeting agendas. The President and EO shall review all proposed agenda items received at least 30 days prior to the noticed meeting and the President shall determine which items shall be placed on that meeting's agenda. The EO shall provide the agenda to all members at least 10 days prior to the meeting and the EO shall provide the meeting packet to all members by email no later than seven days prior to the meeting.

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

- Time for public comment.
- Time for members to recommend new issues to be brought to the DHCC's attention.
- Time for a lunch break if the meeting is a full day.
- Subcommittee agendas shall only contain items dealing with subjects assigned to the respective subcommittee.

Subcommittees - Subcommittees are advisory groups formed to research and deliberate on specific categories of concern, then recommend actions to the full committee (DHCC) for approval. The President shall appoint members to fill positions on each standing subcommittee. A member may serve on multiple subcommittees. Members who attend a subcommittee meeting when not appointed to that subcommittee may sit in the audience, but shall not participate in the meeting. There are four standing subcommittees:

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

Licensing and Examination Subcommittee - The purpose of the Licensing and Examination Subcommittee is to advise the DHCC on policy matters relating to examination and licensure.

Enforcement Subcommittee - The purpose of the Enforcement Subcommittee is to advise the DHCC on policy matters related to protecting the health and safety of consumers. This includes evaluation of disciplinary statutes and maintenance of regulations and guidelines pertaining to enforcement.

Legislative and Regulatory Subcommittee - The purpose of the Legislative and Regulatory Subcommittee is to review and track legislation that affects the DHCC and to recommend positions on legislation. The subcommittee also provides information and recommendations on regulatory additions or changes.

Education Subcommittee - The purpose of the Education Subcommittee is to advise the DHCC on granting, renewing, or withdrawing approval of educational programs and curriculum content. The subcommittee also provides information and recommendations on feasibility studies for new educational programs.

Ad Hoc Subcommittees - The President may establish ad hoc subcommittees as needed. Any member may request that an ad hoc subcommittee be established. The ad hoc

subcommittee is charged with an in-depth review of a specific issue and a recommendation to the DHCC.

Staff Assistance – The DHCC staff are available to provide support and consultation to the DHCC members and subcommittees; however, members must funnel all communications and requests for staff assistance through the EO.

Recordkeeping - All public meetings are recorded using either audio and/or video recording equipment. Recordings shall be maintained until either 30 days from the meeting or until after the minutes are approved or accepted, whichever is later.

Minutes - Meeting minutes are a summary, not a transcript, of the proceedings. Only a quorum may approve meeting minutes and when less than a quorum is present, they may accept the minutes. A vote shall be taken regarding whether or not to accept/approve the minutes at the next meeting following the meeting for which the minutes pertain. Approved or accepted minutes for the open session portions of DHCC meetings shall be made available for distribution to the public and placed on the DHCC's Internet Web Site within 30 working days of approval/acceptance.

Voting - All votes shall be captured in a roll call format as per the Bagley-Keene Open Meeting Act and reflected as such in the minutes.

Chapter 6
DISCIPLINARY MATTERS INVOLVING LICENSEES

When a disciplinary matter involving a licensee arises, the Enforcement Analyst shall prepare a comprehensive report on the issue and provide it to all DHCC members. At the close of the report, the Enforcement Analyst shall propose various positions or stipulations for members to consider regarding the matter and shall provide each member a mail ballot and copy of the voting policy.

Voting on Disciplinary Matters - Each member may vote by mail ballot in favor of one of the proposed disciplinary positions or stipulations, or the member may vote to hold for discussion

by writing on his or her ballot “hold for discussion” as well as the reason for the request to hold for discussion. If two or more members vote to hold for discussion, the matter is set aside until it can be discussed during a closed session at the next meeting. Members shall cast new votes after the discussion.

The DHCC shall approve, by a majority vote, any proposed decision or stipulation before the formal discipline becomes final and the penalty can take effect.

For stipulations, a background memorandum from the assigned deputy attorney general accompanies the mail ballot. A two-week deadline is generally given for return of the mail ballot to the DHCC’s office.

If the matter is held for discussion, legal counsel will preside over the closed session to assure compliance with the Administrative Procedure Act and Open Meeting Act.

Security Regarding Disciplinary Matters - Members shall not directly participate in complaint handling or investigations. The following guidelines apply but members should contact the EO or DHCC legal counsel for answers to specific questions.

- No member shall access a licensee’s or candidate’s file.
- Members shall not intervene on behalf of a licensee, candidate for licensure, or respondent for any reason.
- If a member is contacted by a licensee, candidate for licensure, respondent, or by a respondent’s attorney, the member shall refer the person making contact to the EO and shall immediately notify the EO of the contact event.

Chapter 7
SALARY PER DIEM

Members fill non-salaried positions but are paid $100 per day for each meeting day actually spent in the discharge of official duties. Members are reimbursed travel and other expenses necessarily incurred in the performance of official duties. They are paid from the DHCC’s funds

(Business and Professions Code, Section 103). Salary per diem and travel reimbursement shall be rendered in accordance with the following guidelines:

- The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a DHCC or subcommittee meeting until that meeting is adjourned. Travel time is not included in this component.
- No salary per diem or reimbursement for travel-related expenses shall be paid to members except for attendance at official meetings unless a substantial official service is performed by the member. In the event of attendance at gatherings, events, hearings, conferences, or meetings other than official DHCC or subcommittee meetings in which a substantial official service is performed, the member shall notify the EO and gain approval from the DHCC President prior to the member's attendance.
- For DHCC-specified work, members may be compensated for actual time spent performing work authorized by the President. This may include, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences.
- Reimbursable work does not include miscellaneous reading and information gathering for business not related to any meeting, preparation time for a presentation, or participation at meetings not related to official duties.

Chapter 8
TRAVEL REIMBURSEMENT

Members shall obtain the President's approval prior to embarking on any travel in support of the DHCC except for DHCC meetings and mandatory training.

Rules governing members' reimbursement of authorized travel expenses are consistent with rules that apply to management-level state staff. Members shall coordinate with the EO as soon as possible upon return from travel to file travel expense claims.

Chapter 9

ADDITIONAL RESOURCES

Sample Mail Ballot ***Model with Separate Hold Provisions***

To: All DHCC Members

From: Enforcement Analyst

Date:

RE: Mail Ballot for [First] [Last], License No. _____ Case No. _____

THIS MAIL BALLOT MUST BE RETURNED TO THE DHCC NO LATER THAN _____
(If the ballot does not reach the DHCC by this date your vote may not be counted and the DHCC may lose jurisdiction to act).

Please review the attached documents and vote on the above case. Upon completion of this mail ballot, please return it to me in the enclosed envelope or fax it to me at (916) 263-2688 by the date noted above.

The decision presented is a:

___ Proposed Decision. The DHCC will lose jurisdiction to act on _____ [Government Code Section 11517(d)].

___ Stipulated Decision

___ Default Decision

___ Probationary License

Please choose one option:

◯ I vote to adopt (Choose this option if you accept the decision as written).

◯ I vote to reject (Choose this option if you have questions or concerns).

◯ I vote to recuse myself (Choose this option if you believe you have a conflict).

◯ I vote to hold for discussion (Choose this option if you would like to discuss at the next DHCC meeting)

_____ _____

DHCC Member Signature **Date**

If you have procedural questions about the decision, please contact me at (916) 576-5005.

EXPLANATION OF ENFORCEMENT TERMS

Accusation - Charges filed against a licensee alleging violations of the laws and regulations relating to the practice of dental hygiene.

Default Decision - Licensee fails to respond to the Accusation by filing a Notice of Defense or fails to appear at the administrative hearing.

Denied - The application for licensure as a dental hygienist is denied.

Decision - The order of the DHCC in a disciplinary action.

Interim Suspension Order (ISO) - An order issued upon petition by the DHCC, suspending a licensee from all or a part of his or her practice in dental hygiene.

Petition to Revoke Probation - Charges filed against a probationer seeking revocation of their license based upon violation(s) of probation.

Probation - Terms and conditions placed on a licensee for a specific period of time as a result of disciplinary action.

Probationary License - A conditional license issued to an applicant with terms and conditions for a specific period of time.

Public Reprimand - Licensee was reprimanded for a minor violation(s).

Revoked - Licensee's right to practice is ended and the license is taken back.

Revoked, Stayed, Probation - "Stayed" means the revocation is postponed. Professional practice may continue so long as the licensee complies with the specific terms and conditions ordered. Violation of probation may result in the revocation that was postponed.

Statement of Issues - Charges filed against an applicant to deny licensure.

Stipulated Decision - A Settlement agreed to in lieu of a formal hearing to resolve the accusation and impose discipline.

Surrender - Licensee stipulates to surrender the license. The right to practice is ended.

Suspension - Licensee is prohibited from practicing for a specific period of time.

EXPLANATION OF MAIL BALLOT TERMS

Adopt - A vote to adopt the proposed action means that you accept the action as presented.

Default Decision - If an accusation mailed to the last known address is returned by the post office as unclaimed, or if a respondent fails to file a Notice of Defense or fails to appear at the hearing, the respondent is considered in default. The penalty in a case resolved by default is generally revocation of the license. A default decision can be set aside and the case set for hearing if the respondent petitions for reconsideration before the effective date of the decision and the DHCC grants the petition.

Hold for Discussion - In addition to voting, you should mark this box if you have a question or concern about the decision and would like to discuss the matter with fellow members during a closed session. If you vote to reject, you may also wish to hold the case. TWO votes must be received to hold a case. If the case is a **stipulated decision**, the DHCC staff can explain why they entered into the agreement. If the case is either type, you may contact the DHCC's assigned legal counsel to discuss the merits of the case.

Proposed Decision - Following a hearing, the administrative law judge shall draft a proposed decision recommending an outcome based on the facts and the DHCC's disciplinary guidelines. At its discretion, the DHCC may impose a lesser penalty than that in the proposed decision. If the DHCC desires to increase a proposed penalty, however, it must vote to reject or non-adopt the proposed decision, read the transcript of the hearing, and review all exhibits prior to acting on the case.

Recusal - Mark this box if you believe you cannot participate in making the decision because you have a specific conflict. Common examples are if the person is a member of your family, a close personal friend, or business partner. If you are unsure if you should recuse yourself, you should contact the EO or the assigned DHCC legal counsel.

Reject - A vote to reject (non-adopt) the proposed action means that you disagree with one or more portions of the proposed action and do not want it adopted as the DHCC's decision. This

vote should be used if you believe an additional term or condition of probation should be added (or deleted), or would otherwise modify the proposed penalty.

Stipulated Decision - At any time during the disciplinary process, the parties to the matter (the EO and the respondent) can agree to a disposition of the case. With the EO's consent, the Deputy Attorney General can negotiate a stipulated decision (also referred to as a stipulated agreement) based on the DHCC's disciplinary guidelines. The DHCC may adopt the stipulated decision as proposed, may counter-offer and recommend other provisions, or may reject the agreement. If respondent declines to accept a proposed counter-offer, the case continues in the standard disciplinary process.

Summary of Outcomes - If a proposed decision is rejected, the transcript will be ordered and the case scheduled for argument according to DHCC policy. After reviewing the record, the DHCC will be able to adopt the decision as previously written or modify the decision as it deems appropriate, except that a cost recovery order may not be increased. If a stipulated decision is rejected, the case will be set for hearing unless a counter offer is made during a closed session. If a default decision is rejected, the case will be set for hearing.

ACRONYMS

Agencies

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

Organizations

ADHA	American Dental Hygienists Association
CDHA	California Dental Hygienists Association
CDA	California Dental Association
CDHEA	California Dental Hygiene Educators Association
CAPS	California Assoc. of Private Post-Secondary Schools
CCC	California Community Colleges
CRDTS	Central Regional Dental Testing Services, Inc.
WREB	Western Regional Examination Board

Codes

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

Titles

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

Licenses

FNP	Fictitious Name Permit
LBC	Licensure by Credential
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienist in Alternative Practice
RDHEF	Registered Dental Hygienist in Extended Functions
SLN	Soft Tissue Curretage, Local Anesthetic, and Nitrous Oxide and Oxygen Administration

INDEX

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT B:

Business and Professions Code (BPC) Sections 1900 – 1967.4

BUSINESS AND PROFESSIONS CODE

DENTAL HYGIENISTS

SECTIONS 1900–1967.4

1900. Legislative Intent

It is the intent of the Legislature by enactment of this article to permit the full utilization of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions in order to meet the dental care needs of all of the state's citizens.

1901. (Repealed January 1, 2019) Dental Hygiene Committee of California created

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

(b) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the committee subject to review by the appropriate policy committees of the Legislature.

1902. Definitions

For purposes of this article, the following definitions apply:

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

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

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

(d) "General supervision" means the supervision of dental procedures based on instructions given by a licensed dentist who is not required to be physically present in the treatment facility during the performance of those procedures.

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

1902.1. Priority of committee; Protection of the public

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

1902.2. Disclosure of practice or employment status of licensee

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

(1) Full-time practice or employment in a dental or dental hygiene practice of 32 hours per week or more in California.

(2) Full-time practice or employment in a dental or dental hygiene practice of 32 hours or more outside of California.

(3) Part-time practice or employment in a dental or dental hygiene practice for less than 32 hours per week in California.

(4) Part-time practice or employment in a dental or dental hygiene practice for less than 32 hours per week outside of California.

(5) Dental hygiene administrative employment that does not include direct patient care, as may be further defined by the committee.

(6) Retired.

(7) Other practice or employment status, as may be further defined by the committee.

(b) Information collected pursuant to subdivision (a) shall be posted on the Internet Web site of the committee.

(c) (1) A licensee may report on his or her application for renewal, and the committee, as appropriate, shall collect, information regarding the licensee's cultural background and foreign language proficiency.

(2) Information collected pursuant to this subdivision shall be aggregated on an annual basis, based on categories utilized by the committee in the collection of the data, into both statewide totals and ZIP Code of primary practice or employment location totals.

(3) Aggregated information under this subdivision shall be compiled annually, and reported on the Internet Web site of the committee as appropriate, on or before July 1 of each year.

(d) It is the intent of the Legislature to utilize moneys in the State Dental Hygiene Fund to pay any cost incurred by the committee in implementing this section.

1902.3. Registered dental hygienist licensed in another state; Issuance of permit to practice; Teaching position; Requirements

A registered dental hygienist licensed in another state may teach in a dental hygiene college without being licensed in this state if he or she has a special permit. The committee may issue a special permit to practice dental hygiene in a discipline at a dental hygiene college in this state to any person who submits an application and satisfies all of the following eligibility requirements:

(a) Furnishing satisfactory evidence of having a pending contract with a California dental hygiene college approved by the committee as a full-time or part-time professor, associate professor, assistant professor, faculty member, or instructor.

(b) Furnishing satisfactory evidence of having graduated from a dental hygiene college approved by the committee.

(c) Furnishing satisfactory evidence of having been certified as a diplomate of a specialty committee or, in lieu thereof, establishing his or her qualifications to take a specialty committee examination or furnishing satisfactory evidence of having completed an advanced educational program in a discipline from a dental hygiene college approved by the committee.

(d) Furnishing satisfactory evidence of having successfully completed an examination in California law and ethics developed and administered by the committee.

(e) Paying an application fee, subject to a biennial renewal fee, as provided by Section 1944.

1903. (Repealed January 1, 2019) Committee; Membership; Terms; Officers; Vacancies; Per diem and expenses

(a) (1) The committee shall consist of nine members appointed by the Governor. Four shall be public members, one member shall be a practicing general or public health dentist who holds a current license in California, and four members shall be registered dental hygienists who hold current licenses in California. Of the registered dental hygienists members, one shall be licensed either in alternative practice or in extended functions, one shall be a dental hygiene educator, and two shall be registered dental hygienists. No public member shall have been licensed under this chapter within five years of the date of his or her appointment or have any current financial interest in a dental-related business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1904. Committee meetings

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

1905. Committee functions

(a) The committee shall perform the following functions:

(1) Evaluate all registered dental hygienist, registered dental hygienist in alternative practice, and registered dental hygienist in extended functions educational programs that apply for approval and grant or deny approval of those applications in accordance with regulations adopted by the committee. Any such educational programs approved by the dental board on or before June 30, 2009, shall be deemed approved by the committee. Any dental hygiene program accredited by the Commission on Dental Accreditation may be approved.

(2) Withdraw or revoke its prior approval of a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions educational program in accordance with regulations adopted by the committee. The committee may withdraw or revoke a dental hygiene program approval if the Commission on Dental Accreditation has indicated an intent to withdraw approval or has withdrawn approval.

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

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

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

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

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

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

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

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

1905.1. Authority of committee

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

1905.2. Recommendations

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

1906. Regulations

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

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

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

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

1907. Functions that may be performed by dental hygienist

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

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

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

1908. Practices included in and excluded from dental hygiene

(a) The practice of dental hygiene includes dental hygiene assessment and development, planning, and implementation of a dental hygiene care plan. It also includes oral health education, counseling, and health screenings.

(b) The practice of dental hygiene does not include any of the following procedures:

(1) Diagnosis and comprehensive treatment planning.

(2) Placing, condensing, carving, or removal of permanent restorations.

(3) Surgery or cutting on hard and soft tissue including, but not limited to, the removal of teeth and the cutting and suturing of soft tissue.

(4) Prescribing medication.

(5) Administering local or general anesthesia or oral or parenteral conscious sedation, except for the administration of nitrous oxide and oxygen, whether administered alone or in combination with each other, or local anesthesia pursuant to Section

1909. Procedures dental hygienist is authorized to perform under direct supervision

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

(a) Soft-tissue curettage.

(b) Administration of local anesthesia.

(c) Administration of nitrous oxide and oxygen, whether administered alone or in combination with each other.

1910. Procedures dental hygienist is authorized to perform under general supervision

A registered dental hygienist is authorized to perform the following procedures under general supervision:

(a) Preventive and therapeutic interventions, including oral prophylaxis, scaling, and root planing.

(b) Application of topical, therapeutic, and subgingival agents used for the control of caries and periodontal disease.

(c) The taking of impressions for bleaching trays and application and activation of agents with nonlaser, light-curing devices.

(d) The taking of impressions for bleaching trays and placements of in-office, tooth-whitening devices.

Section 1910.5 - (First of two; Repealed January 1, 2018) Additional authorized duties of registered dental hygienist

(a) In addition to the duties specified in Section 1910, a registered dental hygienist is authorized to perform the following additional duties, as specified:

(1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental hygienist shall follow protocols established by the supervising dentist. This paragraph shall only apply in the following settings:

(A) In a dental office setting.

(B) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand instrumentation, without the use of rotary instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting.

(ii) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(b) The functions described in subdivision (a) may be performed by a registered dental hygienist only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the committee, of having completed a committee-approved course in those functions.

(c) (1) No later than January 1, 2018, the committee shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental hygienist and registered dental hygienist in alternative practice pursuant to Sections 1910.5 and 1926.05 using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. The committee shall use the curriculum submitted by the dental board, pursuant to Section 1753.55, to adopt regulatory language for approval of courses of instruction for the Interim Therapeutic Restoration. Any subsequent amendments to the regulations for the Interim Therapeutic Restoration curriculum that are promulgated by the committee shall be agreed upon by the board and the committee.

(2) Prior to January 1, 2018, the committee shall use the competency-based training protocols established by HWPP No. 172 through the Office of Statewide Health Planning and Development to approve courses of instruction for the procedures authorized in this section.

(3) A registered dental hygienist who has completed the prescribed training in HWPP No. 172 established by the Office of Statewide Health Planning and Development pursuant to Article 1 (commencing with Section 128125) of Chapter 3 of Part 3 of Division 107 of the Health and Safety Code shall be deemed to have satisfied the requirement for completion of a course of instruction approved by the committee.

(4) In addition to the instructional components described in this subdivision, a program shall contain both of the instructional components described in this paragraph:

(A) The course shall be established at the postsecondary educational level.

(B) All faculty responsible for clinical evaluation shall have completed a one-hour methodology course in clinical evaluation or have a faculty appointment at an accredited dental education program prior to conducting evaluations of students. (d) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

Section 1910.5 - (Second of two; Operative January 1, 2018) Additional authorized duties of registered dental hygienist

(a) In addition to the duties specified in Section 1910, a registered dental hygienist is authorized to perform the following additional duties, as specified:

(1) Determine which radiographs to perform on a patient who has not received an initial examination by the supervising dentist for the specific purpose of the dentist making a diagnosis and treatment plan for the patient. In these circumstances, the dental hygienist shall follow protocols established by the supervising dentist. This paragraph only applies in the following settings:

(A) In a dental office setting.

(B) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(2) Place protective restorations, which for this purpose are identified as interim therapeutic restorations, and defined as a direct provisional restoration placed to stabilize the tooth until a licensed dentist diagnoses the need for further definitive treatment. An interim therapeutic restoration consists of the removal of soft material from the tooth using only hand instrumentation, without the use of rotary

instrumentation, and subsequent placement of an adhesive restorative material. Local anesthesia shall not be necessary for interim therapeutic restoration placement. Interim therapeutic restorations shall be placed only in accordance with both of the following:

(A) In either of the following settings:

(i) In a dental office setting.

(ii) In a public health setting, using telehealth, as defined by Section 2290.5, for the purpose of communication with the supervising dentist, including, but not limited to, schools, head start and preschool programs, and community clinics.

(B) After the diagnosis, treatment plan, and instruction to perform the procedure provided by a dentist.

(b) The functions described in subdivision (a) may be performed by a registered dental hygienist only after completion of a program that includes training in performing those functions, or after providing evidence, satisfactory to the committee, of having completed a committee-approved course in those functions.

(c) No later than January 1, 2018, the committee shall adopt regulations to establish requirements for courses of instruction for the procedures authorized to be performed by a registered dental hygienist and registered dental hygienist in alternative practice pursuant to Sections 1910.5 and 1926.05, using the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 172 through the Office of Health Planning and Development. The committee shall use the curriculum submitted by the board pursuant to Section 1753.55 to adopt regulatory language for approval of courses of instruction for the Interim Therapeutic Restoration. Any subsequent amendments to the regulations for the Interim Therapeutic Restoration curriculum that are promulgated by the committee shall be agreed upon by the board and the committee.

(d) This section shall become operative on January 1, 2018.

1911. Dental hygienist, services that can be provided without direct supervision

(a) A registered dental hygienist may provide, without supervision, educational services, oral health training programs, and oral health screenings.

(b) A registered dental hygienist shall refer any screened patients with possible oral abnormalities to a dentist for a comprehensive examination, diagnosis, and treatment plan.

(c) In any public health program created by federal, state, or local law or administered by a federal, state, county, or local governmental entity, a registered dental hygienist may provide, without supervision, dental hygiene preventive services in addition to oral screenings, including, but not limited to, the application of fluorides and pit and fissure sealants. A registered dental hygienist employed as described in this subdivision may submit, or allow to be submitted, any insurance or third-party claims for patient services performed as authorized in this article.

1912. Dental hygienist, general supervision requirement

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

1913. Dental hygienist, authority to perform procedures or provide services

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

1914. Dental hygienist, use of materials and devices authorized

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

1915. Limitations on who may engage in the practice of dental hygiene

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

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

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

(1) Applying nonaerosol and noncaustic topical agents.

(2) Applying topical fluoride.

(3) Taking impressions for bleaching trays.

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

(1) Polishing the coronal surfaces of teeth.

(2) Applying bleaching agents.

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

(4) Applying pit and fissure sealants.

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

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

1916. Dental hygienist, criminal background check

(a) An applicant for licensure under this article shall furnish electronic fingerprint images for submission to state and federal criminal justice agencies, including, but not limited to, the Federal Bureau of Investigation, in order to establish the identity of the applicant and for the other purposes described in this section.

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

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

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

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

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

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

1917. Dental hygienist, requirements for licensure

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

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

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

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

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

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

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

1917.1. Dental hygienist, licensure without examination; Out-of-state dental hygienists

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1917.3. Failure to pass clinical examination; Reexamination

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

1918. Licensure as dental hygienist in extended functions

The committee shall license as a registered dental hygienist in extended functions a person who meets all of the following requirements:

(a) Holds a current license as a registered dental hygienist in California.

(b) Completes clinical training approved by the committee in a facility affiliated with a dental school under the direct supervision of the dental school faculty.

(c) Performs satisfactorily on an examination required by the committee.

(d) Completes an application form and pays all application fees required by the committee.

1920. Automatic licensure as registered dental hygienist

(a) A person who holds a current and active license as a registered dental hygienist in extended functions or a registered dental hygienist in alternative practice on July 1, 2009, shall automatically be issued a license as a registered dental hygienist, unless the person holds a current and active registered dental hygienist license.

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

1921. Authority of registered dental hygienist in extended functions or a registered dental hygienist in alternative practice

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

1922. Licensure as registered dental hygienist in alternative practice

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

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

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

(2) Has successfully completed a bachelor's degree or its equivalent from a college or institution of higher education that is accredited by a national or regional accrediting agency recognized by the United States Department of Education, and a minimum of 150 hours of additional educational requirements, as prescribed by the committee by regulation,

that are consistent with good dental and dental hygiene practice, including, but not necessarily limited to, dental hygiene technique and theory including gerontology and medical emergencies, and business administration and practice management.

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

1924. Grandfathering as registered dental hygienist in alternative practice by virtue of having established practice under the Health Manpower Pilot Project

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

1925. Practices authorized for registered dental hygienist in alternative practice

A registered dental hygienist in alternative practice may practice, pursuant to subdivision (a) of Section 1907, subdivision (a) of Section 1908, subdivisions (a) and (b) of Section 1910, Section 1910.5, and Section 1926.05 as an employee of a dentist or of another registered dental hygienist in alternative practice, as an independent contractor, as a sole proprietor of an alternative dental hygiene practice, as an employee of a primary care clinic or specialty clinic that is licensed pursuant to Section 1204 of the Health and Safety Code, as an

employee of a primary care clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code, as an employee of a clinic owned or operated by a public hospital or health system, or as an employee of a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions Code.

1926. Scope of authority for registered dental hygienist in alternative practice

A registered dental hygienist in alternative practice may perform the duties authorized pursuant to subdivision (a) of Section 1907, subdivision (a) of Section 1908, and subdivisions (a) and (b) of Section 1910 in the following settings:

(a) Residences of the homebound.

(b) Schools.

(c) Residential facilities and other institutions.

(d) Dental health professional shortage areas, as certified by the Office of Statewide Health Planning and Development in accordance with existing office guidelines.

1926.05. Additional authorized duties of registered dental hygienist in alternative practice

(a) In addition to the duties specified in Section 1926, a registered dental hygienist in alternative practice is authorized to perform the duties pursuant to Section 1910.5, in the following settings:

(1) Residences of the homebound.

(2) Schools.

(3) Residential facilities and other institutions. (b) A registered dental hygienist in alternative practice is authorized to perform the duties pursuant to paragraph (2) of subdivision (a) of Section 1910.5 in the settings specified in this section under the general supervision of a dentist.

(b) A registered dental hygienist in alternative practice is authorized to perform the duties pursuant to paragraph (2) of subdivision (a) of Section 1910.5 In the settings specified in this section under the general supervision of a dentist.

1926.1. Operation of mobile dental hygiene clinic; Requirements

Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate a mobile dental hygiene clinic provided by his or her property and casualty insurer as a temporary substitute site for the practice registered by him or her pursuant to Section 1926.3, if both of the following requirements are met:

(a) The licensee's registered place of practice has been rendered and remains unusable due to loss or calamity.

(b) The licensee's insurer registers the mobile dental hygiene clinic with the committee in compliance with Section 1926.3.

1926.2. Operation of mobile dental hygiene clinic registered as dental hygiene office or facility; Mobile unit exempted from certain laws

(a) Notwithstanding any other provision of law, a registered dental hygienist in alternative practice may operate one mobile dental hygiene clinic registered as a dental hygiene office or facility. The owner or operator of the mobile dental hygiene clinic or unit shall be registered and operated in accordance with regulations established by the committee, which regulations shall not be designed to prevent or lessen competition in service areas, and shall pay the fees described in Section 1944.

(b) A mobile service unit, as defined in subdivision (b) of Section 1765.105 of the Health and Safety Code, and a mobile unit operated by an entity that is exempt from licensure pursuant to subdivision (b), (c), or (h) of Section 1206 of the Health and Safety Code, are exempt from this article. Notwithstanding this exemption, the owner or operator of the mobile unit shall notify the committee within 60 days of the date on which dental

hygiene services are first delivered in the mobile unit, or the date on which the mobile unit's application pursuant to Section 1765.130 of the Health and Safety Code is approved, whichever is earlier.

(c) A licensee practicing in a mobile unit described in subdivision (b) is not subject to subdivision (a) as to that mobile unit.

1926.3. Registered dental hygienist in alternative practice; Registration; Time period

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

1926.4. More than one place of practice; Requirements

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

1927. Limitation on practice of registered dental hygienist in alternative practice

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

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

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

1928. Registered dental hygienist in alternative practice, submitting of insurance

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

1929. Registered dental hygienist in alternative practice, hiring of employees

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

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

1930. Registered dental hygienist in alternative practice, relationship with dentist required

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

1931. Registered dental hygienist in alternative practice, requirement of prescription from dentist or physician and surgeon

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

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

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

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

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

1932. Dental hygienists, probationary licenses

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

(1) Successfully completing a professional competency examination.

(2) Submitting to a medical or psychological evaluation.

(3) Submitting to continuing medical or psychological treatment.

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

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

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

(7) Restricting the type or circumstances of practice.

(8) Submitting to continuing education and coursework.

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

(10) Complying with probation monitoring.

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

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

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

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

1933. Substitute licenses

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

1934. Change of address or name

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

1935. Expiration and renewal of license

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

1936. Renewal of expired license

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

1936.1. Continuing education

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

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

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

1937. Suspended licenses

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

1938. Revoked licenses

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

1939. Licenses not renewed within five years of expiration

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

1940. Inactive licenses

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

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

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

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

1941. Approval of educational programs; Need for new educational programs

(a) The committee shall grant or renew approval of only those educational programs for a registered dental hygienist, a registered dental hygienist in alternative practice, or a registered dental hygienist in extended functions that continuously maintain a high quality standard of instruction and, where appropriate, meet the minimum standards set by the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the committee.

(b) A new educational program for registered dental hygienists shall submit a feasibility study demonstrating a need for a new educational program and shall apply for approval from the committee prior to seeking approval for initial accreditation from the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the committee. The committee may approve, provisionally approve, or deny approval of any such new educational program.

(c) For purposes of this section, a new educational program for registered dental hygienists means a program provided by a college or institution of higher education that is accredited by a regional accrediting agency recognized by the United States Department of Education and that has as its primary purpose providing college level courses leading to an associate or higher degree, that is either affiliated with or conducted by a dental school approved by the dental board, or that is accredited to offer college level or college parallel programs by the Commission on Dental Accreditation of the American Dental Association or an equivalent body, as determined by the committee.

1942. "Extramural dental facility"; Registration

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

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

1943. Denial of application to take examination

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

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

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

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

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

1944. Fees

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

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

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

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

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

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

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

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

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

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

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

(11) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars ($750).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1947. Revocation or suspension of license

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

1949. Consequences of unprofessional conduct, incompetence, gross negligence, repeated acts of negligence in the profession, receiving a license by mistake, and the like

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

1950. Consequences of conviction of crime substantially related to the licensee's qualifications, functions, or duties

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

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

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

(1) The time for appeal has elapsed.

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

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

1950.5. Unprofessional conduct defined

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

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

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

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

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

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

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

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

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

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

(j) Advertising in violation of Section 651.

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

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

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

(n) The clearly excessive administering of drugs or treatment, or the clearly excessive use of treatment procedures, or the clearly excessive use of treatment facilities, as determined by the customary practice and standards of the dental hygiene profession. Any person who violates this subdivision is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) or more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days or more than 180 days, or by both a fine and imprisonment.

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

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

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

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

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

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

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

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

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

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

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

1951. Probation options

The committee may discipline a licensee by placing him or her on probation under various terms and conditions that may include, but are not limited to, the following:

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

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians appointed by the committee, if warranted by the physical or mental condition of the licensee. If the committee requires the licensee to submit to an examination, the committee shall receive and consider any other report of a complete diagnostic examination given by one or more physicians of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee.

(d) Requiring restitution of fees to the licensee's patients or payers of services, unless restitution has already been made.

(e) Providing the option of alternative community service in lieu of all or part of a period of suspension in cases other than violations relating to quality of care.

1952. Violation of controlled substance laws as unprofessional conduct

It is unprofessional conduct for a person licensed under this article to do any of the following:

(a) Obtain or possess in violation of law, or except as directed by a licensed physician and surgeon, dentist, or podiatrist, a controlled substance, as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Section 4022.

(b) Use a controlled substance, as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or a dangerous drug as defined in Section 4022, or alcoholic beverages or other intoxicating substances, to an extent or in a manner dangerous or injurious to himself or herself, to any person, or the public to the extent that the use impairs the licensee's ability to conduct with safety to the public the practice authorized by his or her license.

(c) Be convicted of a charge of violating any federal statute or rules, or any statute or rule of this state, regulating controlled substances, as defined in Division 10 (commencing with Section

11000) of the Health and Safety Code, or any dangerous drug, as defined in Section 4022, or be convicted of more than one misdemeanor, or any felony, involving the use or consumption of alcohol or drugs, if the conviction is substantially related to the practice authorized by his or her license.

(1) The record of conviction or a copy certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of a violation of this section. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(2) The committee may order the license suspended or revoked, or may decline to issue a license, when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under any provision of the Penal Code, including, but not limited to, Section 1203.4 of the Penal Code, allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

1953. Identification in patient record required; Violation

(a) A registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions who performs a service on a patient in a dental office shall identify himself or herself in the patient record by signing his or her name or identification number and initials next to the service performed, and shall date those treatment entries in the record.

(b) A repeated violation of this section constitutes unprofessional conduct.

1954. Holding oneself out as able to perform professional services beyond the scope of one's license and field of competence as unprofessional conduct; Exception

(a) It is unprofessional conduct for a person licensed under this article to perform, or hold himself or herself out as able to perform, professional services beyond the scope of his or her license and field of competence, as established by his or her education, experience, and training. This includes, but is not limited to, using an instrument or device in a manner that is not in accordance with the customary standards and practices of the dental hygiene profession.

(b) This section shall not apply to research conducted by accredited dental schools or dental hygiene schools, or to research conducted pursuant to an investigational device exemption issued by the United States Food and Drug Administration.

1955. Duty to release records; Penalties

(a) (1) A licensee who fails or refuses to comply with a request for a patient's dental or dental hygiene records that is accompanied by that patient's written authorization for release of the records to the committee, within 15 days of receiving the request and authorization, shall pay to the committee a civil or administrative penalty or fine up to a maximum of two hundred fifty dollars ($250) per day for each day that the documents have not been produced after the 15th day, up to a maximum of five thousand dollars ($5,000) unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the dental or dental hygiene records of a patient that is accompanied by that patient's written authorization for release of records to the committee together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's dental hygiene records to the committee within 30 days of receiving this request, authorization, and notice shall subject the health care facility to a civil or administrative penalty or fine, payable to the committee, of up to a

maximum of two hundred fifty dollars ($250) per day for each day that the documents have not been produced after the 30th day, up to a maximum of five thousand dollars ($5,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the committee in obtaining the patient's authorization. The committee shall pay the reasonable cost of copying the dental hygiene records.

(b) (1) A licensee who fails or refuses to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the committee shall pay to the committee a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the committee shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(2) A licensee who fails or refuses to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the committee is guilty of a misdemeanor punishable by a fine payable to the committee not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the committee shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order issued in the enforcement of a subpoena mandating the release of patient records to the committee, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the committee a civil penalty of up to one thousand dollars ($1,000) per day for each day

that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the committee against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the committee is guilty of a misdemeanor punishable by a fine payable to the committee not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the committee against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or permit.

(d) A failure or refusal to comply with a court order issued in the enforcement of a subpoena mandating the release of records to the committee constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil or administrative penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For the purposes of this section, a "health care facility" means a clinic or health care facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

1956. Negligence as unprofessional conduct

It is unprofessional conduct for a person licensed under this article to require, either directly or through an office policy, or knowingly permit the delivery of dental hygiene care that discourages necessary treatment, or permits clearly excessive, incompetent, unnecessary, or grossly negligent treatment, or repeated negligent acts, as determined by the standard of practice in the community.

1957. Petition for reinstatement or modification of penalty

(a) A person whose license has been revoked or suspended, who has been placed on probation, or whose license was surrendered pursuant to a stipulated settlement as a condition to avoid a disciplinary administrative hearing, may petition the committee for reinstatement or modification of the penalty, including modification or termination of probation, after a period of not less than the following minimum periods have elapsed from the effective date of the decision ordering disciplinary action:

(1) At least three years for reinstatement of a license revoked for unprofessional conduct or surrendered pursuant to a stipulated settlement as a condition to avoid an administrative disciplinary hearing.

(2) At least two years for early termination, or modification of a condition, of a probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license revoked for mental or physical illness, or termination, or modification of a condition, of a probation of less than three years.

(b) The petition shall state any fact required by the committee.

(c) The petition may be heard by the committee, or the committee may assign the petition to an administrative law judge designated in Section 11371 of the Government Code.

(d) In considering reinstatement or modification or penalty, the committee or the administrative law judge hearing the petition may consider the following:

(1) All activities of the petitioner since the disciplinary action was taken.

(2) The offense for which the petitioner was disciplined.

(3) The petitioner's activities during the time the license or permit was in good standing.

(4) The petitioner's rehabilitative efforts, general reputation for truth, and professional ability.

(e) The hearing may be continued from time to time as the committee or the administrative law judge as designated in Section 11371 of the Government Code finds necessary.

(f) The committee or the administrative law judge may impose necessary terms and conditions on the licentiate in reinstating a license or permit or modifying a penalty.

(g) A petition shall not be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole.

(h) A petition shall not be considered while there is an accusation or petition to revoke probation pending against the person.

(i) The committee may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section. Nothing in this section shall be deemed to alter Sections 822 and 823.

1958. Misdemeanor for false representation, failing to furnish names of associates, using controlled substances while engaged in practice, and the like

A person, company, or association is guilty of a misdemeanor, and upon conviction, shall be punished by imprisonment in a county jail not less than 10 days nor more than one year, or by a fine of not less

than one hundred dollars ($100) nor more than one thousand five hundred dollars ($1,500), or by both that fine and imprisonment, who does any of the following:

(a) Assumes the title of "registered dental hygienist," "registered dental hygienist in alternative practice," or "registered dental hygienist in extended functions" or appends the letters "R.D.H.," "R.D.H.A.P.," or "R.D.H.E.F." to his or her name without having had the right to assume the title conferred upon him or her through licensure.

(b) Assumes any title, or appends any letters to his or her name, with the intent to represent falsely that he or she has received a dental hygiene degree or a license under this article.

(c) Engages in the practice of dental hygiene without causing to be displayed in a conspicuous place in his or her office his or her license under this article to practice dental hygiene.

(d) Within 10 days after demand is made by the executive officer of the committee, fails to furnish to the committee the name and address of all persons practicing or assisting in the practice of dental hygiene in the office of the person, company, or association, at any time within 60 days prior to the demand, together with a sworn statement showing under and by what license or authority this person, company, or association and any employees are or have been practicing or assisting in the practice of dental hygiene. This sworn statement shall not be used in any prosecution under this section.

(e) Is under the influence of alcohol or a controlled substance while engaged in the practice of dental hygiene in actual attendance on patients to an extent that impairs his or her ability to conduct the practice of dental hygiene with safety to patients and the public.

1958.1. Registered sex offenders

(a) Notwithstanding any other law, with regard to an individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, under military law, or under federal law, all of the following shall apply:

(1) The committee shall deny an application by the individual for licensure pursuant to this article.

(2) If the individual is licensed under this article, the committee shall promptly revoke the license of the individual. The committee shall not stay the revocation nor place the license on probation.

(3) The committee shall not reinstate or reissue the individual's licensure under this article. The committee shall not issue a stay of license denial and place the license on probation.

(b) This section shall not apply to any of the following:

(1) An individual who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that requires his or her registration as a sex offender.

(2) An individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code. However, nothing in this paragraph shall prohibit the committee from exercising its discretion to discipline a licensee under other provisions of state law based upon the licensee's conviction under Section 314 of the Penal Code.

(3) Any administrative adjudication proceeding under Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that is fully adjudicated prior to January 1, 2013. A petition for reinstatement of a revoked or surrendered license shall be considered a new proceeding for purposes of this paragraph, and the prohibition against reinstating a license to an individual who is required to register as a sex offender shall be applicable.

1959. Identification as dental hygienist

A person who holds a valid, unrevoked, and unsuspended license as a registered dental hygienist, registered dental hygienist in alternative

practice, or registered dental hygienist in extended functions under this article may append the letters "R.D.H.," "R.D.H.A.P.," or "R.D.H.E.F.," respectively, to his or her name.

1960. Penalties for bartering transcript or diploma, making or using false diploma, making a false statement in an affidavit, practicing without a valid license, or practicing under a false name

For the first offense, a person is guilty of a misdemeanor and shall be punishable by a fine of not less than two hundred dollars ($200) nor more than three thousand dollars ($3,000), or by imprisonment in a county jail for not to exceed six months, or by both that fine and imprisonment, and for the second or a subsequent offense is guilty of a felony and upon conviction thereof shall be punished by a fine of not less than two thousand dollars ($2,000) nor more than six thousand dollars ($6,000), or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by both that fine and imprisonment, who does any of the following:

(a) Sells or barters or offers to sell or barter a dental hygiene degree or transcript or a license issued under, or purporting to be issued under, laws regulating licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(b) Purchases or procures by barter a diploma, license, or transcript with intent that it shall be used as evidence of the holder's qualification to practice dental hygiene, or in fraud of the laws regulating the practice of dental hygiene.

(c) With fraudulent intent, makes, attempts to make, counterfeits, or materially alters a diploma, certificate, or transcript.

(d) Uses, or attempts or causes to be used, any diploma, certificate, or transcript that has been purchased, fraudulently issued, counterfeited, or materially altered or in order to procure licensure as a registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions.

(e) In an affidavit required of an applicant for an examination or license under this article, willfully makes a false statement in a material regard.

(f) Practices dental hygiene or offers to practice dental hygiene, as defined in this article, either without a license, or when his or her license has been revoked or suspended.

(g) Under any false, assumed or fictitious name, either as an individual, firm, corporation or otherwise, or any name other than the name under which he or she is licensed, practices, advertises, or in any other manner indicates that he or she practices or will practice dental hygiene, except a name specified in a valid permit issued pursuant to Section 1962.

1961. Penalty for practicing without a valid license under circumstances that cause risk of bodily harm, serious physical or mental illness, or death

A person who willfully, under circumstances that cause risk of bodily harm, serious physical or mental illness, or death, practices, attempts to practice, advertises, or holds himself or herself out as practicing dental hygiene without having at the time of so doing a valid, unrevoked, and unsuspended license as provided in this article, is guilty of a crime, punishable by imprisonment in a county jail for up to one year. The remedy provided in this section shall not preclude any other remedy provided by law.

1962. Use of name by registered dental hygienist in alternative practice in professional association

(a) An association, partnership, corporation, or group of three or more registered dental hygienists in alternative practice engaging in practice under a name that would otherwise be in violation of Section 1960 may practice under that name if the association, partnership, corporation, or group holds an unexpired, unsuspended, and unrevoked permit issued by the committee under this section.

(b) An individual registered dental hygienist in alternative practice or a pair of registered dental hygienists in alternative practice who practice dental hygiene under a name that would otherwise violate Section 1960 may practice under that name if the licensees hold a valid permit issued by the committee

under this section. The committee shall issue a written permit authorizing the holder to use a name specified in the permit in connection with the holder's practice if the committee finds all of the following:

(1) The applicant or applicants are duly licensed registered dental hygienists in alternative practice.

(2) The place where the applicant or applicants practice is owned or leased by the applicant or applicants, and the practice conducted at the place is wholly owned and entirely controlled by the applicant or applicants and is an approved area or practice setting pursuant to Section 1926.

(3) The name under which the applicant or applicants propose to operate contains at least one of the following designations: "dental hygiene group," "dental hygiene practice," or "dental hygiene office," contains the family name of one or more of the past, present, or prospective associates, partners, shareholders, or members of the group, and is in conformity with Section 651 and not in violation of subdivisions (i) and (l) of Section 1950.5.

(4) All licensed persons practicing at the location designated in the application hold valid licenses and no charges of unprofessional conduct are pending against any person practicing at that location.

(c) A permit issued under this section shall expire and become invalid unless renewed in the manner provided for in this article for the renewal of permits issued under this article.

(d) A permit issued under this section may be revoked or suspended if the committee finds that any requirement for original issuance of a permit is no longer being fulfilled by the permitholder. Proceedings for revocation or suspension shall be governed by the Administrative Procedure Act.

(e) If charges of unprofessional conduct are filed against the holder of a permit issued under this section, or a member of an association, partnership, group, or corporation to whom a permit has been issued under this section, proceedings shall not

be commenced for revocation or suspension of the permit until a final determination of the charges of unprofessional conduct, unless the charges have resulted in revocation or suspension of a license.

1963. Jurisdiction at the discretion of the committee

The committee may file a complaint for violation of any part of this article with any court of competent jurisdiction and may, by its officers, counsel and agents, assist in presenting the law or facts at the trial. The district attorney of each county in this state shall prosecute all violations of this article in their respective counties in which the violations occur.

1964. Injunction

In addition to the other proceedings provided for in this article, on application of the committee, the superior court of any county shall issue an injunction to restrain an unlicensed person from conducting the practice of dental hygiene, as defined in this article.

1965. Procedure to request injunction

If a person has engaged in or is about to engage in an act that constitutes an offense against this chapter, the superior court of any county, on application of 10 or more persons holding licenses to practice dental hygiene issued under this article, may issue an injunction or other appropriate order restraining that conduct. Proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

1966. Rehabilitation for impairment; Diversion program authorized

(a) It is the intent of the Legislature that the committee seek ways and means to identify and rehabilitate licensees whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licensees so afflicted may be treated and returned to the practice of dental hygiene in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the committee establish a diversion program as a voluntary alternative approach to traditional disciplinary actions.

(b) One or more diversion evaluation committees shall be established by the committee. The committee shall establish criteria for the selection of each diversion evaluation committee. Each member of a diversion evaluation committee shall receive per diem and expenses as provided in Section 103.

1966.1. Diversion program, acceptance into, participation in, withdrawal from

(a) The committee shall establish criteria for the acceptance, denial, or termination of licensees in a diversion program. Unless ordered by the committee as a condition of a licensee's disciplinary probation, only those licensees who have voluntarily requested diversion treatment and supervision by a diversion evaluation committee shall participate in a diversion program.

(b) A licensee who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A licensee under current investigation by the committee may also request entry into a diversion program by contacting the committee. The committee may refer the licensee requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licensee to enter into the diversion program, the committee may require the licensee, while under current investigation for any violations of this article or other violations, to execute a statement of understanding that states that the licensee understands that his or her violations of this article or other statutes, that would otherwise be the basis for discipline, may still be investigated and the subject of disciplinary action.

(d) If the reasons for a current investigation of a licensee are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1951, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the committee shall close the investigation without further action if

the licensee is accepted into the committee's diversion program and successfully completes the requirements of the program. If the licensee withdraws or is terminated from the program by a diversion evaluation committee, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the committee.

(e) Neither acceptance nor participation in the diversion program shall preclude the committee from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licensee for any unprofessional conduct committed before, during, or after participation in the diversion program.

(f) All licensees shall sign an agreement of understanding that the withdrawal or termination from the diversion program at a time when a diversion evaluation committee determines the licensee presents a threat to the public's health and safety shall result in the utilization by the committee of diversion treatment records in disciplinary or criminal proceedings.

(g) Any licensee terminated from the diversion program for failure to comply with program requirements is subject to disciplinary action by the committee for acts committed before, during, and after participation in the diversion program. A licensee who has been under investigation by the committee and has been terminated from the diversion program by a diversion evaluation committee shall be reported by the diversion evaluation committee to the committee.

1966.2. Duties of diversion evaluation committee

Each diversion evaluation committee shall have the following duties and responsibilities:

(a) To evaluate those licensees who request to participate in the diversion program according to the guidelines prescribed by the committee and to consider the recommendations of any licensees designated by the committee to serve as consultants on the admission of the licensee to the diversion program.

(b) To review and designate those treatment facilities to which licensees in a diversion program may be referred.

(c) To receive and review information concerning a licensee participating in the program.

(d) To consider in the case of each licensee participating in a program whether he or she may safely continue or resume the practice of dental hygiene.

(e) To perform other related duties as the committee may by regulation require.

1966.3. Diversion evaluation committee, closed sessions authorized

Notwithstanding the provisions of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a diversion evaluation committee may convene in closed session to consider reports pertaining to any licentiate requesting or participating in a diversion program. A diversion evaluation committee shall only convene in closed session to the extent that it is necessary to protect the privacy of a licensee.

1966.4. Diversion evaluation program, Compliance required

Each licensee who requests participation in a diversion program shall agree to cooperate with the treatment program designed by a diversion evaluation committee and to bear all costs related to the program, unless the cost is waived by the committee. Any failure to comply with the provisions of a treatment program may result in termination of the licensee's participation in a program.

1966.5. Diversion evaluation program, Records: Purging; Confidentiality

(a) After a diversion evaluation committee, in its discretion, has determined that a licensee has been rehabilitated and the diversion program is completed, the diversion evaluation

committee shall purge and destroy all records pertaining to the licensee's participation in the diversion program.

(b) Except as authorized by subdivision (f) of Section 1966.1, all committee and diversion evaluation committee records and records of proceedings pertaining to the treatment of a licensee in a program shall be kept confidential and are not subject to discovery or subpoena.

1966.6. Reports to the diversion evaluation committee; Representation in an action for defamation

The committee shall provide for the representation of any person making reports to a diversion evaluation committee or the committee under this article in any action for defamation for reports or information given to the diversion evaluation committee or the committee regarding a licensee's participation in the diversion program.

1967. Authorization of registered dental hygienists to render professional services as professional corporation

A registered dental hygienist in alternative practice corporation is a professional corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that professional corporation and its shareholders, officers, directors, and professional employees rendering professional services are in compliance with the Moscone-Knox Professional Corporation Act (commencing with Section 13400) of Part 4 of Division 3 of Title 1 of the Corporations Code, this article, and all other statutes and regulations now or hereafter adopted pertaining to the professional corporation and the conduct of its affairs. With respect to a registered dental hygienist in alternative practice corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Dental Hygiene Committee of California.

1967.1. Unprofessional conduct and violations of this article

It shall constitute unprofessional conduct and a violation of this article for any person licensed under this article to violate, attempt to violate, directly or indirectly, assist in or abet the violation of, or conspire to violate any provision or term of this article, the Moscone-Knox Professional Corporation Act, or any regulations duly adopted under those laws.

1967.2. Licensure scope and provisions

A licensee employed by, or practicing in, a registered dental hygienist in alternative practice corporation pursuant to Section 13401.5 of the Corporations Code shall practice within the scope of their license and shall be subject to all applicable licensure provisions in their respective practice act.

1967.3. Income of registered dental hygienist not accrued to the benefit of a shareholder that is a disqualified person

The income of a registered dental hygienist in alternative practice corporation attributable to professional services rendered while a shareholder is a disqualified person, as defined in subdivision (e) of Section 13401 of the Corporations Code, shall not in any manner accrue to the benefit of such shareholder or his or her shares in the registered dental hygienist in alternative practice corporation.

1967.4. Requisite bylaw that capital stock owned by a disqualified or deceased person to be sold to the professional corporation; Insurance for claims arising out of the rendering of professional services

(a) The bylaws of a registered dental hygienist in alternative practice corporation shall include a provision whereby the capital stock of the professional corporation owned by a disqualified person, as defined in subdivision (e) of Section 13401 of the Corporations Code, or a deceased person, shall be sold to the professional corporation or to the remaining

shareholders of the professional corporation not later than 90 days after disqualification, if the shareholder becomes a disqualified person, or not later than six months after death, if the shareholder becomes deceased.

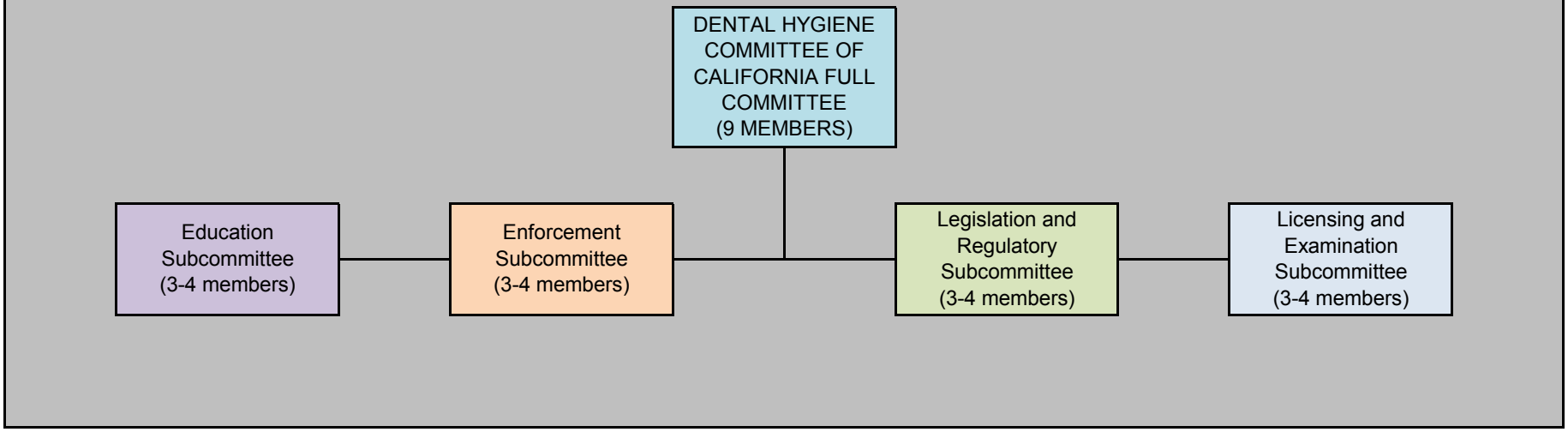
(b) A registered dental hygienist in alternative practice corporation shall provide adequate security by insurance or otherwise for claims against it by its patients arising out of the rendering of professional services.

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT C:

Current Organizational Chart Showing Relationship of Committees and Membership of Each Subcommittee

DENTAL HYGIENE COMMITTEE OF CALIFORNIA ORGANIZATION CHART



THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT D:

Placeholder only – No Attachment D because the DHCC did not conduct any major studies

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT E:

DHCC Quarterly Performance Measures for the past 3 years (there are no Annual Performance Measures available to report)

Department of Consumer Affairs

Dental Hygiene Committee of California

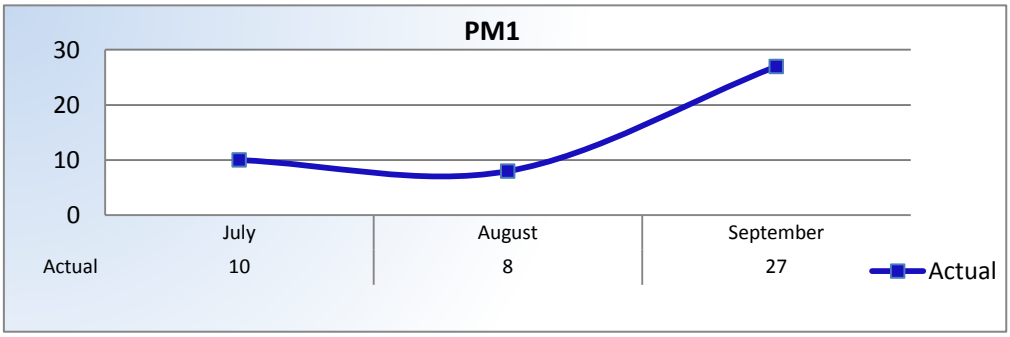
Performance Measures

Q1 Report *(July - September 2014)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

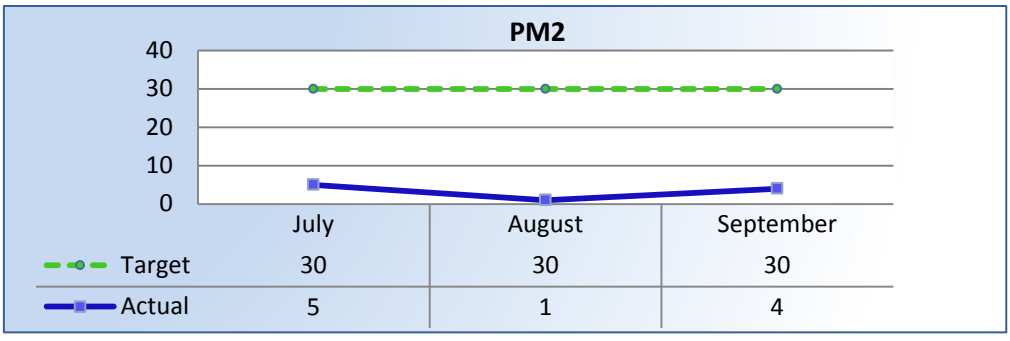


Total Received: 45 Monthly Average: 15

Complaints: 10 | **Convictions**: 35

PM2 | Intake

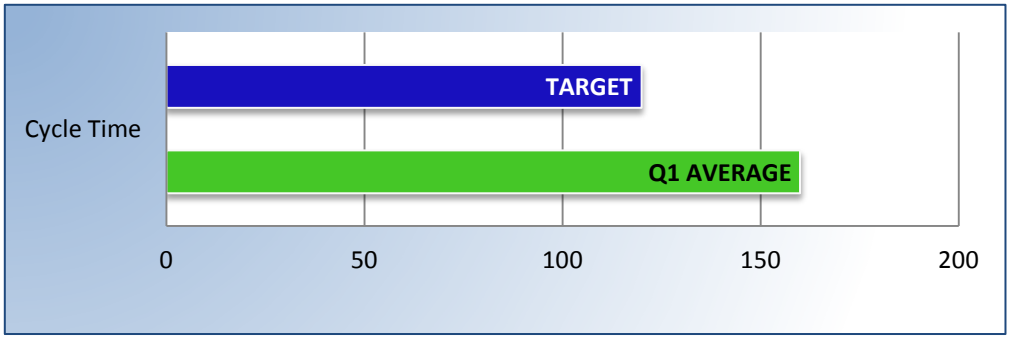
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 4 Days

PM3 | Intake & Investigation

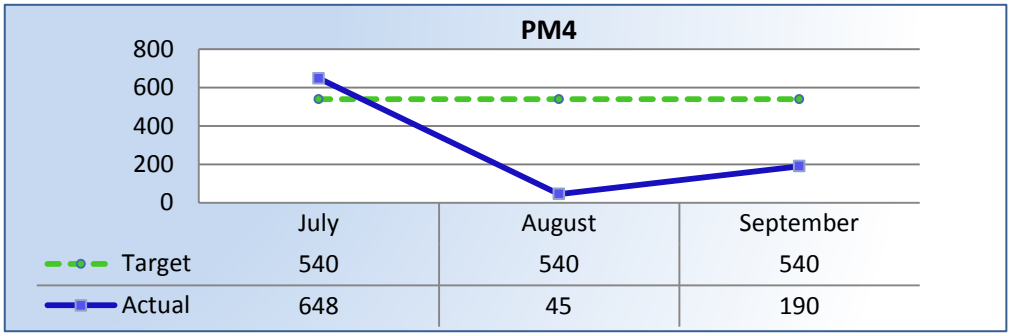
Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.



Target Average: 270 Days | **Actual Average:** 160 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Committee and prosecution by the AG).



Target Average: 540 Days | **Actual Average:** 268 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

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

The Committee did not report any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

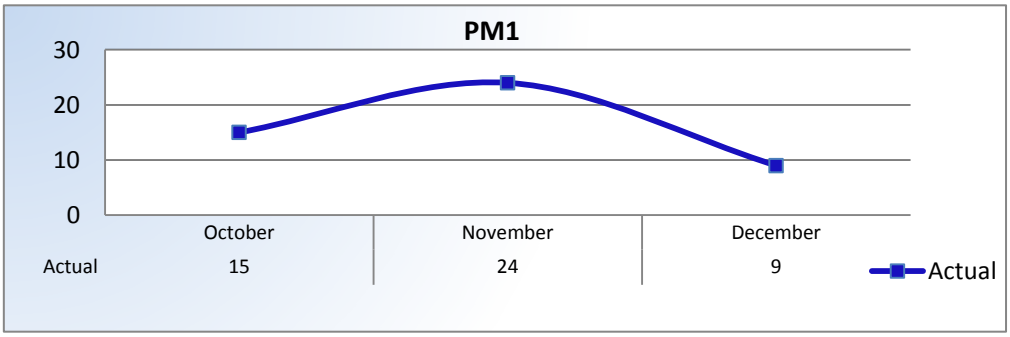
Performance Measures

Q2 Report *(October - December 2014)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

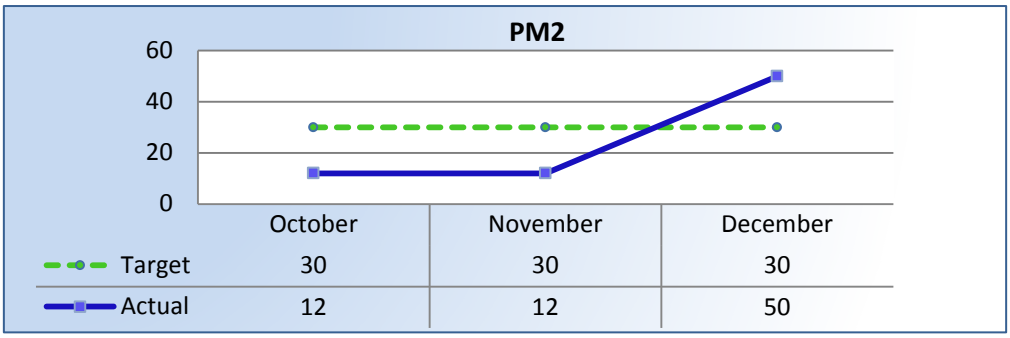


Total Received: 48 Monthly Average: 16

Complaints: 23 | **Convictions**: 25

PM2 | Intake

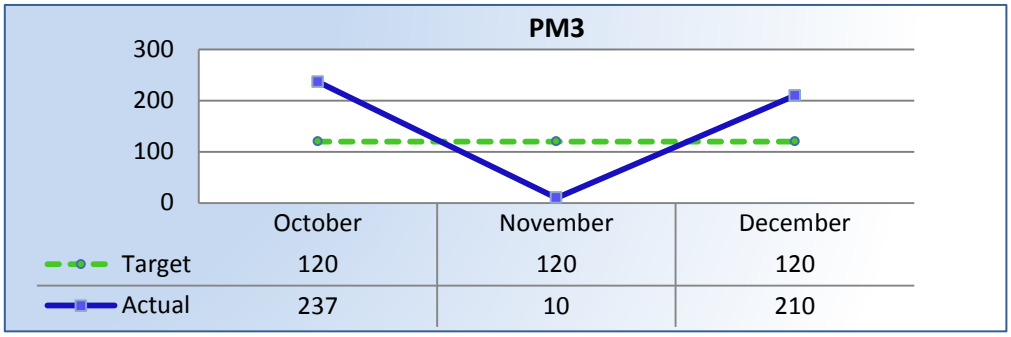
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 21 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

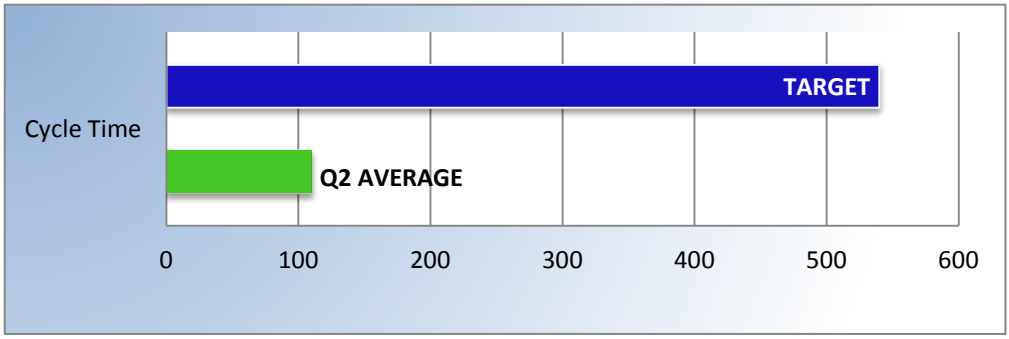


	October	November	December
Target	120	120	120
Actual	237	10	210

Target Average: 270 Days | **Actual Average:** 58 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Committee and prosecution by the AG).



Target Average: 540 Days | **Actual Average:** 110 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

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

The Committee did not report any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

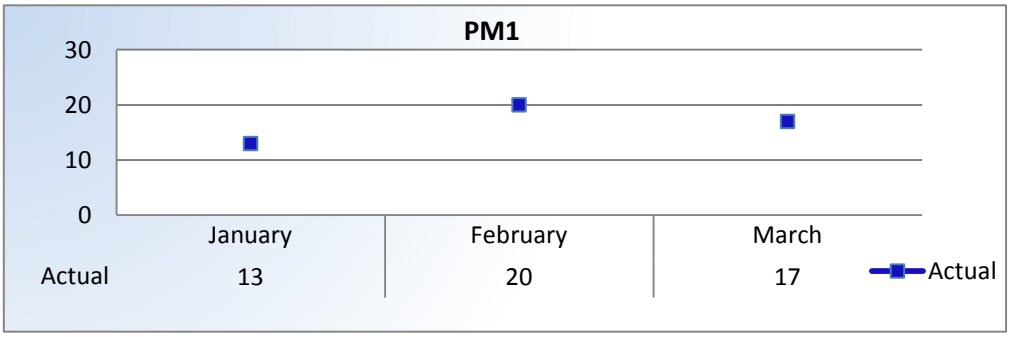
Performance Measures

Q3 Report *(January - March 2015)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

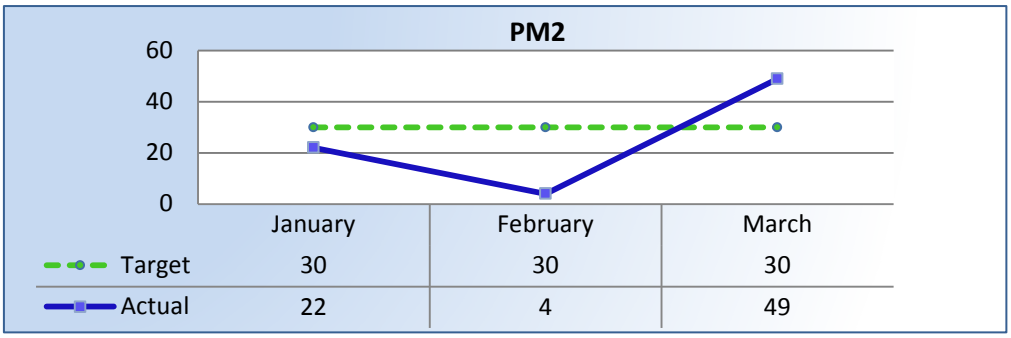


Total Received: 50 Monthly Average: 17

Complaints: 21 | **Convictions**: 29

PM2 | Intake

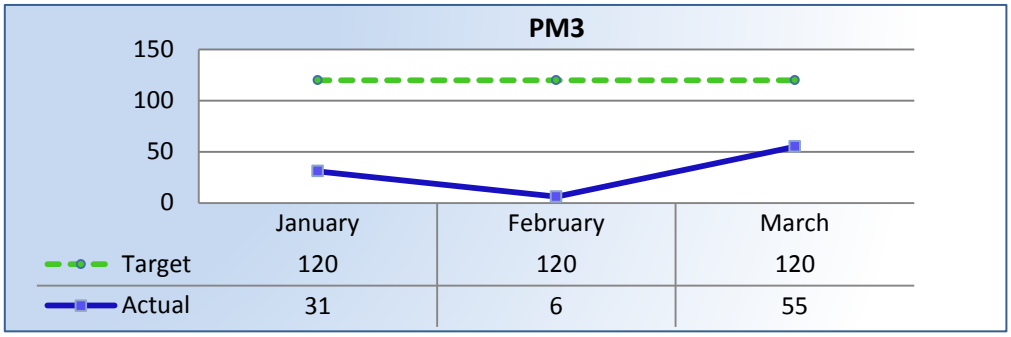
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 27 Days

PM3 | Intake & Investigation

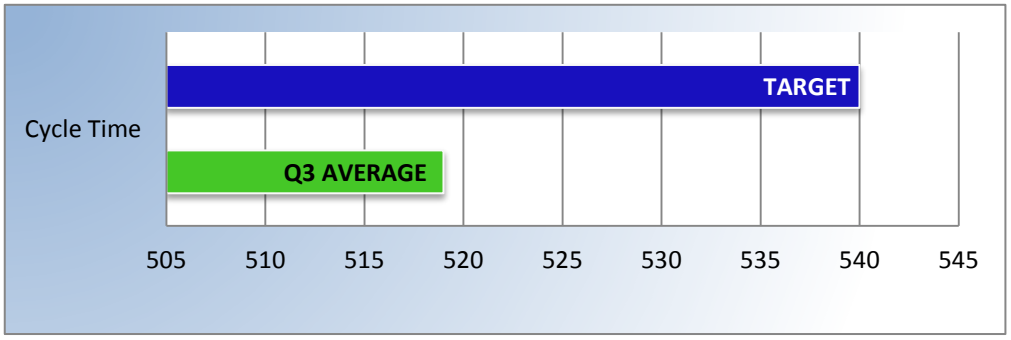
Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.



Target Average: 270 Days | **Actual Average:** 38 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Committee and prosecution by the AG).



Target Average: 540 Days | **Actual Average:** 519 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

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

The Committee did not have any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

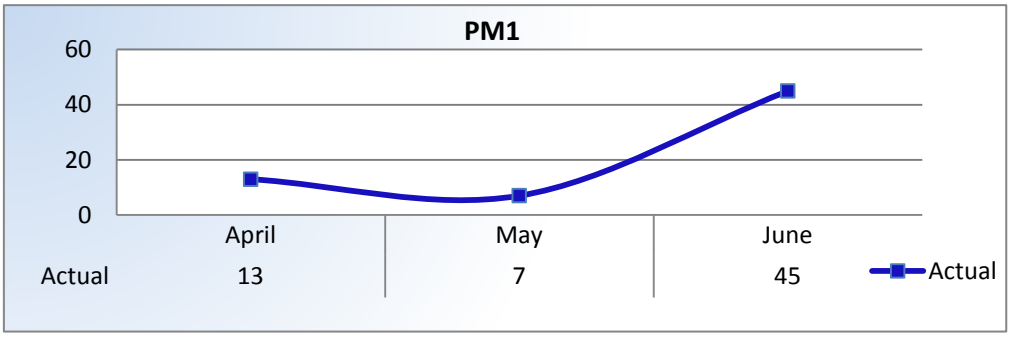
Performance Measures

Q4 Report *(April - June 2015)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

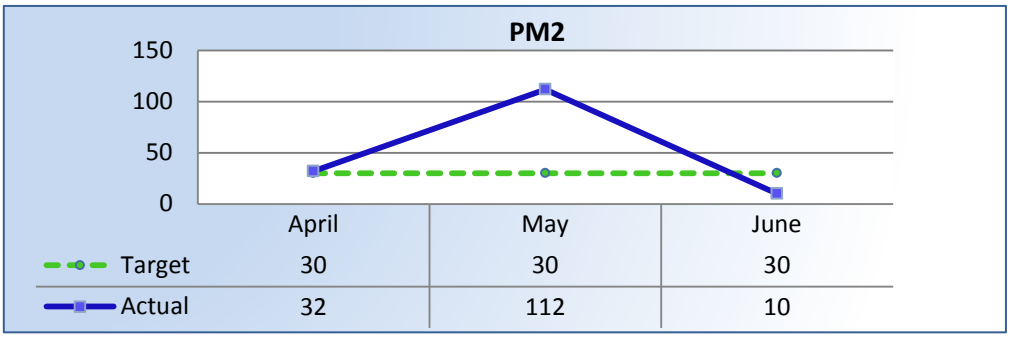


Total Received: 65 Monthly Average: 22

Complaints: 22 | **Convictions**: 43

PM2 | Intake

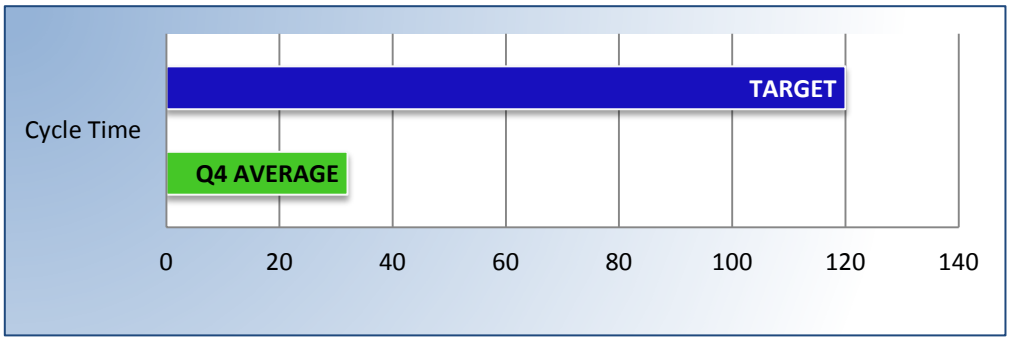
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 18 Days

PM3 | Intake & Investigation

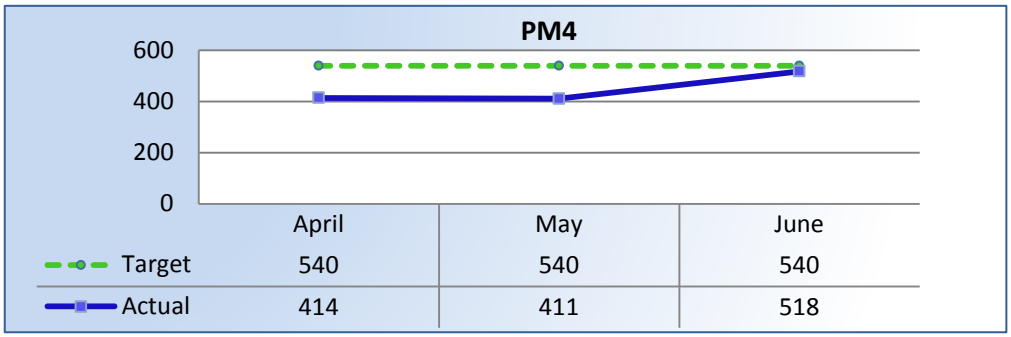
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



Target Average: 120 Days | **Actual Average:** 32 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	April	May	June
Target	540	540	540
Actual	414	411	518

Target Average: 540 Days | **Actual Average:** 482 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

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

The Committee did not have any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

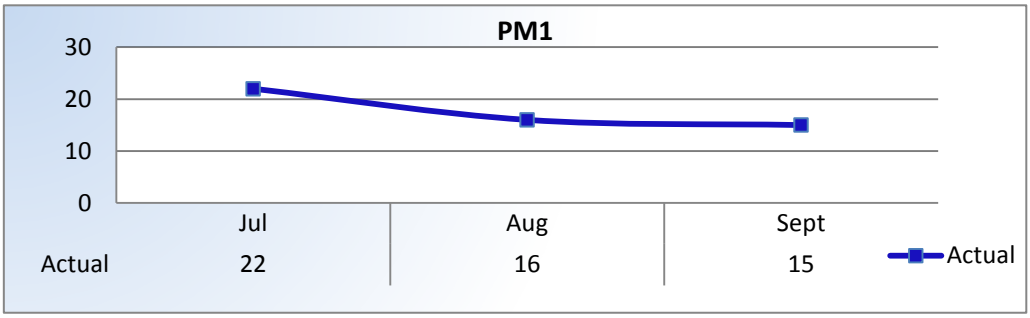
Performance Measures

Q1 Report *(July - September 2015)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

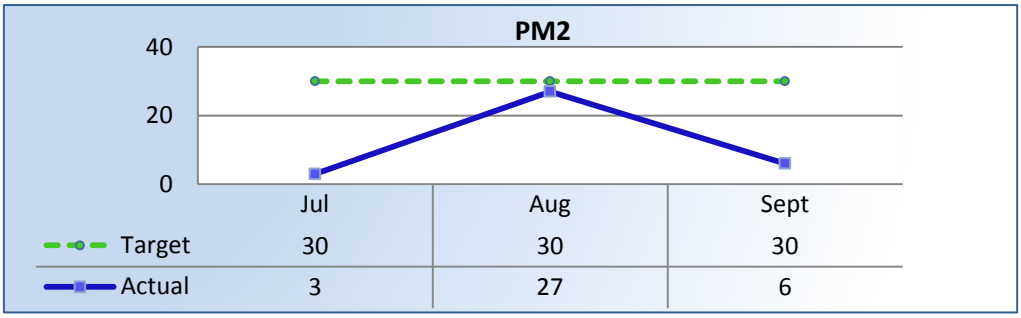


Total Received: 53 **Monthly Average**: 18

Complaints: 12 | **Convictions**: 41

PM2 | Intake

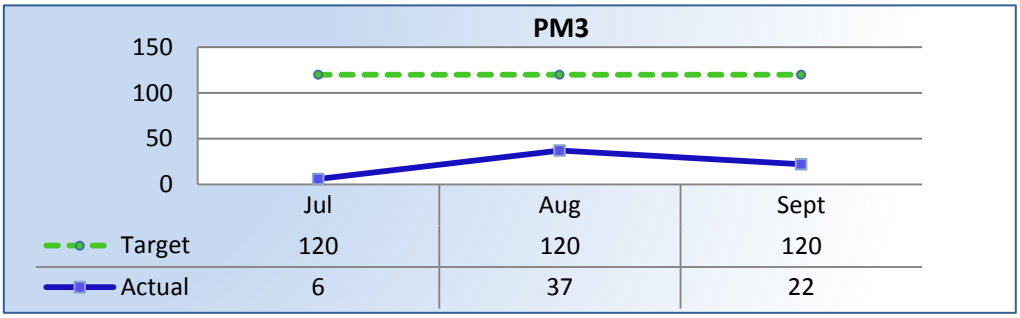
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 13 Days

PM3 | Intake & Investigation

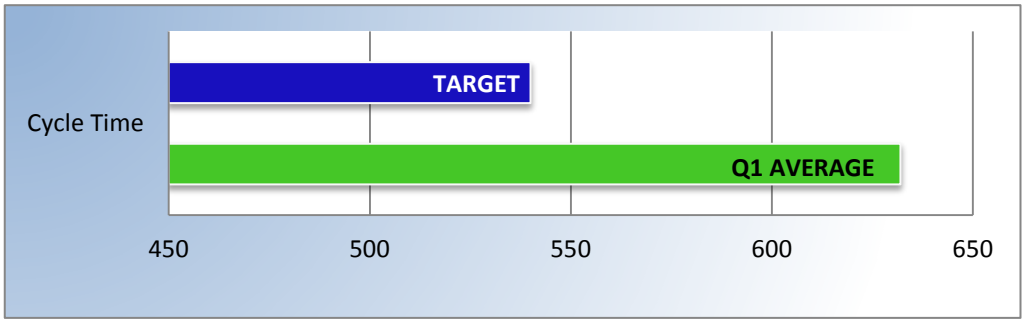
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



Target Average: 120 Days | **Actual Average:** 23 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



Target Average: 540 Days | **Actual Average:** 632 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

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

The Committee did not have any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

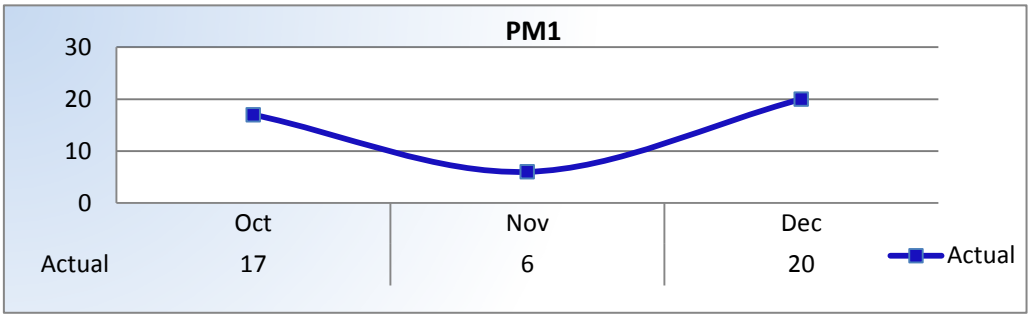
Performance Measures

Q2 Report *(October - December 2015)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

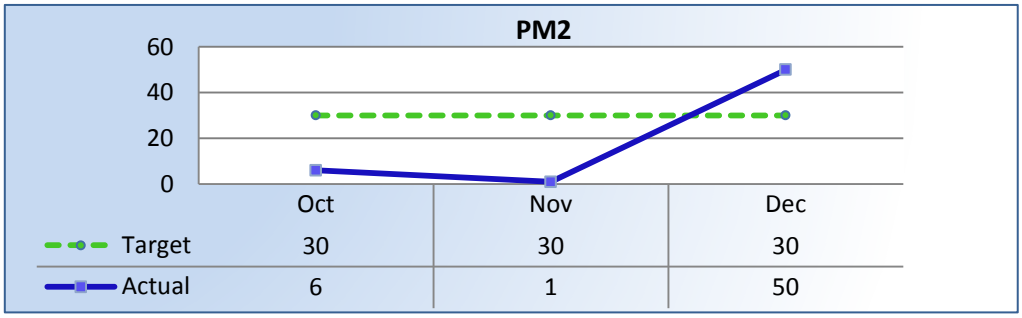


Total Received: 43 **Monthly Average**: 14

Complaints: 14 | **Convictions**: 29

PM2 | Intake

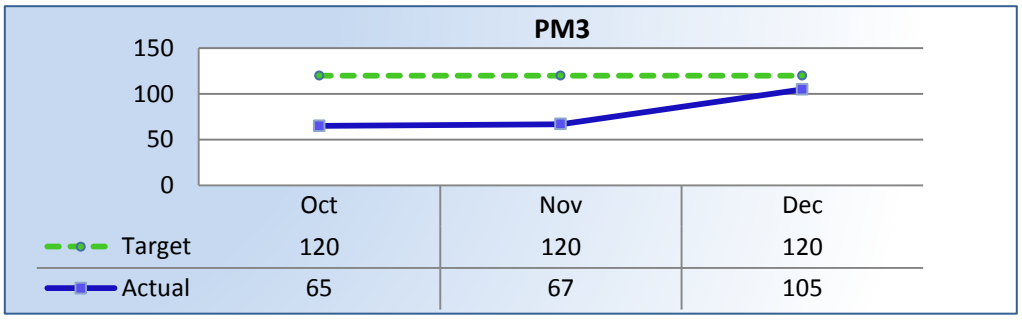
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 25 Days

PM3 | Intake & Investigation

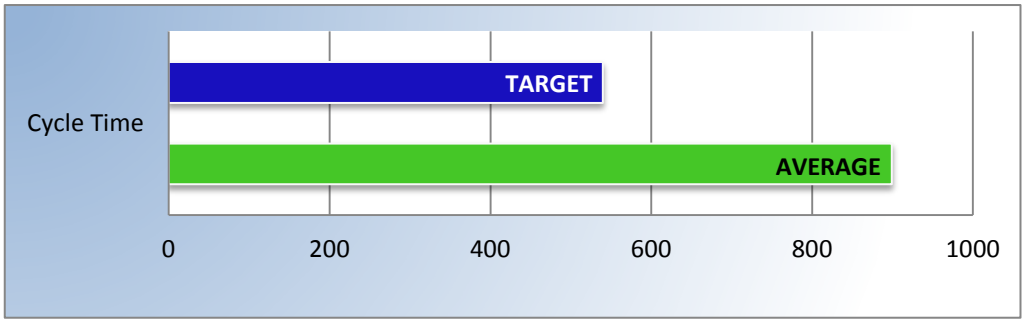
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



Target Average: 120 Days | **Actual Average:** 78 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



Target Average: 540 Days | **Actual Average:** 899 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

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

PM8 |Probation Violation Response

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

The Committee did not have any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

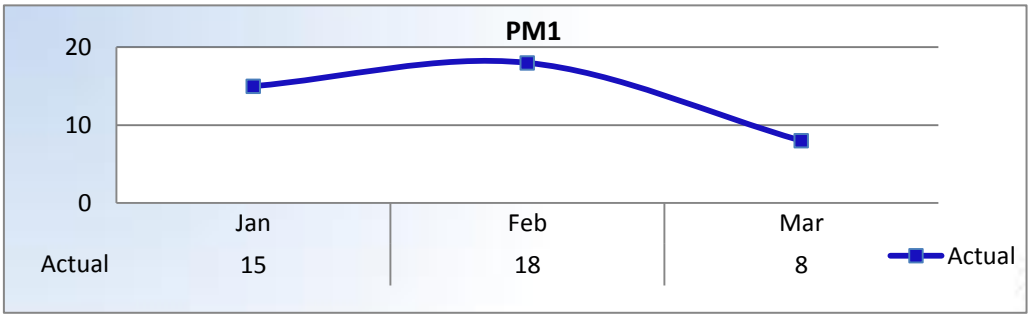
Performance Measures

Q3 Report *(January – March 2016)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

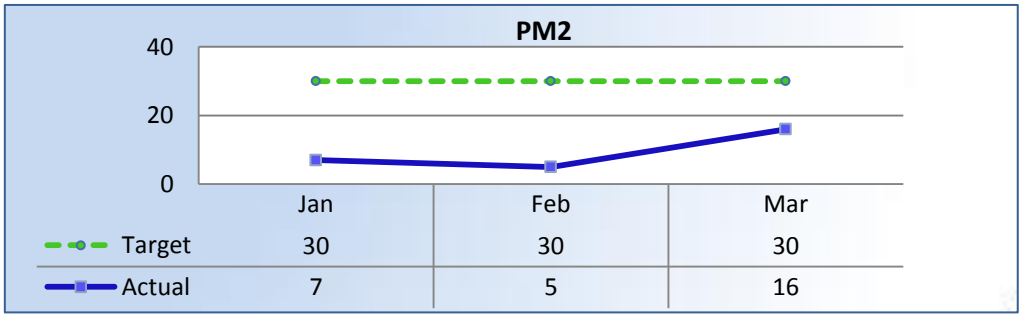


Total Received: 41 **Monthly Average**: 14

Complaints: 11 | **Convictions**: 30

PM2 | Intake

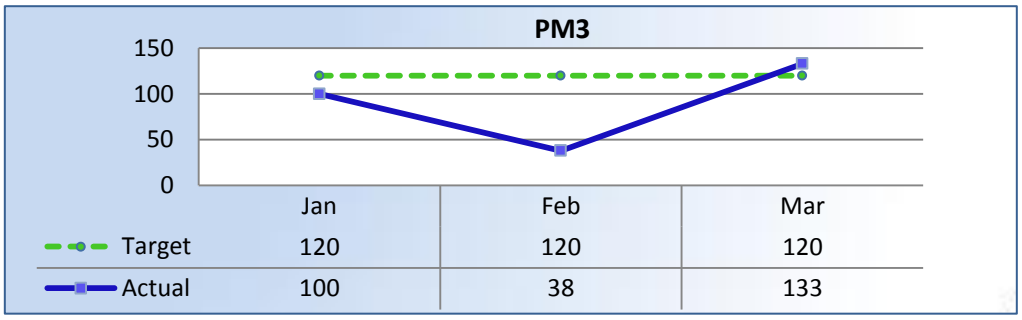
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 9 Days

PM3 | Intake & Investigation

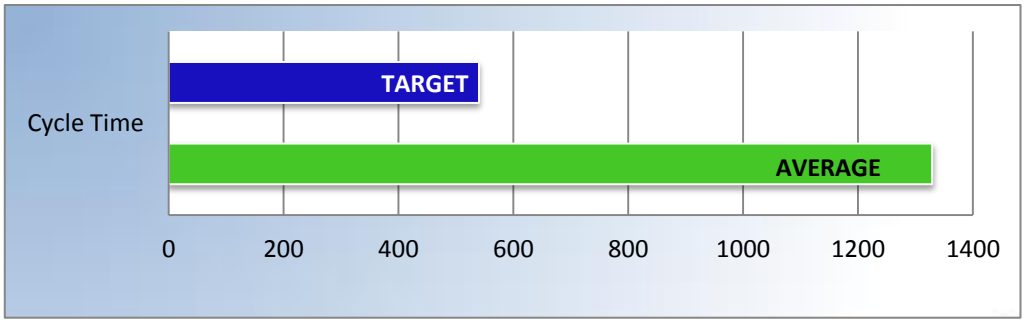
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



Target Average: 120 Days | **Actual Average:** 77 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



Target Average: 540 Days | **Actual Average:** 1,329 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

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

The Committee did not have any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** N/A

Department of Consumer Affairs

Dental Hygiene Committee of California

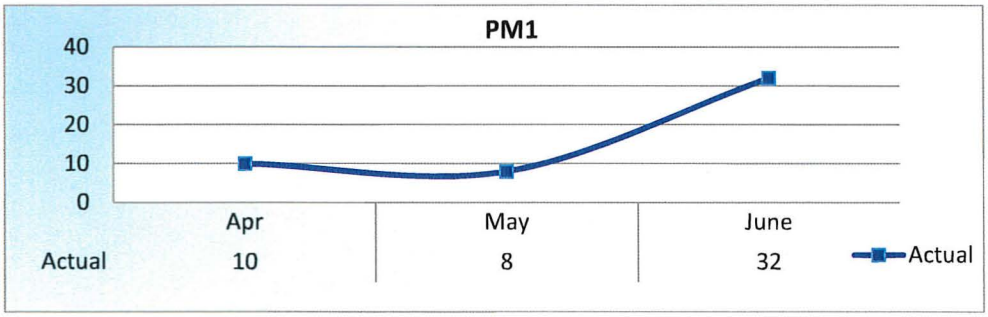
Performance Measures

Q4 Report *(April - June 2016)*

To ensure stakeholders can review the Committee's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

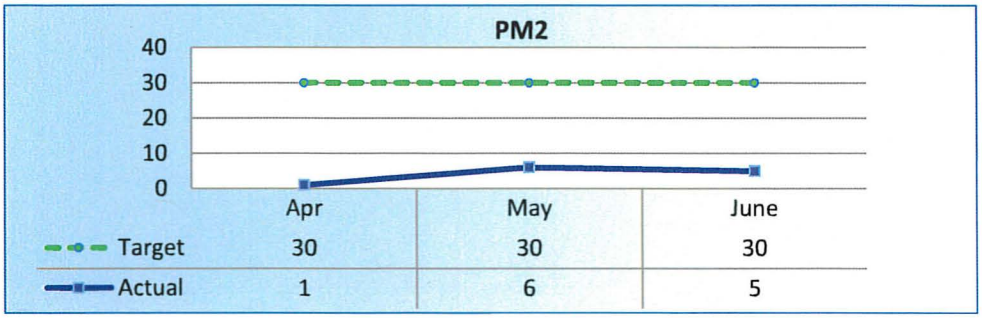


Total Received: 50 **Monthly Average**: 17

Complaints: 14 | **Convictions**: 36

PM2 | Intake

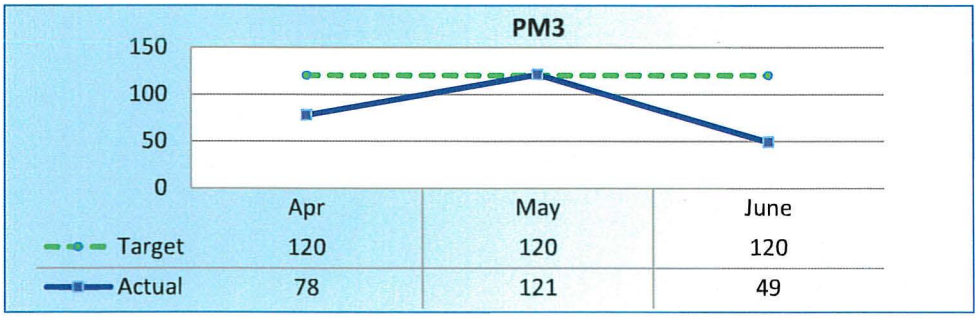
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 30 Days | **Actual Average: 4** Days

PM3 | Intake & Investigation

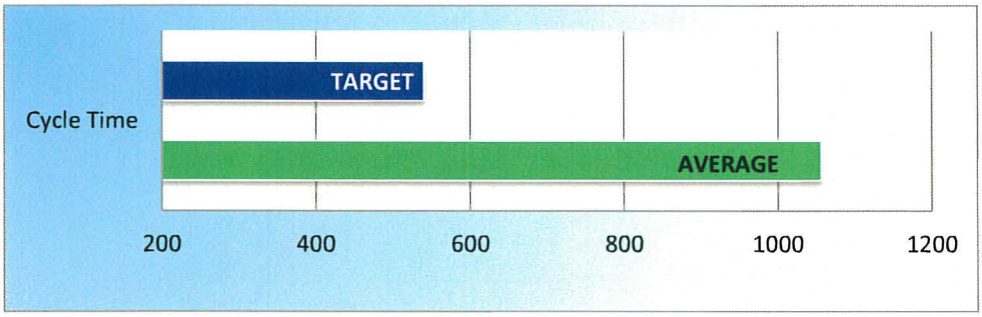
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation)



Target Average: 120 Days | **Actual Average:** 69 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



Target Average: 540 Days | **Actual Average:** 1,056 Days

PM7 |Probation Intake

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

The Committee did not contact any new probationers this quarter.

Target Average: 10 Days | **Actual Average:** n/a

PM8 |Probation Violation Response

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

The Committee did not have any probation violations this quarter.

Target Average: 15 Days | **Actual Average:** n/a

Department of Consumer Affairs

Dental Hygiene Committee

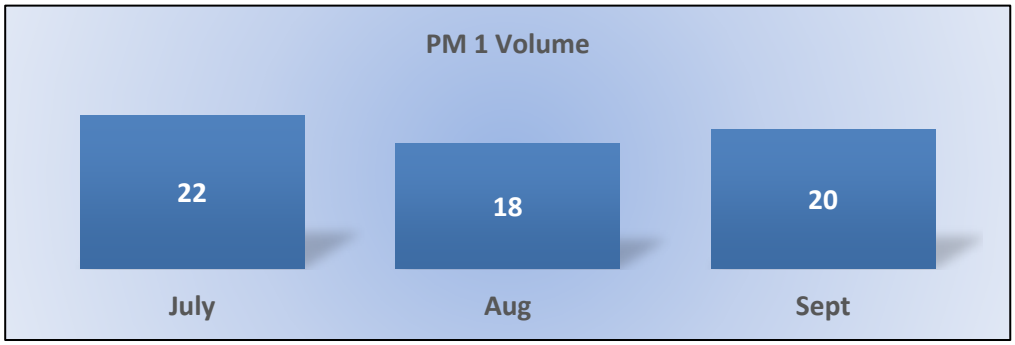
Enforcement Performance Measures

Q1 Report *(July - September 2016)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

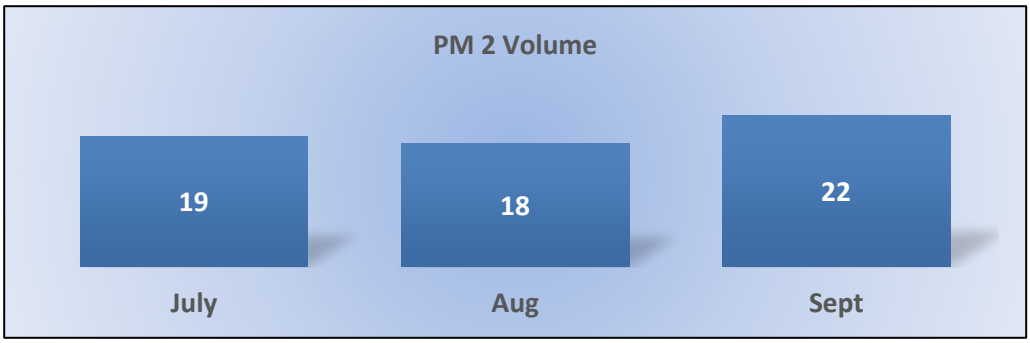


Total Received: 60 | **Monthly Average**: 20

Complaints: 11 | **Convictions**: 49

PM2 | Intake – Volume

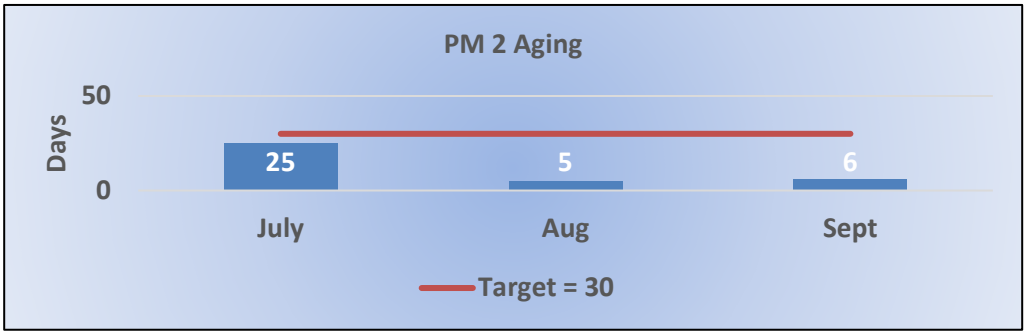
Number of complaints closed or assigned to an investigator.



Total: 59 | **Monthly Average:** 20

PM2 | Intake – Cycle Time

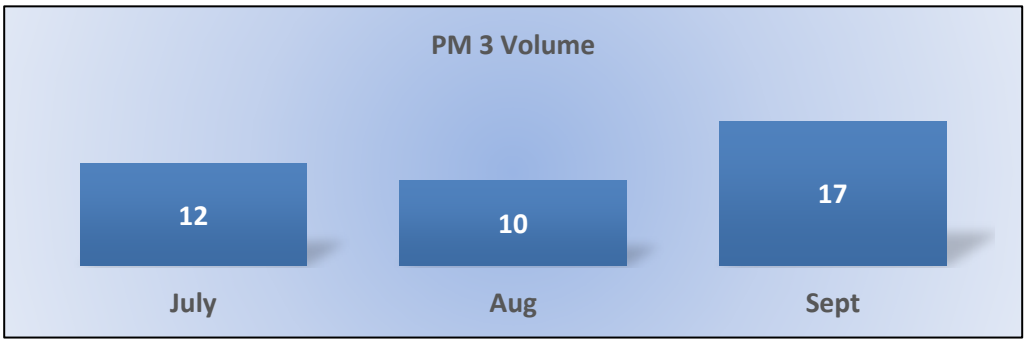
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 12 Days

PM3 | Investigations – Volume

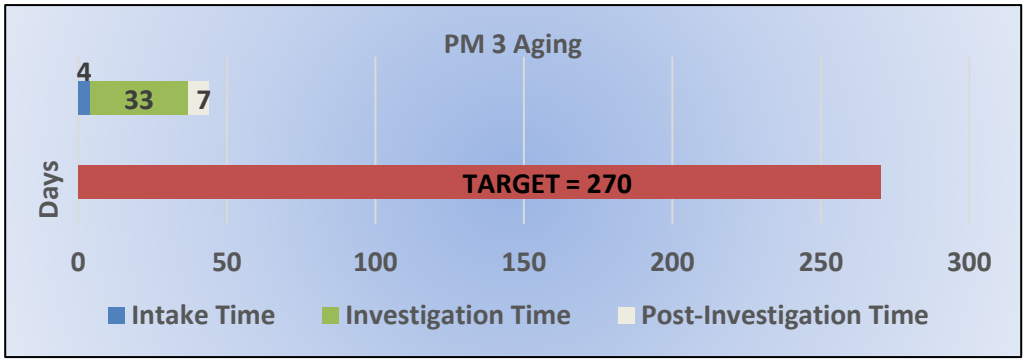
Number of investigations closed (not including cases transmitted to the Attorney General).



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

PM3 | Investigations – Cycle Time[1]

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

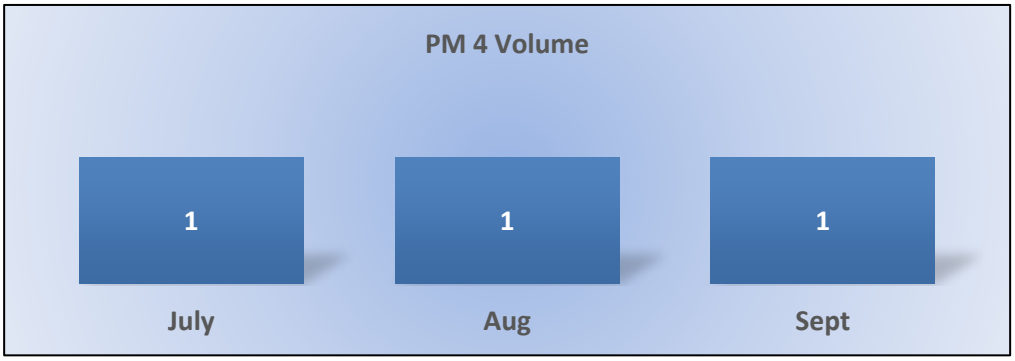


Target Average: 270 Days | **Actual Average:** 42 Days

[1] *Due to rounding, there might be small discrepancies between the PM3 "Actual Average", and the sum of the individual case stages (i.e., Intake time + Investigation time + Post-Investigation time).*

PM4 | Formal Discipline – Volume

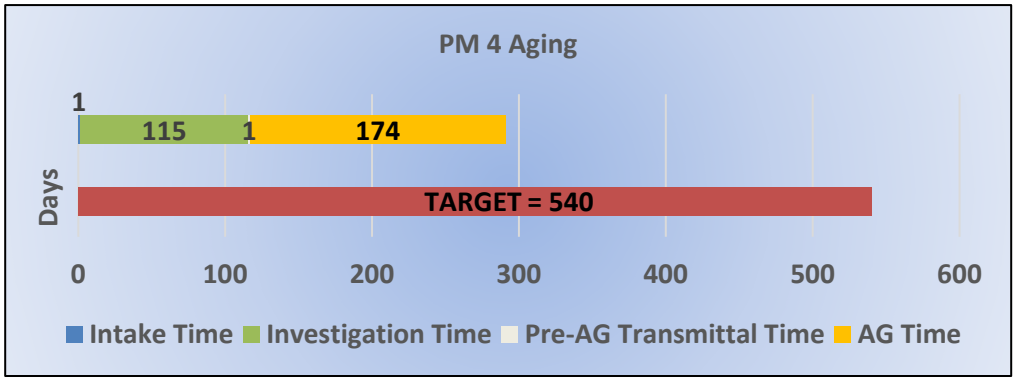
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Total: 3

PM4 | Formal Discipline – Cycle Time[2]

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

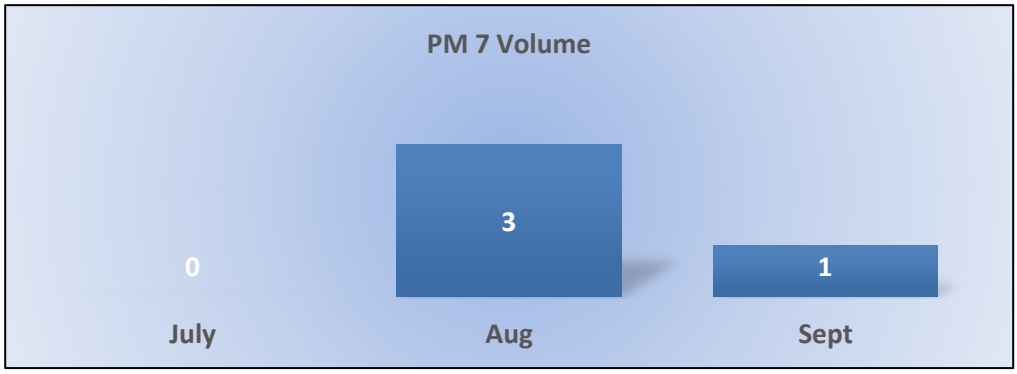


Target Average: 540 Days | **Actual Average:** 291 Days

[2] *Due to rounding, there might be small discrepancies between the PM4 "Actual Average", and the sum of the individual case stages (i.e., Intake time + Investigation time + Pre-AG Transmittal time + AG time).*

PM7 |Probation Intake – Volume

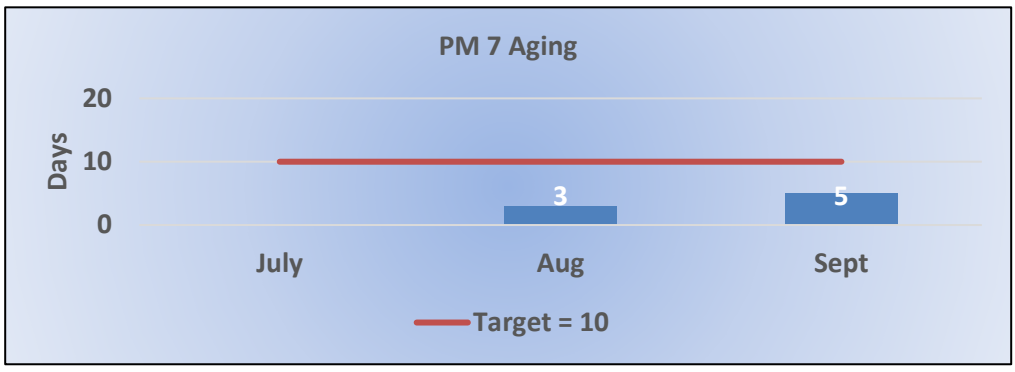
Number of new probation cases.



Total: 4

PM7 |Probation Intake – Cycle Time

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



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

PM8 |Probation Violation Response – Volume

Number of probation violation cases.

The Committee did not have any probation violations this quarter.

PM8 |Probation Violation Response – Cycle Time

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

The Committee did not have any probation violations this quarter.

Department of Consumer Affairs

California Board of Accountancy

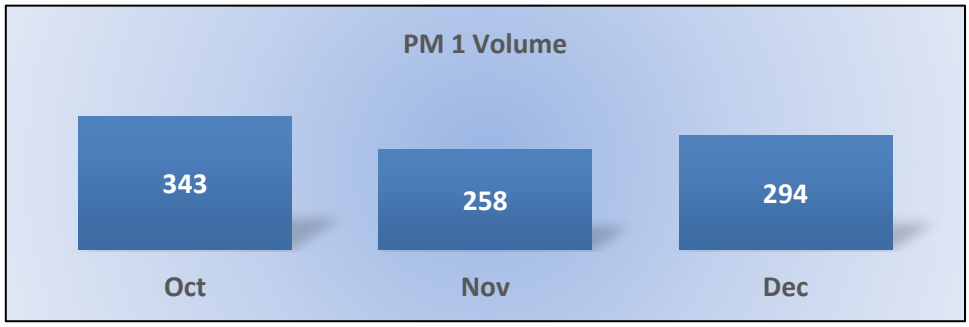
Enforcement Performance Measures

Q2 Report *(October - December 2016)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

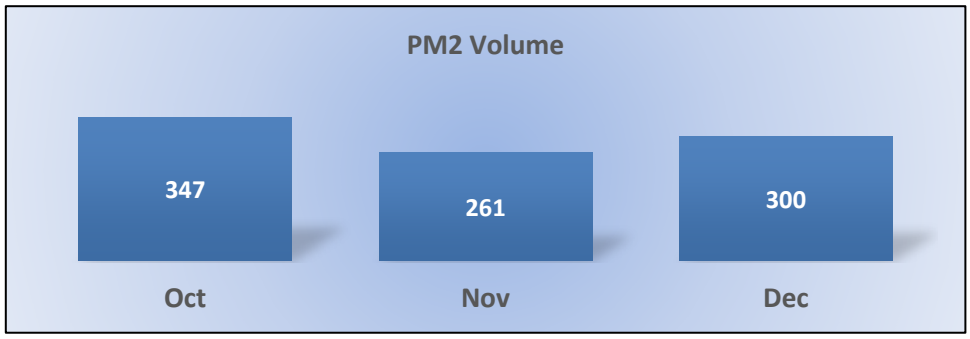


Total Received: 895 **Monthly Average**: 298

Complaints: 801 | **Convictions**: 94

PM2 | Intake – Volume

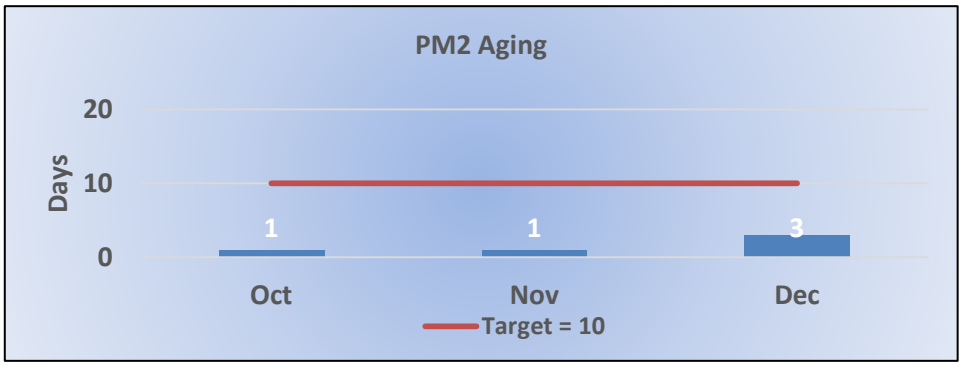
Number of complaints closed or assigned to an investigator.



Total: 908 **| Monthly Average:** 303

PM2 | Intake – Cycle Time

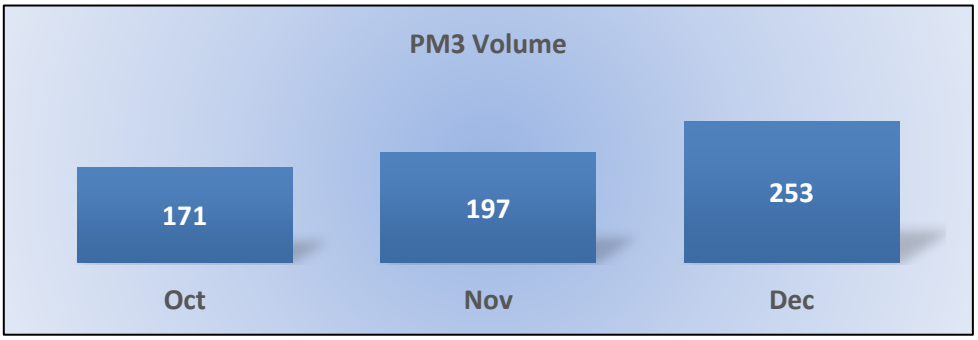
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



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

PM3 | Investigations – Volume

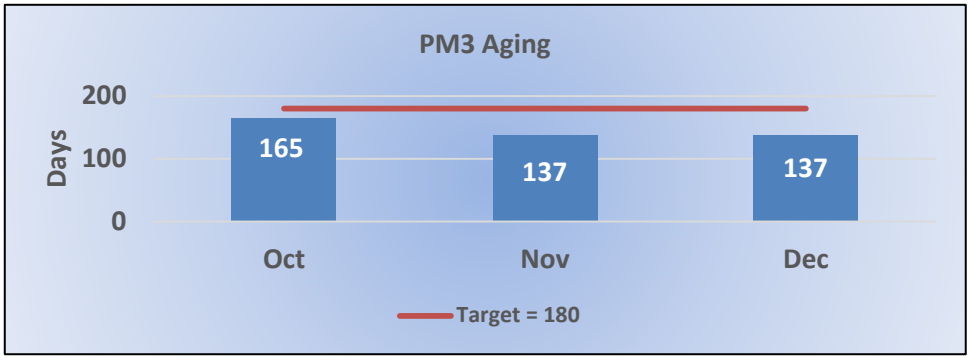
Number of investigations closed (not including cases transmitted to the Attorney General).



Total: 621 | **Monthly Average:** 207

PM3 | Investigations – Cycle Time

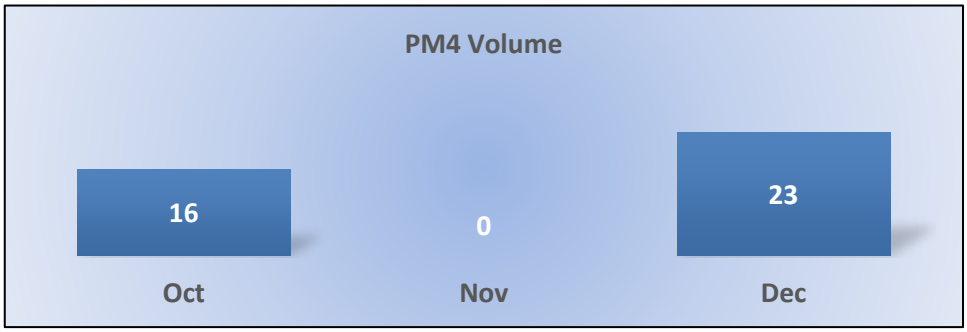
Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General.
(Includes intake and investigation.)



Target Average: 180 Days | **Actual Average:** 145 Days

PM4 | Formal Discipline – Volume

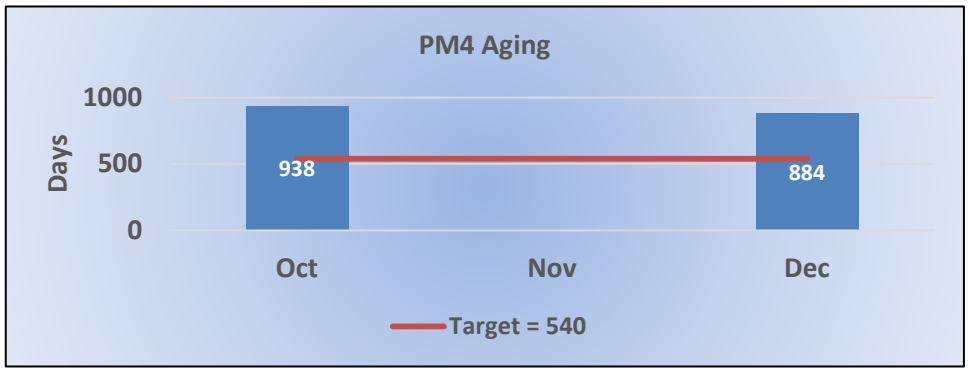
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



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

PM4 | Formal Discipline – Cycle Time

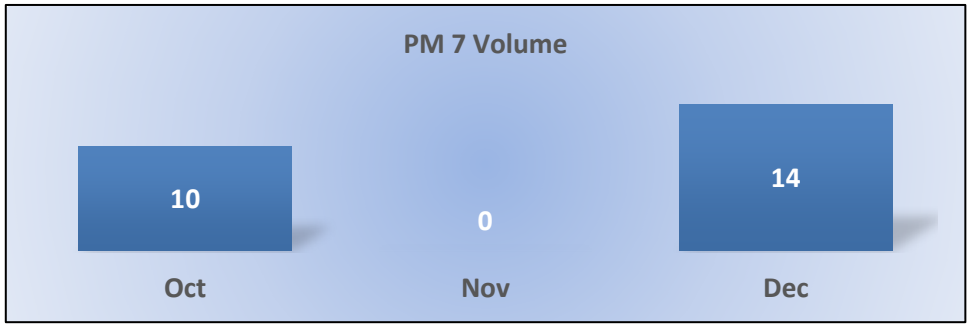
Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General.
(Includes intake, investigation, and case outcome.)



Target Average: 540 Days | **Actual Average:** 906 Days

PM7 |Probation Intake – Volume

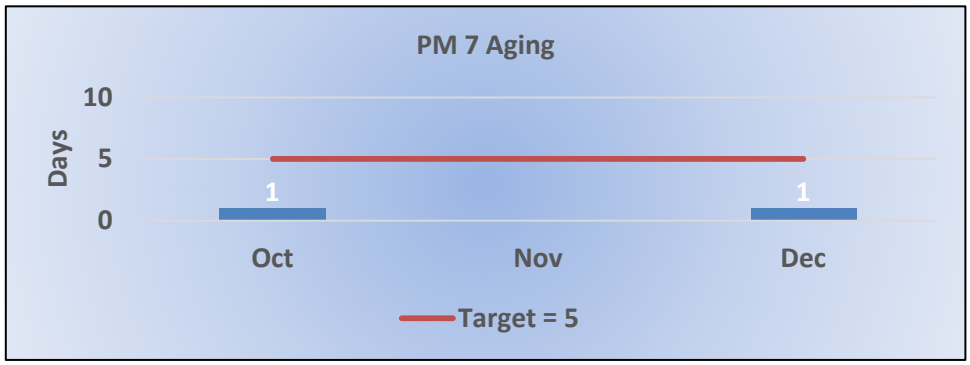
Number of new probation cases.



Total: 24

PM7 |Probation Intake – Cycle Time

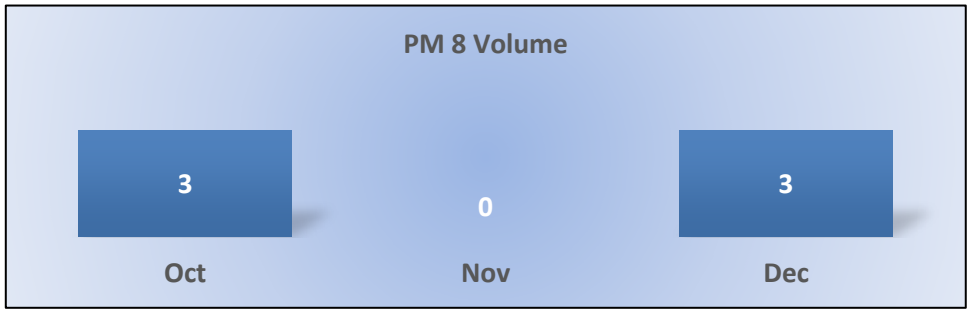
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 5 Days | **Actual Average:** 1 Day

PM8 |Probation Violation Response – Volume

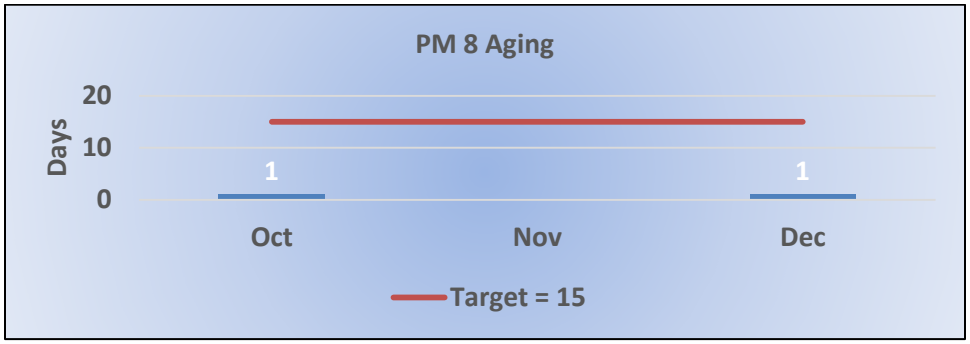
Number of probation violation cases.



Total: 6

PM8 |Probation Violation Response – Cycle Time

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



Target Average: 15 Days | **Actual Average:** 1 Day

Department of Consumer Affairs

California Board of Accountancy

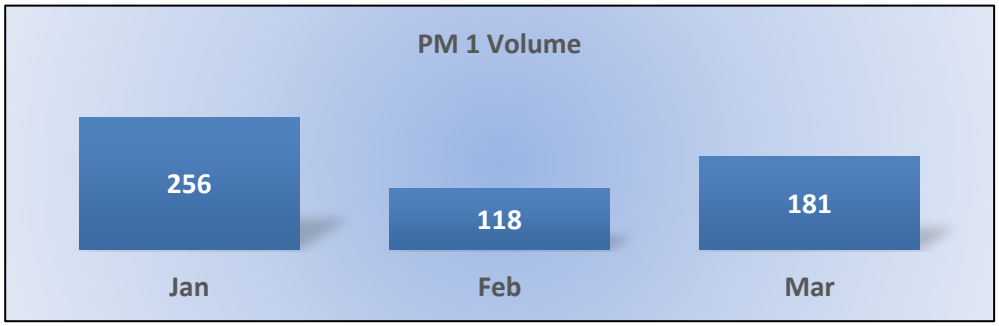
Enforcement Performance Measures

Q3 Report *(January – March 2017)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

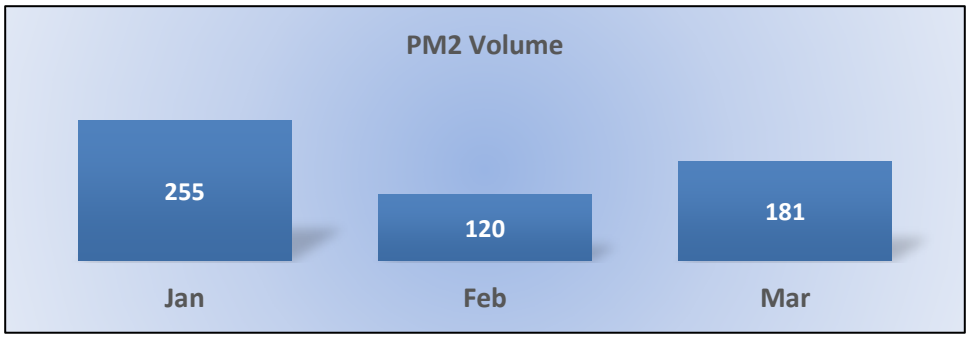


Total Received: 555 **Monthly Average**: 185

Complaints: 444 | **Convictions**: 111

PM2 | Intake – Volume

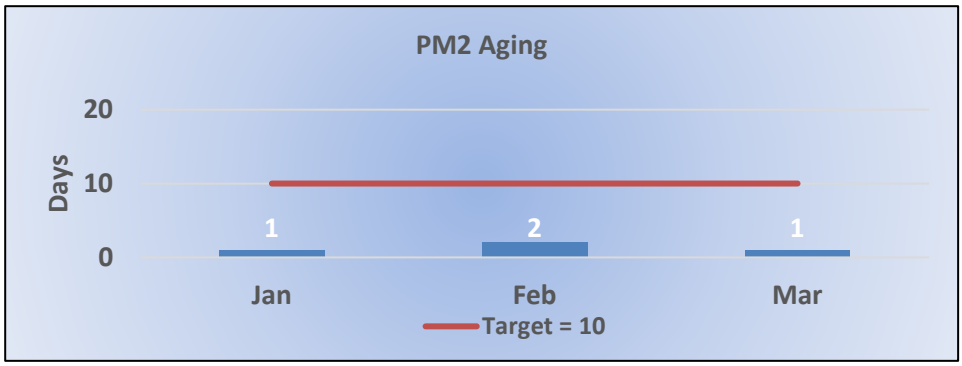
Number of complaints closed or assigned to an investigator.



Total: 556 **| Monthly Average:** 185

PM2 | Intake – Cycle Time

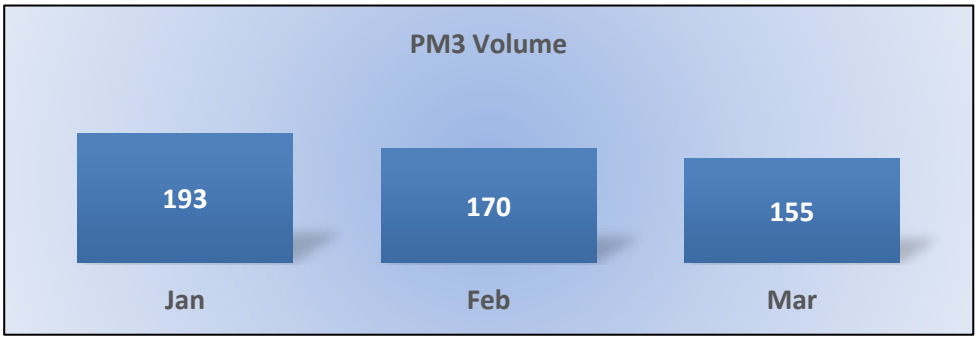
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



Target Average: 10 Days | **Actual Average:** 1 Day

PM3 | Investigations – Volume

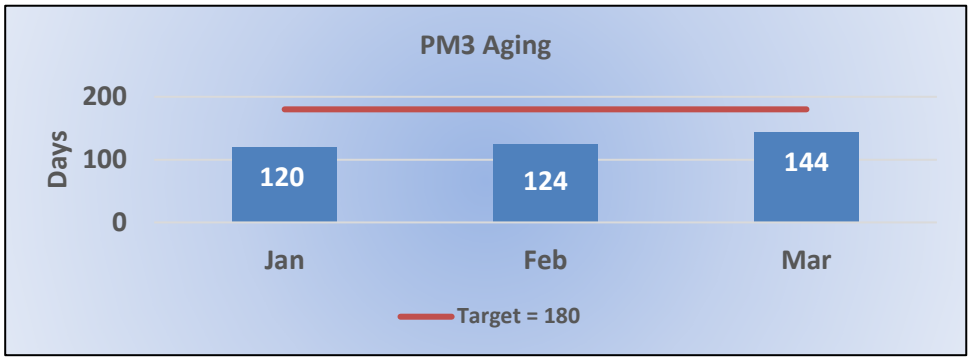
Number of investigations closed (not including cases transmitted to the Attorney General).



Total: 518 | **Monthly Average:** 173

PM3 | Investigations – Cycle Time

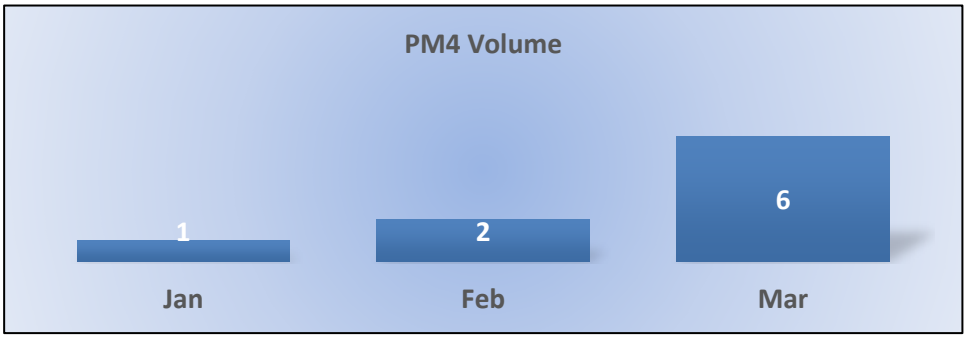
Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General.
(Includes intake and investigation.)



Target Average: 180 Days | **Actual Average:** 128 Days

PM4 | Formal Discipline – Volume

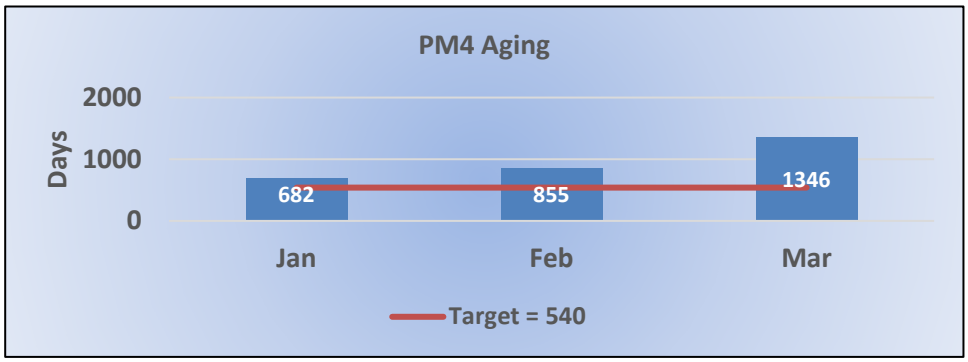
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Total: 9 | **Monthly Average**: 3

PM4 | Formal Discipline – Cycle Time

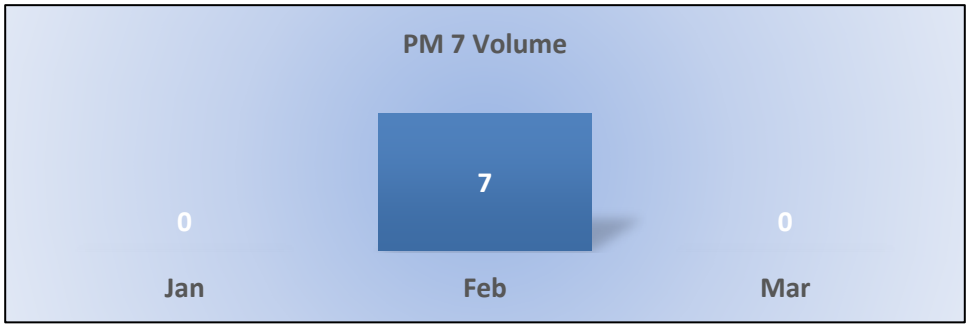
Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General. (Includes intake, investigation, and case outcome.)



Target Average: 540 Days | **Actual Average:** 1,163 Days

PM7 |Probation Intake – Volume

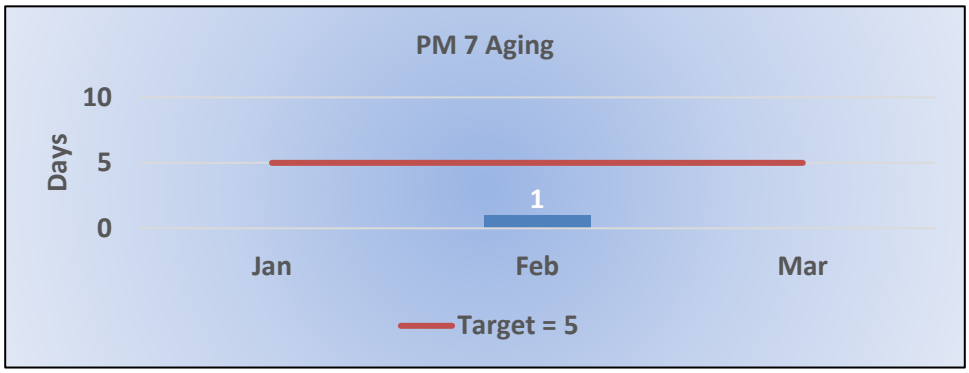
Number of new probation cases.



Total: 7

PM7 |Probation Intake – Cycle Time

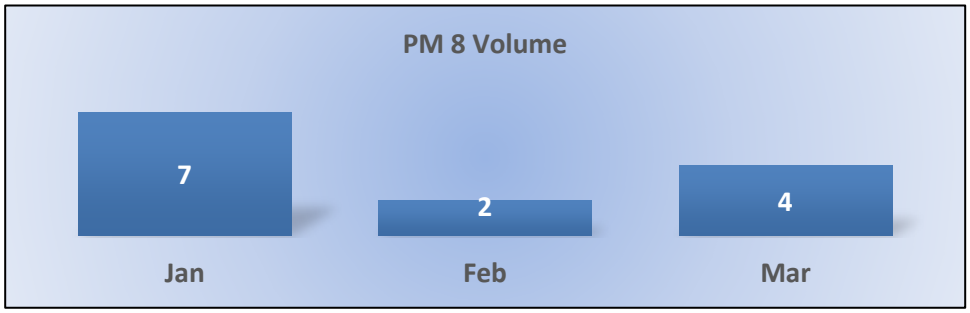
Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 5 Days | **Actual Average:** 1 Day

PM8 |Probation Violation Response – Volume

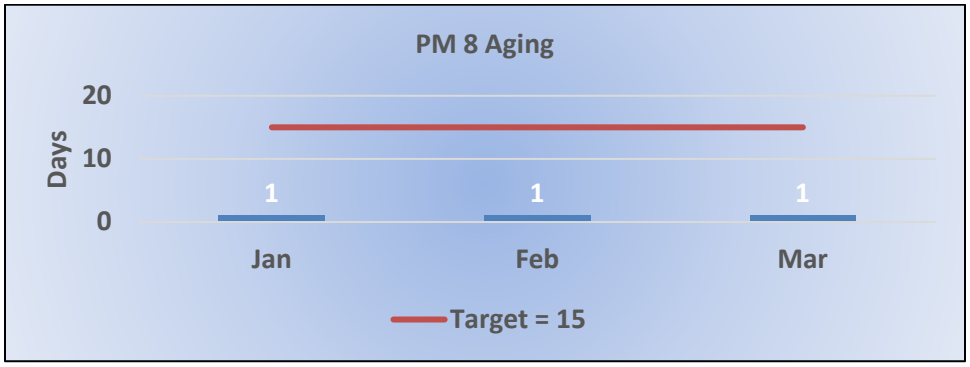
Number of probation violation cases.



Total: 13

PM8 |Probation Violation Response – Cycle Time

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



Target Average: 15 Days | **Actual Average:** 1 Day

Department of Consumer Affairs

Dental Hygiene Committee

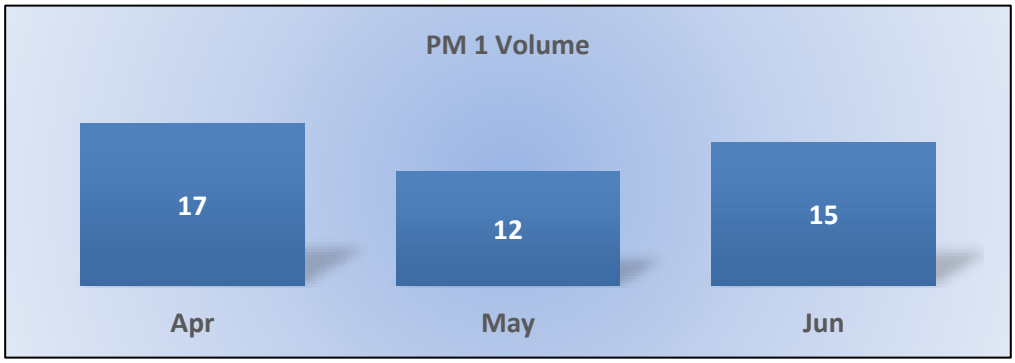
Enforcement Performance Measures

Q4 Report *(April - June 2017)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

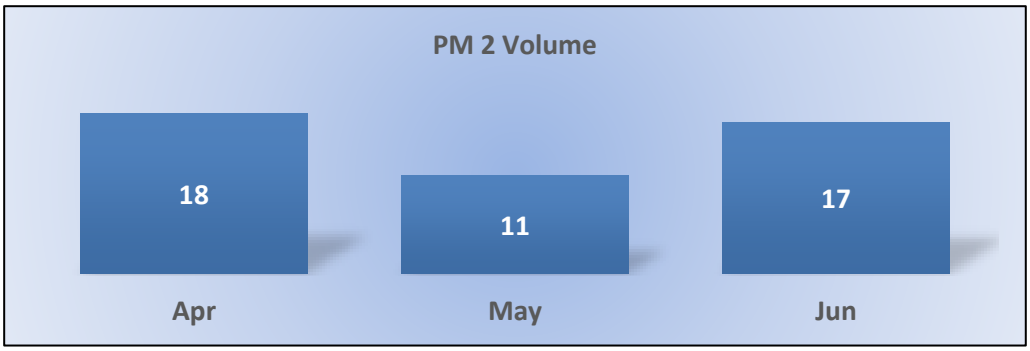


Total Received: 44 | **Monthly Average**: 15

Complaints: 8 | **Convictions**: 36

PM2 | Intake – Volume

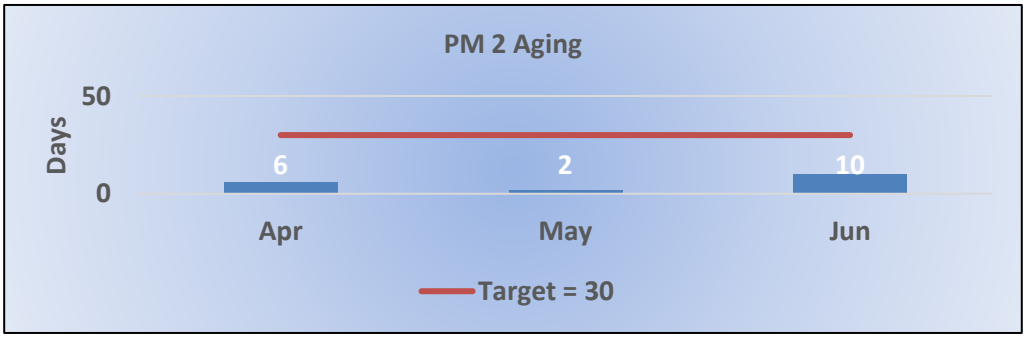
Number of complaints closed or assigned to an investigator.



Total: 46 | **Monthly Average:** 15

PM2 | Intake – Cycle Time

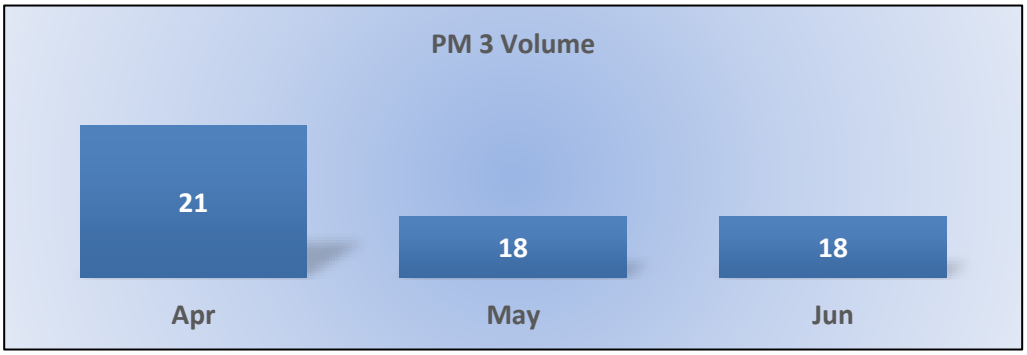
Average number of days from complaint receipt,
to the date the complaint was closed or assigned to an investigator.



Target Average: 30 Days | **Actual Average:** 6 Days

PM3 | Investigations – Volume

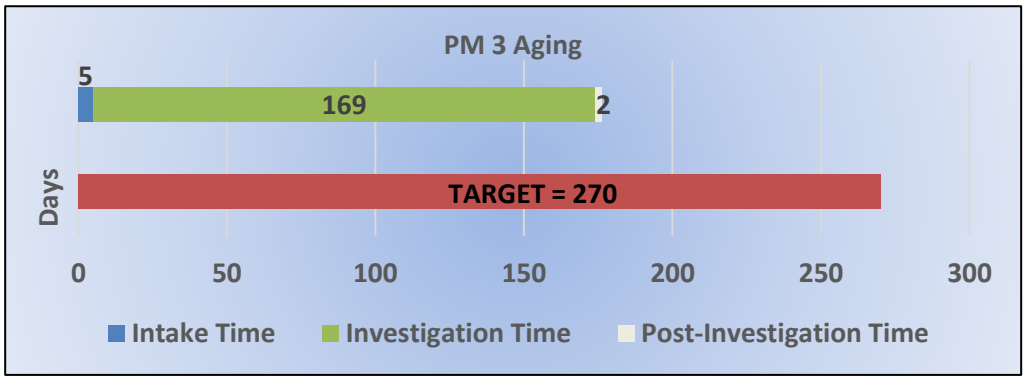
Number of investigations closed (not including cases transmitted to the Attorney General).



Total: 57 | **Monthly Average:** 19

PM3 | Investigations – Cycle Time[1]

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

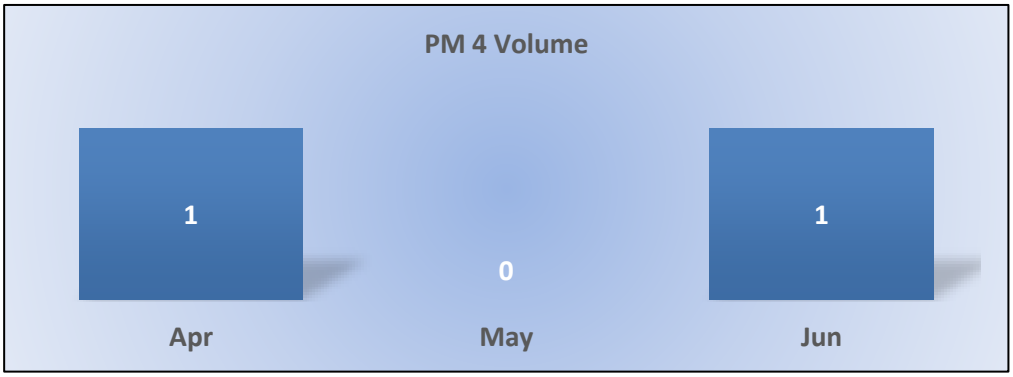


Target Average: 270 Days | **Actual Average:** 178 Days

[1] *Due to rounding, there might be small discrepancies between the PM3 "Actual Average", and the sum of the individual case stages (i.e., Intake time + Investigation time + Post-Investigation time).*

PM4 | Formal Discipline – Volume

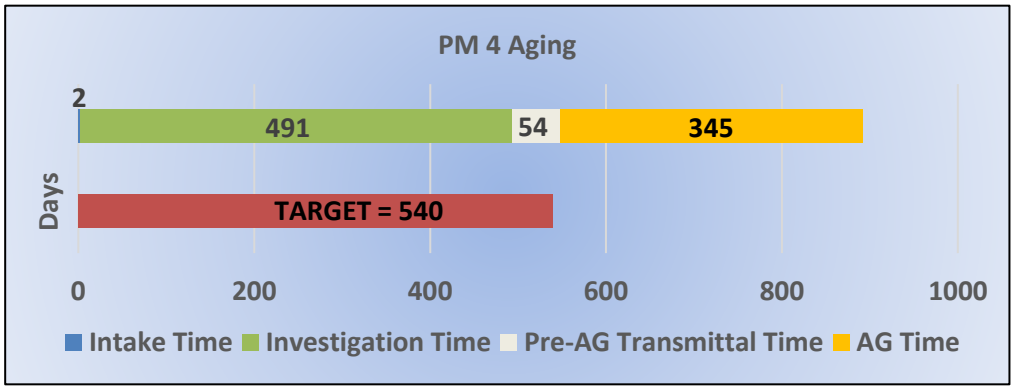
Cases closed after transmission to the Attorney General for formal disciplinary action. This includes formal discipline, and closures without formal discipline (e.g., withdrawals, dismissals, etc.).



Total: 2

PM4 | Formal Discipline – Cycle Time[2]

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

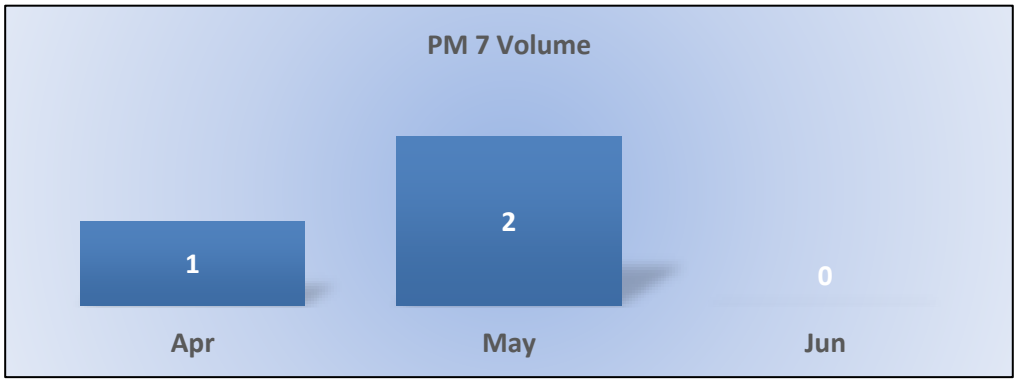


Target Average: 540 Days | **Actual Average:** 892 Days

[2] *Due to rounding, there might be small discrepancies between the PM4 "Actual Average", and the sum of the individual case stages (i.e., Intake time + Investigation time + Pre-AG Transmittal time + AG time).*

PM7 | Probation Intake – Volume

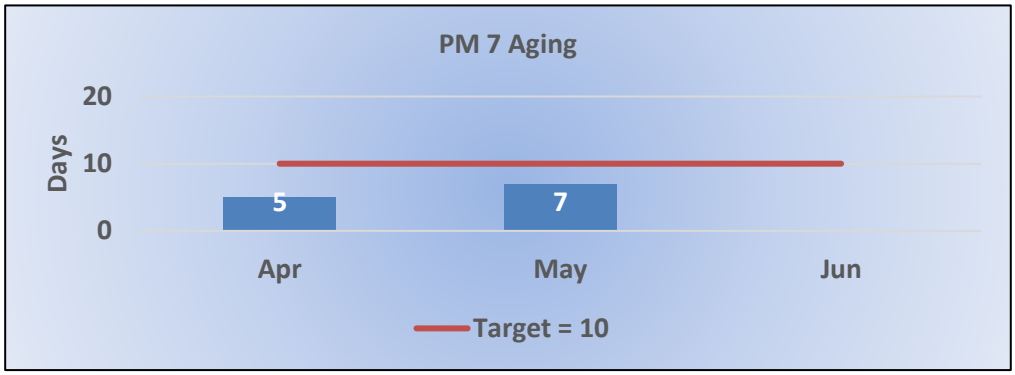
Number of new probation cases.



Total: 3

PM7 | Probation Intake – Cycle Time

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



Target Average: 10 Days | **Actual Average:** 6 Days

PM8 | Probation Violation Response – Volume

Number of probation violation cases.

The Committee did not have any probation violations this quarter.

PM8 | Probation Violation Response – Cycle Time

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

The Committee did not have any probation violations this quarter.

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT F:

Uniform Standards Related to Substance Abuse and Disciplinary Guidelines

(dated April 2012)

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Dental Hygiene Committee of California

DHCC
Dental Hygiene
Committee
of California

Uniform Standards Related to Substance Abuse and Disciplinary Guidelines

(April 2012)

Table of Contents

Introduction

The Dental Hygiene Committee of California is a consumer protection agency with the primary mission of protecting consumers of dental hygiene services from potentially harmful licensees. In keeping with its obligation to protect the consumer, the Committee has adopted the following Disciplinary Guidelines for disciplinary orders and conditions of probation for violations of the laws governing the practice of dental hygienist as well as Uniform Standards Related to Substance Abuse and Disciplinary Guidelines

The Committee carefully considers all facts and circumstances associated with each case in its efforts to protect consumers. Subsequently, an Administrative Law Judge ("ALJ") shall provide in all proposed decisions a detailed basis of his or her decision in the "Findings of Fact" particularly when there is a deviation from the Disciplinary Guidelines. Justification for the deviation shall be clearly outlined in the decision to enable the Committee to understand the reasons and to evaluate the suitability of the decision. However, an ALJ is prohibited from deviating from the Uniform Standards Related to Substance Abuse.

If at the time of hearing the ALJ finds that the Respondent, for any reason, is not capable of safe practice, the ALJ shall order outright revocation of the license. This is particularly important in cases of patient sexual abuse or bodily harm.

Suspension of a license may also be appropriate where the public may be better protected if the practice of the dental hygienist is suspended in order to correct deficiencies in skills, education or rehabilitation.

Dental Hygiene Committee of California

UNIFORM STANDARDS RELATED TO SUBSTANCE ABUSE AND DISCIPLINARY GUIDELINES

Section 1138 Division 11 of Title 16, Article 10 entitled “Uniform Standards Related to Substance Abuse and Disciplinary Guidelines” of the California Code of Regulations is added to read:

Article 10. Uniform Standards Related to Substance Abuse and Disciplinary Guidelines

Section 1138. Uniform Standards Related to Substance Abuse and Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Section 11400 et seq. of the Government Code) the Committee shall comply with the “Uniform Standards Related to Substance Abuse and Disciplinary Guidelines” Dated April 2012 that are hereby incorporated by reference. Deviation from the Disciplinary Guidelines, including the standard terms of probation, is appropriate where the Committee, in its sole discretion, determines that the facts of the particular case warrant such a deviation. However, neither the Committee nor an administrative law judge may impose any conditions or terms of probation that are less restrictive than the Uniform Standards Related to Substance Abuse. The Disciplinary Guidelines apply to all disciplinary matters; the Uniform Standards describe the consequences that apply to a substance abusing licensee. If a licensee has not been identified as a substance abusing licensee, for example, through stipulation, in a case involving drugs or alcohol, a clinical diagnostic evaluation shall be ordered and the remaining provisions of the uniform standards may be made contingent at the discretion of the Committee (DHCC) upon a clinical diagnostic evaluator’s report that the licensee has a substance abuse problem. The clinical diagnostic evaluation report shall be submitted in its entirety to the Committee.

Note: Authority cited: Sections 315, 315.4, 1905 and 1906 of the Business and Professions Code; and Section 11400.20 of the Government Code. Reference: Sections 315, 315.2, 315.4, 1947, 1949, 1950 and 1950.5 of the Business and Professions Code; and Sections 11400.20 and 11425.50(e) of the Government Code.

UNIFORM STANDARDS RELATED TO SUBSTANCE ABUSE

The following standards shall be adhered to in all cases in which a license is placed on probation due to a substance abuse problem. These standards are not guidelines and shall be followed in all instances, except that the Committee may impose more restrictive conditions if necessary to protect the public.

PETITION FOR REINSTATEMENT

Nothing herein shall limit a committee's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code Section 11522 or statutes applicable to the committee that contains different provisions for reinstatement or reduction of penalty.

Clinical Diagnostic Evaluations:

Whenever a licensee is ordered to undergo a clinical diagnostic evaluation, the evaluator shall be a licensed practitioner who holds a valid, unrestricted license to conduct clinical diagnostic evaluations, has 3 years experience in providing evaluations of health care professionals with substance abuse disorders, and is approved by the Committee. The evaluations shall be conducted in accordance with accepted professional standards for conducting substance abuse clinical diagnostic evaluations.

Clinical Diagnostic Evaluation Report:

The clinical diagnostic evaluation report shall set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem, whether the licensee is a threat to himself or herself or others, and recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

The evaluator shall not have a financial, personal, familial or business relationship with the licensee within the last 5 years. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself or herself or others, the evaluator shall notify the Committee within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the Committee no later than 10 days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.

The Committee shall review the clinical diagnostic evaluation to determine whether or not the licensee is safe to return to either part-time or full-time practice and what restrictions or recommendations should be imposed on the licensee based on the application of the following criteria:

License type, licensee's history, documented length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse problem, and whether the licensee is a threat to himself or herself or others.

The respondent shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.

2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee's substance abuse.

3. Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

When determining if the licensee should be required to participate in inpatient, outpatient or any other type of treatment, the Committee shall take into consideration the recommendation of the clinical diagnostic evaluation, license type, licensee's history, length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse problem, and whether the licensee is a threat to himself or herself or others.

Worksite Monitor Requirements:

If the Committee determines that a worksite monitor is necessary for a particular licensee, the worksite monitor must meet the following requirements to be considered for approval by the Committee:

The worksite monitor shall not have any current or former financial, personal, familial or business relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Committee. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Committee. However, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

The worksite monitor's license scope of practice shall include the scope of practice of the licensee who is being monitored or be another health care professional if no monitor with like scope of practice is available or be a person in a position of authority who is capable of monitoring the licensee at work.

The worksite monitor shall have an active unrestricted license, with no disciplinary action within the last 5 years.

The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and agrees to monitor the licensee as set forth by the Committee.

The worksite monitor must adhere to the following required methods of monitoring the licensee:
a) Have face-to-face contact with the licensee at least once per week in the work environment or more frequently if required by the Committee;
b) Interview other staff in the office regarding the licensee's behavior, if applicable; and
c) Review the licensee's work attendance.

Reporting by the worksite monitor to the Committee shall be as follows:

Any suspected substance abuse must be orally reported to the Committee and the licensee's employer within 1 business day of occurrence. If occurrence is not during the Committee's normal business hours the oral report must be within the first hour of the next business day. A written report shall be submitted to the Committee within 48 hours of the occurrence.

The worksite monitor shall complete and submit a written report monthly or as directed by the Committee. The report shall include: the licensee's name; license number; worksite monitor's name and signature; worksite monitor's license number; worksite location(s); dates licensee had face-to-face contact with monitor; staff interviewed if applicable; attendance report; any change in behavior and/or personal habits; any indicators that can lead to suspected substance abuse.

The licensee shall complete the required consent and sign an agreement with the worksite monitor and the Committee to allow the Committee to communicate with the worksite monitor.

Positive Test

If a licensee tests positive for a banned substance, the Committee shall order the licensee to cease practice. The Committee shall also immediately notify the licensee's employer that the licensee has been ordered to cease practice and he or she may not resume work until the order is lifted.

Major and Minor Violations

Major Violations include, but are not limited to, the following:

1. Failure to complete a Committee ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Committing multiple minor violations of probation conditions and terms;
4. Treating a patient while under the influence of drugs or alcohol;

5. Committing any drug or alcohol offense that is a violation of the Business and Professions Code or state or federal law;
6. Failure to obtain biological testing for substance abuse;
7. Testing positive for a banned substance; and
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

If a licensee commits a major violation, the Committee shall order the licensee to cease any practice of dental hygiene and refer the matter for disciplinary action or other action as determined by the Committee.

Consequences

Major Violations include, but are not limited to following:

1. License will be ordered to cease practice.
    a. the licensee must undergo a new clinical diagnostic evaluation, and
    b. the licensee must test negative for a least a month of continuous drug testing before being allowed to go back to work.
2. Termination of a contract/agreement.
3. Referral for disciplinary action, such as suspension, revocation, or other action as determined by the committee.

Minor Violations include, but are not limited to, the following:

1. Failure to submit required documentation as required;
2. Unexcused absence at required meetings;
3. Failure to contact a monitor as required; and
4. Any other violations that do not present an immediate threat to the licensee or to the public.

If a licensee commits a minor violation, the Committee shall determine what action is appropriate.

Consequences
Minor Violations include, but are not limited to:

1. Removal from practice
2. Practice limitations
3. Required supervision
4. Increased documentation
5. Issuance of citation and fine or a warning notice
6. Required re-evaluation/testing
7. Other action as determined by the committee

Drug Testing Standards

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

1. The Committee may order a licensee to drug test at any time. Additionally, each licensee shall be RANDOMLY drug tested in accordance with the schedule below:

Level	Segments of Probation/Diversion	Minimum Range of Number of Random Tests
I	Year 1	52-104 per year
II	Year 2+	36-104 per year

*The minimum range of 36-104 test identified in level II, is for the second year of probation or diversion, and up to 5 years thereafter.

Nothing precludes the Committee from increasing the number of random tests for any reason. If the Committee finds or reasonably suspects that a licensee has committed a violation of the Committee's testing program or who has committed a Major Violation, as identified above, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

2. Licensees shall be randomly drug tested at least 52 times per year for the first year and at any time as directed by the Committee. After the first year, licensee shall be randomly drug tested at least 36 times per year, and at any time as directed by the Committee;

3. Drug testing may be required on any day, including weekends and holidays;

4. The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he or she will be tested again. The Committee should be prepared to report data to support back-to-back testing, as well as numerous different intervals of testing.

5. Licensees shall be required to make daily contact to determine if drug testing is required;

6. Licensees shall be drug tested on the date of notification as directed by the Committee;

7. Collection of specimens shall be observed;

8. Prior to vacation or absence, alternative drug testing location(s) must be approved by the Committee; and

The Committee may use other testing methods in place of, or to supplement biological sample testing, if the alternate testing method is appropriate.

EXCEPTION TO TESTING FREQUENCY SCHEDULE

I. PREVIOUS TESTING SOBRIETY

In cases where a committee has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the committee, the committee may give consideration to that testing in altering the testing.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT

An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur a work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.

III. NOT EMPLOYED IN HEALTH CARE FIELD

A committee may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level 1 testing frequency schedule, otherwise level II testing shall be in effect.

IV. TOLLING

A committee may postpone all testing for any person whose probation of diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the committee upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year level I of the testing frequency schedule, otherwise level II testing shall be in effect.

V. SUBSTANCE USE DISORDER NOT DIAGNOSED

In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology screening may be adopted by the committee, but not to be less than 24 times per year.

Disciplinary Guidelines

In determining whether revocation, suspension or probation is to be imposed in a given case, factors such as the following should be considered:

1. Nature and severity of the act(s), offenses, or crime(s) under consideration;
2. Actual or potential harm to the public;
3. Actual or potential harm to any patient;
4. Prior disciplinary record;
5. Number and/or variety of current violations;
6. Mitigation evidence; or aggravation
7. Rehabilitation evidence;
8. In case of a criminal conviction, compliance with conditions of sentence or court-ordered probation;
9. Overall criminal record;
10. Time passed since the act(s) or offense(s) occurred; and
11. If applicable, evidence of expungement proceedings pursuant to Penal Code Section 1203.4.

Situations in which Revocation Shall Be Imposed

In addition to violation of the laws governing dental hygienist, there are other circumstances that necessitate outright revocation as the recommended penalty:

1. Failure to file a notice of defense or to appear at a disciplinary hearing, where the Committee has requested revocation;
2. Violation of the conditions of a Respondent's probation order;
3. Substantiated evidence or convictions of physical or sexual abuse offenses; and
4. Second offenses, unless the Respondent can demonstrate that he or she has been fully rehabilitated.

Recommended Action by Violation

The Business and Professions Code Section 1900, and general provision sections of the Business and Professions Code specify the offenses for which the Committee may take disciplinary action. Below are the code sections with the recommended disciplinary actions listed by the degree of the offense.

When filing an Accusation, the Office of the Attorney General may also cite additional related statutes and regulations.

*Note: Under conditions of probation you will find the applicable numbered conditions included in a decision and order.

Probationary Terms and Conditions

As part of the Committee's mission to protect the consumer, any disciplinary order in which probation is imposed should include conditions that ensure consumer protection.

For purposes of implementation of these conditions of probation, any reference to the Committee also means staff working for the Dental Hygiene Committee of California.

Probationary Term

The Committee generally recommends a minimum probation term of 3 years. The term may be increased depending upon the severity of the violation(s).

Probationary Conditions

Conditions of probation are divided into 2 categories:

1. ***Standard*** conditions that are included in all probation orders; and
2. ***Additional*** conditions which are applicable to the nature of the violation(s).

Model Language for Probation Orders

When a stipulated settlement or proposed decision contains probationary terms and conditions, the following language shall be included:

- **Licensees:** Registered Dental Hygienist (RDH), Registered Dental Hygienist in Alternative Practice (RDHAP), Registered Dental Hygienist in Extended Functions (RDHEF) license no. _____ issued to Respondent _____ is hereby revoked; however, the revocation is stayed and Respondent's license is placed on probation for _____ years on the following terms and conditions.

- **Applicants:** The application of Respondent _____ for licensure is hereby granted; however, the license shall be immediately revoked, the order of revocation stayed, and Respondent's license placed on probation for a period of _____ years on the following conditions:

- **Reinstatements:** The petition of _____ for reinstatement of the RDH, RDHAP, RDHEF license is hereby GRANTED, as follows.

  RDH, RDHAP, RDHEF number _____ is reinstated. The license will be immediately revoked; however, the revocation is stayed for _____ years on the following terms and conditions:

  In cases in which a petitioner for reinstatement has not practiced dental hygiene for an extended amount of time, he or she must retake the licensing exam before reinstatement. This information must be provided to the Administrative Law Judge so that the following can be included in the proposed decision the condition (number 13): "Upon successful completion of the licensure examination, a license shall be issued to Respondent."

  NOTE: If cost recovery was ordered in the revocation or surrender of a license and the cost recovery has not been paid in full by Petitioner, a probation condition requiring payment of original cost recovery on a payment plan shall be included in the decision.

List of Probation Conditions

STANDARD PROBATION CONDITIONS

Introductory Language and Conditions 1- 15 are required as follows:

1) Severability Clause
2) Obey All Laws
3) Quarterly Reports
4) Probation Program
5) Interview with the Committee
6) Changes of Name, Address of Record or Employment
7) Tolling Provisions
8) Notification of Employer
9) Cost Recovery (Does not apply to Applicants)
10) Probation Monitoring Costs
11) Violation of Probation
12) License Surrender
13) Completion of Probation
14) Law and Ethics Supplemental Exam
15) Continuing Education Course(s)

ADDITIONAL PROBATION CONDITIONS

In addition to the standard conditions (1-15), additional conditions (16-29) are required if the offense involves one of the following: sexual misconduct, alcohol/drug abuse, mental/physical disabilities, fraudulent conduct, or lack of knowledge or skills. Any of these additional conditions may be included if relevant to the violation:

16) Actual Suspension
17) Psychological Evaluation
18)Psychotherapy
19) Physical Examination
20) Billing Monitor
21) Clinical Diagnostic Evaluation
22) Submit Biological Samples
23) Worksite Monitor
24)Practice Monitor
25) Restriction of Practice
26) RDH Clinical Examination
27) Abstain from Alcohol
28)Abstain from Control Substances
29) Restitution

Standard Probation Conditions

1. Severability Clause

Each condition of probation is a separate and distinct condition. If any condition of this Decision and Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Decision and Order, and all other applications thereof, shall not be affected. Each condition of this Decision and Order shall separately be valid and enforceable to the fullest extent permitted by law.

Rationale: *The severability clause is required for all decisions and orders and stipulated agreements where there are conditions of probation, to avoid the possibility of all probation conditions being invalidated upon a successful appeal.*

2. Obey All Laws

Respondent shall obey all federal, state, US Military and local laws and all regulations. A full and detailed account of any and all violations of law shall be reported by the Respondent to the Committee in writing within 72 hours of occurrence.

CRIMINAL COURT ORDERS: If Respondent is under criminal court orders by any governmental agency, including probation or parole, and the orders are violated, this shall be deemed a violation of probation and may result in the filing of an accusation or petition to revoke probation or both.

OTHER BOARD OR REGULATORY AGENCY ORDERS: If Respondent is subject to any other disciplinary order from any other health-care related board or any professional licensing or certification regulatory agency in California or elsewhere, and violates any of the orders or conditions imposed by other agencies, this shall be deemed a violation of probation and may result in the filing of an accusation or petition to revoke probation or both.

Rationale: *If there has been a violation of any law or regulation that is substantially related to the qualifications, functions, or duties of an RDH, RDHAP, and/or RDHEF, this would constitute a violation of Respondent's probation and allow the Committee to carry out the disciplinary order.*

3. Quarterly Reports

Respondent shall submit quarterly declarations under penalty of perjury stating whether there has been compliance with all the conditions of probation.

Rationale: *By the Respondent making declarations under penalty of perjury, this assures the Committee that the Respondent is making true statements to the Committee. Receiving these reports quarterly allows the Committee to track the Respondent's compliance, and provides a process for review in determining whether or not his or her license should be restored at the completion of his or her probation.*

4. Probation Program

Respondent shall comply with the Committee's probation program and shall, upon notice, submit quarterly reports to the Committee's staff. Respondent shall contact enforcement staff regarding any questions specific to the probation order. Respondent shall not have any unsolicited or unapproved contact with victims or complainants associated with the case or persons serving the Committee as expert consultants.

Rationale: *Comply with the probation monitoring program to ensure consumer protection and the Respondent cannot use the excuse they didn't understand. In addition, this protects the victims; complainants and witnesses from harassment by the Respondent.*

5. Interview with the Committee

Respondent shall appear in person for interviews with the Committee upon request at various intervals and with reasonable notice. In addition, Respondent shall participate in telephonic interviews upon request by the Committee.

Rationale: *This condition allows the Committee to schedule in-person interviews to monitor Respondent's compliance with the probation order to ensure public protection. In addition, Respondent shall participate in telephone interviews upon the request of the Committee.*

6. Changes of Name, Address of Record or Employment

Respondent shall notify the Committee in writing of any and all changes of physical address, address of record, e-mail, or employment including location and address within 30 days of such change. Respondent shall notify Committee of a legal name change within 10 days of such change.

Rationale: *This condition allows the Committee to be informed of Respondent's current name, address of record, employment information, including his or her business address, phone number, and employer (if applicable) in the event the Committee needs to locate the Respondent or communicate with his or her employer.*

7. Tolling Provisions

In the event Respondent should leave California to practice outside the state, Respondent must provide written notification to the Committee of the dates of departure and anticipated return to the state. Respondent's probation is tolled, if and when he or she ceases practicing in California. Period of practice outside of California will not apply to the reduction of the probationary period.

Respondent shall provide a list of all states, United States territories, and elsewhere in the world where he or she has ever been licensed as a dental hygienist or held any health-care related professional license or certificate. Respondent shall further provide information regarding the status of each license and certificate and any changes in the license or certificate status during the term of probation. Respondent shall inform the Committee if he or she applies for or obtains a license outside of California during the term of probation.

For purposes of this condition, non-practice due to Committee ordered suspension or in compliance with any other condition of probation, shall be considered a period of non-practice and the time period will be tolled.

Rationale: *Ensures that Respondent may not complete probation without being fully monitored for his or her period of probation in California. This further ensures that the Committee is aware of all licensure outside of California as an RDH, RDHAP, or RDHEF or in any health care related capacity.*

8. Notification to Employer

If Respondent is currently employed, in the process of applying for employment, or contracted to provide services as a dental hygienist, he or she shall provide a copy of the Committee's Decision to his or her employer, supervisor or contractor no later than the effective date of the Committee's Decision. Respondent shall notify any future employers, supervisors or contractors of his or her probationary status with the Committee prior to accepting such employment. The Respondent shall provide to the Committee the names, physical addresses, and telephone numbers of all employers, supervisors and contractors.

Respondent shall complete the required consent and sign an agreement with the employer and supervisor, or contractor, and the Committee to allow the Committee to communicate with the employer and supervisor or contractor.

Respondent shall cause each employer and supervisor or contractor to submit quarterly written declarations to the Committee. These declarations shall include a performance evaluation.

Respondent shall notify the Committee, in writing, of any change in his or her employment status, within 10 days of such change.

Rationale: *Respondent's license being placed on probation shows the Committee that his or her conduct is in need of rehabilitation, subsequently, Respondent's deficiencies should be noted to the employer as to protect the health and welfare of the public.*

9. Cost Recovery

Respondent shall pay to the Committee its costs of investigation and enforcement in the amount of $_____. Respondent shall be permitted to pay these costs in a payment plan approved by the Committee, with payments to be completed no later than 6 months prior to the end of the probationary term.

Rationale: *The Committee incurs costs associated with the investigation and disciplinary process; this condition requires the Respondent to reimburse the Committee for those expenditures.*

10. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Committee, which may be adjusted on an annual basis. Such costs shall be made payable to the Committee and mailed to the Committee. Failure to pay costs within 30 days of the due date is a violation of probation.

Rationale: *Periodically, the Committee incurs expenditures associated with the necessary travel to meet with Respondent in order to monitor his or her probation compliance; this condition requires the Respondent to reimburse the Committee for those costs.*

11. Violation of Probation

If Respondent violates probation in any respect, the Committee may, after giving Respondent notice and the opportunity to be heard, revoke probation and carry out the disciplinary order that was stated. If an accusation or petition to revoke probation is filed against Respondent during probation, the Committee shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final. No petition for modification or termination of probation shall be considered while there is an accusation or petition to revoke probation pending against Respondent.

Rationale: *This condition allows the Committee to carry out the disciplinary order stated in the decision when a Respondent fails to comply with any of his or her probation conditions.*

12. License Surrender

During Respondent's term of probation, if he or she wishes to cease practice, Respondent may request in writing to surrender the license(s) to the Committee. The Committee shall evaluate the request and notify Respondent in writing whether to grant the request. Upon formal acceptance of the license surrender, Respondent's license will no longer be subject to the conditions of probation. Respondent shall return the pocket license(s) and wall certificate(s) to Committee within 10 days of the effective date of the surrender.

Surrender of Respondent's license shall be considered a disciplinary action and shall become a part of Respondent's license history with the Committee. A dental hygienist whose license has been surrendered may petition the Committee for reinstatement of his or her license no sooner than 3 years from the effective date of the surrender decision.

Rationale: *If Respondent feels he or she cannot follow any one of the conditions of the probation order due to a discontinuance of practice, this condition gives him or her the option to voluntarily surrender his or her license.*

13. Completion of Probation

Upon successful completion of probation, Respondent's license will be fully restored.

Rationale: *When the Respondent has completed his or her term of probation by successfully fulfilling all of the conditions, he or she has demonstrated his or her ability to practice unrestricted.*

14. Law and Ethics Supplemental Exam

Respondent shall take and successfully complete the California Law and Ethics supplemental exam within 60 days of the effective date of the decision.

Rationale: *In cases of fraudulent behavior, improper record keeping, or a deficiency of knowledge or skills, this condition will help to remedy these deficiencies.*

15. Continued Education Course

Respondent shall take and successfully complete not less than ____ hours each year of probation in the following area(s)_____. Coursework must be pre-approved by the Committee or its designee. All coursework shall be taken at the graduate level at an accredited educational institution or by an approved continuing education provider. Classroom attendance is specifically required: correspondence or home study coursework shall not count toward meeting this requirement. The coursework must be in addition to any continuing education courses that may be required for license renewal.

Within 60 days of the effective date of this Decision, Respondent shall submit to the Committee or its designee for its prior approval a plan for meeting the educational requirements. All costs of the coursework shall be paid by the respondent.

Rationale: *In cases of fraudulent behavior, improper record keeping, or a deficiency of knowledge or skills, this condition will help to remedy these deficiencies.*

Additional Probation Conditions

16. Actual Suspension

Respondent is suspended from the practice of RDH, RDHAP, RDHEF for ____ days beginning with the effective date of this Decision.

Rationale: *Restricting Respondent's practice of dental hygiene for a limited amount of time offers an additional penalty and an opportunity for Respondent to satisfy other conditions that are primary.*

17. Psychological Evaluation

Within 90 days of the effective date of this Decision and on a periodic basis thereafter as may be required by the Committee, Respondent shall undergo a psychological evaluation (and psychological testing, if deemed necessary) by a Committee appointed California licensed psychologist or board certified psychiatrist. Respondent shall execute a release authorizing the evaluator to release all information to the Committee.

If the Committee concludes from the results of the evaluation that Respondent is unable to practice independently and or safely, upon notification from the Committee he or she shall immediately cease practice and shall not resume practice until notified by the Committee Respondent shall pay all costs associated with the psychological evaluation. Failure to pay costs will be considered a violation of the probation order.

Rationale: *Psychological evaluations shall be utilized when an offense calls into question the judgment and/or emotional and/or mental condition of the Respondent or where there has been a history of abuse or dependency of alcohol or controlled substances. When appropriate, Respondent shall be barred from rendering dental hygiene services under the terms of probation until he or she has undergone an evaluation, the evaluator has recommended resumption of practice, and the Committee has accepted and approved the evaluation. Note: if you order psychological evaluation you must request psychotherapy.*

18. Psychotherapy

Within 45 days of the effective date of this decision, or within 45 days of a determination that psychotherapy is required, Respondent shall submit a proposed therapist and plan of therapy to be approved by the Committee. The cost of therapy shall be borne by Respondent. The plan of therapy shall include the nature of the treatment and its proposed duration. The psychotherapist shall agree to submit quarterly reports to the Committee regarding the progress and participation of Respondent. The treatment program shall not be terminated except upon committee approval after submission of the results of the program by the psychotherapist. If there is a need for ongoing psychiatric psychological treatment, Respondent shall, within 30 days of the requirement notice, submit to the Committee for prior approval the name and qualifications of a psychiatrist licensed mental health professional of Respondent's choice. If the psychological evaluation recommends that Respondent seek treatment from a specific type of mental health professional (e.g. psychiatrist, psychologist, licensed clinical social worker or marriage and family therapist), Respondent shall undergo and continue psychotherapy until further notice from the Committee or its designee. Respondent shall have the treating psychotherapist mental health care professional submit quarterly status reports to the Committee or its designee indicating whether the Respondent is capable of practicing hygiene safely.

Rationale: *This condition should be imposed whenever there is evidence that the Respondent may have a psychological problem that may impact his or her being able to practice safely. If the Respondent is already in therapy this condition should be imposed to ensure that he or she continues to receive help.*

19. Physical Examination

Within 90 days of the effective date of this Decision, Respondent shall undergo a physical examination by a California licensed physician and surgeon approved by the Committee. A physician or surgeon shall have no prior or current financial, personal, familial or business relationship with the Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Committee, and shall agree to serve as Respondent's monitor. Respondent shall bear all costs of such an examination. Respondent shall comply with any treatment recommendations contained in the evaluation report submitted to the Committee by the physician and surgeon. Respondent shall ensure that the physician and surgeon provides the initial evaluation report and all written progress reports to the Committee on a quarterly basis or as otherwise determined by the Committee.

Rationale: *This condition permits the Committee to require the probationer to obtain appropriate treatment for physical problems/disabilities which could affect safe practice of dental hygiene. The physical examination can also be conducted to ensure that there is no physical evidence of alcohol/substance abuse.*

20. Billing Monitor

Within 30 days of the effective date of this Decision, Respondent shall submit to the Committee for prior approval, billing monitor(s), the name and qualifications of one or more Dental Board or Committee licensees whose license is valid and in good standing. A monitor shall have no prior or current financial, personal, familial or business relationship with the Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Committee, and shall agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs. The Committee shall provide the approved monitor with copies of the Committee Decision and a proposed monitoring plan. Within 15 days of receipt of the Decision and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 days of the effective date of this Decision, and continuing throughout probation, Respondent's billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Committee that includes an evaluation of Respondent's billing practices indicating whether Respondent is billing appropriately. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Committee.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Committee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of RDHAP within 3 days after being so notified by the Committee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

Rationale: *Monitoring shall be utilized when Respondent's ability to appropriately bill, is at issue or as a result of questionable judgment in billing.*

21. Clinical Diagnostic Evaluation

Within 20 days of the effective date of the Decision and at any time upon order of the Committee, Respondent shall undergo a clinical diagnostic evaluation. A evaluator shall have no prior or current financial, personal, familial or business relationship with the Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Committee, and shall agree to serve as Respondent's monitor. Respondent shall provide the evaluator with a copy of the Committee's Decision prior to the clinical diagnostic evaluation being performed.

Respondent is ordered to cease any practice of dental hygiene, beginning on the effective date of the Decision, pending the results of the clinical diagnostic evaluation. During this time, Respondent shall submit to random drug testing at least 2 times per week. At any other time the Respondent is ordered to undergo a clinical diagnostic evaluation, he or she shall be ordered to cease practice for a minimum of 1 month pending the results of a clinical diagnostic evaluation. During such time, the Respondent shall submit to random drug testing at least 2 times per week.

Respondent shall cause the evaluator to submit to the Committee a written clinical diagnostic evaluation report within 10 days from the date the evaluation was completed, unless an extension, not to exceed 30 days, is granted to the evaluator by the Committee. Cost of such evaluation shall be paid by the Respondent. Respondent shall comply with any restrictions or recommendations made as a result of the clinical diagnostic evaluation.

Respondent's may not resume practice until the Committee determines that he or she is able to safely practice either full-time or part-time and has had at least 1 month of negative drug test results. Respondent shall comply with any restrictions or recommendations made as a result of the clinical diagnostic evaluation.

Rationale: *This provision should be included when a Respondent's license is placed on probation for a substance or alcohol abuse problem or where the conditions of the Uniform Standards Related to Substance Abuse apply so that the Committee has the ability to order at any time during the probation period a Respondent to undergo an evaluation to determine if he or she is currently safe to practice.*

22. Submit Biological Samples

Respondent shall immediately submit to random and directed biological sample testing paid for by Respondent, at the request of the Committee. The Respondent shall be subject to a minimum of 52 random tests per year within the first year of probation and at minimum of 36 random tests per year thereafter for the duration of the probationary term. If Respondent tests positive for a banned substance, Respondent shall be ordered by the Committee to immediately cease practice of dental hygiene, and may not practice unless and until notified by the Committee.

Respondent shall make daily contact as directed by the Committee to determine if he or she must submit to drug testing. Respondent shall submit his or her drug test on the same day that he or she is notified that a test is required. All alternative drug testing sites due to vacation or travel outside of California must be approved by the Committee prior to the vacation or travel.

Rationale: *This provision should be included when a Respondent's license is placed on probation for a substance or alcohol abuse problem or where the conditions of the Uniform Standards Related to Substance Abuse apply so that the Committee can monitor whether or not the Respondent is abstaining from the use of banned substances or alcohol.*

23. Worksite Monitor

Respondent shall submit the name of the proposed worksite monitor within 20 days of the effective date of the Decision. A monitor shall have no prior or current financial, personal, familial or business relationship with the Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Committee, and shall agree to serve as Respondent's monitor. Respondent shall complete any required consent and sign an agreement with the worksite monitor and the Committee regarding the Respondent and the worksite monitor's requirements and reporting responsibilities. Once a worksite monitor is approved, Respondent may not practice unless the monitor is present at the worksite. If the worksite monitor terminates the agreement with the Committee and the Respondent, the Respondent shall not resume practice until another worksite monitor is approved by the Committee.

Rationale: *This provision should be included when a Respondent's license is placed on probation for substance or alcohol abuse or where the conditions of the Uniform Standards Related to Substance Abuse apply so that the Committee becomes aware of potential problems a probationer may have before any patient harm occurs.*

24. Practice Monitor

Within 30 days of the effective date of this Decision, Respondent shall submit to the Committee for prior approval, practice monitor(s), the name and qualifications of one or more Dental Board or Committee licensees whose license is valid and in good standing. A monitor shall have no prior or current financial, personal, familial or, business relationship with the Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Committee, and shall agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Committee shall provide the approved monitor with copies of the Committee Decision and a proposed monitoring plan. Within 15 days of receipt of the Decision and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Committee that includes an evaluation of Respondent's practices indicating whether Respondent is providing appropriate care to patients. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Committee.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Committee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 days. If Respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of RDHAP within 3 days after being so notified by the Committee. Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

Rationale: *Monitoring shall be utilized when Respondent's ability to provide appropriate care to patients is at issue, or as a result of deficient care being provided to patients.*

25. Restriction of Practice

During probation Respondent is prohibited from providing dental hygiene services to patients who are (insert restriction). Within 30 days from the effective date of the decision, Respondent shall submit to the Committee, for prior approval, a plan to implement this restriction. Respondent shall submit proof satisfactory to the Committee of compliance with this term of probation.

Rationale: *In cases wherein some factor of the patient population at large (e.g. age, gender) may put a patient at risk if treatment by the Respondent, this condition should be utilized. Additional language can be added for clarification.*

26. RDH Clinical Examination

Respondent shall cease practice until he or she successfully passes the Dental Hygiene Clinical Licensing Exam or Western Regional Examination Board (WREB). Respondent shall pay the established examination fees. Failure to pass the exam within 2 years of the effective date of the Decision shall be a violation of probation and be sufficient cause for revoking probation and imposing an order of revocation.

Rationale: *In cases involving practice deficiencies, it may be appropriate to require the Respondent to take and pass the clinical hygiene examination or equivalent during the course of the probation period. In some instances, it may be appropriate for Respondent to be ordered to cease practice until the examination is passed (condition precedent).*

27. Abstain from Alcohol

Respondent shall completely abstain from the intake of alcohol during the period of probation.

Rationale: *This provision should be included when a Respondent has an alcohol problem or where the conditions of the Uniform Standards Related to Substance Abuse apply so that the Committee can monitor whether the Respondent is in violation of probation.*

28. Abstain from Controlled Substances

Respondent shall completely abstain from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act and dangerous drugs as defined in Section 4022 of the Business and Professions Code, except when lawfully prescribed by a licensed practitioner for a bona fide illness.

Rationale: *This provision should be included when a Respondent has a substance abuse problem or where the conditions of the Uniform Standards Related to Substance Abuse apply so that the Committee can monitor whether the Respondent is in violation of probation.*

29. Restitution

Respondent shall pay restitution to Respondent's patient(s) (specify) or the payer(s) of services (specify), in the amount of $ _____. Respondent shall be permitted to pay these costs in a payment plan approved by the Committee, with payment to be completed no later than 6 months prior to the end of probation.

Rationale: *Respondent should not be permitted to financially benefit from violation of the law Respondent should be required to make restitution. This condition should be imposed when Respondent has engaged in fraudulent behavior, including fraudulent billing or improper record keeping, or a deficiency of knowledge or skill resulting in harm to a patient.*

Accusations and Decisions

To provide a foundation for consistency and clarity in each disciplinary action, the Committee asks that the below guidelines be followed.

ACCUSATIONS

The Committee has the authority, pursuant to Section 125.3 of the Business and Professions Code, to recover costs of investigation and prosecution of its cases. Further the Committee has the authority, pursuant to Section 1951(d) of the Business and Professions Code, to order restitution in cases. The Committee requests that this fact be included in the pleading and made part of the Accusation.

STIPULATED SETTLEMENTS & PROPOSED DECISIONS

The Committee will consider agreeing to stipulated settlements to promote consumer protection. All stipulations must be accompanied by a memo from the Deputy Attorney General addressed to Committee members explaining the background of the case, defining the allegations, mitigating and aggravating circumstances, admissions and proposed penalty along with a recommendation.

Proposed Decisions and Stipulation should include, at a minimum, the following:

1. Names and addresses of the Respondent;
2. Specific code section(s) violated with the definition of the code section(s) in the Determination of Issues;
3. Clear description of the acts or omissions that caused the violation to occur;
4. Explanation of mitigating and aggravating factors;
5. Explanation of discipline imposed from Committee's Disciplinary Guidelines;
6. Detailed explanation if Committee’s guidelines not imposed.

Recommended Language for Cost Recovery for Revocations and Surrenders

When the Decision and Order results in revocation or surrender of the license, cost recovery should be included as follows:

"If and when Respondent's license is reinstated, he or she shall pay to the Committee costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $_____. Respondent shall be permitted to pay these costs in a payment plan approved by the Committee. Nothing in this provision shall be construed to prohibit the Committee from reducing the amount of cost recovery upon reinstatement of the license."

Denial of Licensure

Pursuant to Business and Professions Code 480, the Committee has authority to protect the public in denying licensure to any applicant whose misconduct or criminal history is substantially related to the qualifications, functions, or duties of a dental hygienist.

The Committee may deny licensure on the basis of:

- Conviction of a crime substantially related to the practice of dental hygiene;
- Any act involving dishonesty, fraud, or deceit with intent to substantially benefit self or another or to substantially injure another;
- Any act which is grounds for revocation of a license;
- Making a false statement on the application

Any person, whose application for a license has been denied by the Committee, may reapply to the Committee for a license after a period of 1 year has elapsed from the date of the denial.

Demonstrations of Rehabilitation

- In evaluating the rehabilitation of an applicant or licensee, the Committee considers the following:

  1. The nature and severity of the crime(s) under consideration;
  2. Evidence of any acts committed subsequent to the crime(s) under consideration as grounds for disciplinary action or denial of license;
  3. The time that has elapsed since the commission of the crime(s);
  4. The extent to which the applicant or licensee has complied with any terms of probation or any other sanctions lawfully imposed against the applicant or licensee;
  5. Evidence, if any, of rehabilitation by the applicant or licensee demonstrating that Respondent has gained an appreciation of and taken responsibility for the gravity of the misconduct and remorse for the harm caused, shown by a course of conduct that convinces and assures the Committee that the public would be safe if Respondent is permitted to be licensed to practice dental hygiene.

- The following is a list of items the Committee will consider in determining whether or not the applicant or licensee has been rehabilitated:

  1. Copies of court documents pertinent to conviction, including documents specifying conviction and sanctions, and proof of completion of sanction;
  2. Letter from applicant or licensee describing underlying circumstances of arrest and conviction record as well as any rehabilitation efforts or changes in life since that time to prevent future problems;
  3. Letters of reference from professors or colleagues within the field of dental hygiene;
  4. Letters of reference from past and/or current employers;
  5. Letters from recognized recovery programs attesting to current sobriety and length of time of sobriety if there has been a history of alcohol or drug abuse;
  6. A current mental status examination by a clinical psychologist or psychiatrist approved by the Committee. The evaluation should address the likelihood of similar acts or convictions in the future, and should speak to the suitability of the dental hygiene profession for the applicant;
  7. Letters of reference from other knowledgeable professionals, such as probation or parole officers;
  8. Copy of certificate of rehabilitation or evidence of expungement proceedings;
  9. Evidence of compliance with and completion of terms of probation, parole, restitution, or any other sanctions.

Evidence of Mitigation

The Respondent is permitted to present mitigating circumstances at a hearing. The same opportunity is provided in the settlement process.

The following documents are examples of appropriate evidence the Respondent may submit to demonstrate his or her rehabilitative efforts and competency in dental hygiene:

1. Recent, dated letters from counselors regarding Respondent's participation in a rehabilitation or recovery program, where appropriate. These should include a description of the program, the number of sessions the Respondent has attended, the counselor's diagnosis of Respondent's condition and current state of rehabilitation (or improvement), the counselor's basis for determining improvement, and the credentials of the counselor;
2. Recent letters describing Respondent's participation in support groups, e.g., Alcoholics Anonymous, Narcotics Anonymous, etc., where appropriate, and sobriety date;
3. Recent, dated laboratory analyses or drug screen reports, where appropriate;
4. Recent, dated physical examination or assessment report by a licensed physician, nurse practitioner, or physician assistant approved by the Committee;
5. Certificates or transcripts of courses related to dental hygiene which Respondent may have completed since the date of the violation.

Petition for Penalty Relief and Reinstatements

Pursuant to Business and Professions Code Section 1957 (a), an individual whose license has been revoked, suspended, or surrendered, or whose license has been placed on probation must wait a specified minimum amount of time before petitioning the Committee for penalty relief or reinstatement.

- A person with a revoked or surrendered license must wait at least 3 years from the effective date of his or her Decision to petition for reinstatement;
- A person with a term of probation of 3 years or more must wait at least 2 years from the effective date of his or her Decision to petition for early termination;
- A person with whose license is placed on probation must wait at least 2 years from the effective date of his or her Decision to petition for modification of a condition;
- A person with a term of probation of less than 3 years must wait at least 1 year from the effective date of his or her Decision to petition for early termination.
- A person who has been revoked is required to submit electronic fingerprints as part of reinstatement petition for penalty relief.

PETITION HEARINGS

The primary concerns of the Committee at reinstatement or penalty relief hearings are that the evidence presented by the Petitioner that demonstrates his or her rehabilitation to ensure consumer protection.

The Committee will consider the following criteria:

1. Nature and severity of the act(s) or offense(s);

2. Total criminal record;

3. The time that has elapsed since commission of the act(s) or offense(s);

4. Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against such person;

5. If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code;

6. Evidence, if any, of rehabilitation submitted by the Petitioner demonstrating that Petitioner has gained an appreciation of and taken responsibility for the gravity of the misconduct and remorse for the harm caused, shown by a course of conduct that convinces and assures the Committee that the public would be safe if Respondent is permitted to be licensed to practice dental hygiene.

The Petition Decision should include a summary of the offense and the specific codes violated which resulted in the revocation, surrender or probation of the license.

The Committee requires that comprehensive information be elicited from the Petitioner regarding his/her rehabilitation. The Petitioner should provide details that include:

A. Continuing education pertaining to the offense and its effect on the practice of dental hygiene;

B. Specifics of rehabilitative efforts and results which should include programs, psychotherapy, medical treatment, etc., and the duration of such efforts;

C. If applicable, copies of court documents pertinent to conviction, including documents specifying conviction and sanctions, and proof of completion of sanctions;

D. If applicable, copy of Certificate of Rehabilitation or evidence of expungement proceedings;

E. If applicable, evidence of compliance with and completion of terms of probation, parole, restitution, or any other sanctions;

F. A culpability or non-culpability statement.

If the Committee should deny a request for reinstatement of licensure or penalty relief, the Committee requests that the ALJ provide technical assistance in the formulation of language clearly setting forth the reasons for denial. Such language would include methodologies or approaches which would demonstrate rehabilitation. If a petitioner fails to appear for his or her scheduled reinstatement or penalty relief hearing, such action shall result in a default decision to deny reinstatement of the license or reduction of penalty.

Index of Violations

Applicable Dental Hygiene Licensure Statutes

Conviction of a Crime

Section 1950 (a) **Conviction of a Crime.**
Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3–5 years probation depending on nature and severity of crime.*

1. *Standard Conditions (1-15)*
2. *Actual Suspension (16)*

For appropriate cases the following additional conditions shall be imposed:
3. *Billing Monitor (20)*
4. *Worksite Monitor (23)*
5. *Practice Monitor (24)*
6. *Restriction of Practice (25)*
7. *Restitution (29)*

Unprofessional Conduct

Section 1950.5 (a) **Obtaining of Any Fee by Fraud or Misrepresentation.**
Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3-5 years probation.*

1. *Standard Conditions (1-15)*
2. *Billing Monitor (20)*
3. *Worksite Monitor (23)*
4. *Restitution (29)*

Section 1950.5 (b) **Aiding or Abetting of Any Unlicensed Person to Practice Dentistry.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1-15)*
2. *Worksite Monitor (23)*
3. *Practice Monitor (24)*
4. *Restitution (29)*

Section 1950.5 (c) **Aiding or Abetting of Any licensed Person to Practice Dentistry Unlawfully.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1-15)*
2. *Worksite Monitor (23)*
3. *Practice Monitor (24)*
4. *Restitution (29)*

Section 1950.5 (d) **Sexual Abuse, Sexual Misconduct or Relations with a Patient.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation*

Section 1950.5 (e) **Use of Any False, Assumed or Fictitious Name Other Than Licensed to Practice.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation.*

1. *Standard Conditions (1-15)*
2. *Billing Monitor (20)*
3. *Practice Monitor (24)*

Section 1950.5 (f) **Accepting or Receiving a Commission.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3 – 5 years probation.*

1. *Standard Conditions (1- 15)*
2. *Billing Monitor (20)*
3. *Restitution (29)*

Section 1950.5 (g) **False or Misleading Advertising.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1-15)*
2. *Billing Monitor (20)*
3. *Restitution (29)*

Section 1950.5 (h) **Advertising Superiority.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1- 15)*
2. *Restitution (29)*

Section 1950.5 (i) **Employing or Using Solicitors.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1- 15)*
2. *Billing Monitor (20)*
3. *Restitution (29)*

Section 1950.5 (j) **Advertising in Violation of Section 651.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1- 15)*
2. *Restitution (29)*

Section 1950.5 (k) **Advertising to Perform Painless Service.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1- 15)*
2. *Restitution (29)*

Section 1950.5 (l) **Violation of Any Provisions of This Division.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard terms (1–15)*
2. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 1950.5 (m) **Permitting of Any Person to Operate Dental Radiographic Equipment Who Has Not Met The Requirements of Section 1656.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1- 15)*
2. *Worksite Monitor (23)*
3. *Practice Monitor (24)*

Section 1950.5 (n) **Excessive Administration of Drugs or Treatment.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard terms (1–15)*
2. *Restriction of Practice (25)*
3. *Clinical Diagnostic Evaluation(21)*
4. *Worksite Monitor (23)*
5. *Practice Monitor (24)*

Section 1950.5 (o) **Threats or Harassment Against an Employee or Patient.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation.*

1. *Standard Conditions (1- 15)*
2. *Psychological Evaluation (17)*
3. *Psychotherapy (18)*
4. *Worksite Monitor (23)*
5. *Practice Monitor (24)*

Section 1950.5 (p) **Suspension or Revocation of a License Issued by Another Agency or State That Would be Grounds in This State.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3-5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 1950.5 (q) **Alteration of Patient Record with Intent to Deceive.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-14)*
2. *Billing Monitor (20)*
3. *Worksite Monitor (23)*
4. *Practice Monitor (24)*

Section 1950.5 (r) **Unsafe or Unsanitary Office Conditions.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3 years probation.*

1. *Standard Conditions (1-15)*
2. *Worksite Monitor (23)*
3. *Practice Monitor (24)*

Section 1950.5 (s) **Abandonment of Patient.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard terms (1–14)*
2. *Actual Suspension (15)*
3. *Restriction of Practice(23)*

Section 1950.5 (t) **Willful Misrepresentation of Facts Relating to Discipline to Patients.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard Conditions (1-14)*
2. *Worksite Monitor (23)*
3. *Practice Monitor (24)*

Section 1950.5 (u) **Securing a License by Fraud or Deceit.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed with 3 years probation*

1. *Standard terms (1–14)*
2. *Actual Suspension (15)*
3. *Restriction of Practice(23)*

Section 1950.5 (v) **Any Action or Conduct That Would Have Warranted the Denial**

of a License.

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation.*

1. *Standard Conditions (1-14)*
2. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 1950.5 (w) **Aiding or Abetting Licensee to Practice in a Negligent Manner.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation.*

1. *Standard Conditions (1-14)*
2. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 1950.5 (x)(y) **Failure to Report the Death of a Patient to Committee.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation.*

1. *Standard Conditions (1-14)*
2. *Any additional probation condition warranted by nature and severity of action or conduct.*

Section 1952(a) **Obtain or Possess Any Controlled Substance.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-14)*
2. *Psychological Evaluation (17)*
3. *Psychotherapy (18)*
4. *Submit to Biological Samples Testing (22)*
5. *Worksite Monitor (23)*
6. *Practice Monitor (24)*
7. *Abstain from Alcohol (26)*
8. *Abstain from Control Substance (27)*

Section 1952 (b) **Use of a Controlled Substance.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *Psychological Evaluation (17)*
3. *Psychotherapy (18)*
4. *Physical Examination (19)*
5. *Submit to Biological Samples Testing (22)*
6. *Worksite Monitor (23)*
7. *Practice Monitor (24)*
8. *Abstain from Alcohol (25)*
9. *Abstain from Controlled Substances (27)*

Section 1952 (c) **Conviction Involving Controlled Substance.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation depending on nature and severity of violation*.

1. *Standard Conditions (1- 15)*
2. *Psychological Evaluation (17)*
3. *Psychotherapy (18)*
4. *Physical Examination (19)*
   Submit to Biological sample testing (22)
5. *Worksite Monitor (23)*
6. *Practice Monitor (24)*
7. *Abstain from Alcohol (26)*
8. *Abstain from Controlled Substance (27)*

Section 1953 (b) **Failure to Identify Yourself In Patient Record (Repeated Acts).**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 1956 **Negligence/Gross Negligence.**

Maximum Penalty: *Revocation*
Minimum Penalty: *Revocation stayed 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-14)*
2. *Actual Suspension (15)*
3. *Billing Monitor (if appropriate) (20)*
4. *Clinical Diagnostic Evaluation (21)*
5. *Worksite Monitor (23)*
6. *Practice Monitor (24)*

General Business and Professions Code Provisions

Section 125 Misdemeanor Offenses by Licensees.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 3 years probation.*

1. *Standard Conditions (1-15)*
2. *Actual Suspension (16)*
3. *Restitution (29)*
4. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 125.6 Refusal to Treat Patient.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 3 years probation.*

1. *Standard Conditions (1-15)*
2. *Worksite Monitor (23)*
3. *Practice Monitor (24)*

Section 125.9 Failure to Comply with Citation.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 3 years probation.*

1. *Standard Conditions (1-15)*
2. *Compliance with citation, if applicable*
3. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 480 Denial of a License.

- Maximum Penalty: *Denial of license*
  Minimum Penalty: *Revocation stayed with 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *Any additional probation conditions warranted by nature and severity of action or conduct.*

Section 496 Subversion of Licensing Examinations.

- Maximum Penalty: *Denial of license or Revocation*
  Minimum Penalty: *Revocation stayed with 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *RDH Clinical Examination (26)*

Section 498 Securing License by Fraud, Deceit, or Misrepresentation.

- Maximum Penalty: *Denial of license, or Revocation*
  Minimum Penalty: *Revocation stayed with 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *RDH Clinical Examination (26)*

Section 650 Accepting or Receiving Rebates.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 3 years probation.*

1. *Standard Conditions (1-15)*
2. *Restitution (29)*

Section 651 False, Misleading or Deceptive Public Communications.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 3 years probation.*

1. *Standard Conditions (1-14)*
2. *Restitution (where appropriate) (29).*

Section 654.2 Charges, Billings, Solicitations or Referrals without Disclosure of Beneficial Interest Prohibited.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 3 years probation.*

1. *Standard Conditions (1-15)*
2. *Billing Monitor (20)*

Section 726 Commission of Act of Sexual Abuse or Misconduct with Patient.

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation*

Section 810 Insurance Fraud

- Maximum Penalty: *Revocation*
- Minimum Penalty: *Revocation stayed with 5 years probation.*

1. *Standard Conditions (1-15)*
2. *Actual Suspension (16)*
3. *Billing Monitor (20)*
4. *Worksite Monitor (23)*
5. *Practice Monitor (24)*
6. *Restitution (where appropriate) (29)*

Section 822 Psychological or Physical Illness.

- Maximum Penalty: *Revocation or Suspension*
  Minimum Penalty: *Revocation stayed with 3–5 years probation depending on nature and severity of violation.*

1. *Standard Conditions (1-15)*
2. *Actual Suspension (16)*
3. *Psychological Evaluation (17)*
4. *Psychotherapy (18)*
5. *Physical Examination (19)*
6. *Any additional probation conditions warranted by nature and severity of action or conduct.*

SECTION 12 - ATTACHMENT G:

Copy of the Joint Legislative Sunset Review Committee Background Paper for the Dental Board of California

(March 14, 2011, pages 8-9)

appraisal efforts were met with considerable employee resistance, and the appraisals were never completed.

Additionally, a 2009 Enforcement Process Assessment (Enforcement Assessment) of DBC indicated that the lack of personnel performance evaluations is evident in various areas of the enforcement program. Personnel appraisals, the Enforcement Assessment indicated are especially important in the case review and audit process to effectively track and manage investigations, and concluded that a consideration should be given to monthly reports, training participation and attendance to measure staff productivity and investigative progress, which will also help in conducting annual appraisals with staff.

Staff Recommendation: ***DBC should explain to the Committee its system of work performance evaluations and ensure that these evaluations or appraisals are completed by staff on a timely basis.***

ISSUE #4: (CLARIFICATION OF THE AUTHORITY OF DBC OVER THE DENTAL HYGIENE COMMITTEE AND DENTAL ASSISTANTS.) Is there some clarification needed regarding the authority which DBC has over the Dental Hygiene Committee and the Dental Assisting Forum?

Background: In 1974, the Legislature created the Committee on Dental Auxiliaries (COMDA) to provide advice on the functions of and work settings of dental auxiliaries, including dental assistants and dental hygienists. COMDA was vested with the authority to administer dental auxiliary license examinations, issue and renew dental auxiliary licenses, evaluate auxiliary educational programs, and recommend regulatory changes regarding dental auxiliaries. SB 853 (Perata) (Chapter 31, Statutes of 2008) abolished COMDA and transferred the regulation of dental hygienists to the Dental Hygiene Committee, and the regulation of RDAs and RDAEFs to DBC. SB 853 was the result of years of negotiations between stakeholders to create within the jurisdiction of DBC the Dental Hygiene Committee of California (DHCC). It removed dental hygienists from the more restrictive COMDA and provided it with a more autonomous regulatory direction. This was an action consistent with JLSRC's conclusion that the dental hygienists had reached the point where their responsibilities warranted a regulatory body separate from DBC. While the DHCC is proving successful, there have been issues raised regarding its autonomy. It has been argued that the autonomy that was designed and expected with the independent funding and governance of this new Committee has been sometimes limited by the suggestion that their actions, outside of changing the scope of practice for dental hygiene, requires special reporting or some kind of consent from DBC. Dental hygiene advocates claim that the adoption of the regulatory packet that will create the Dental Hygiene Practice Act remains stalled, and the DHCC is still acting under the old regulations that are found only in the Dental Practice Act that is controlled by DBC. However, according to DBC staff, it is unclear as to why the DBC is responsible for the failure to enact DHCC regulations. With new appointments due to occur in January 2012, it is imperative that the DHCC's ability to adopt regulations independent of DBC be clarified. Without clarification, the DHCC members are unclear as to what they can do as a Committee.

Additionally, SB 853 also stated legislative intent that DBC create and implement an effective forum where dental assistant services and regulatory oversight of dental assistants can be heard and discussed in full and where all matters relating to dental assistants can be discussed, including matters related to licensure and renewal, duties, standards or conduct and enforcement. In response to SB 853, in 2009, DBC established two groups to deal with dental assisting issues: The Dental Assisting Committee (DAC) composed of DBC members and chaired by the RDA appointee to DBC; and the Dental

Assisting Forum (DAF), composed of RDAs and RDAEFs. According to DBC, "the purpose of the DAF is to be a forum where dental assistants can be heard, and to discuss all matters relating to dental assistants in the State, including requirements for dental assistant licensure and renewal, duties, supervision, appropriate standards of conduct and enforcement for dental assistants." This purpose is essentially similar to the legislative intent specified in SB 853. The DAC meets at every board meeting and the DAF held short meetings in January and April 2010, and met again in January 2011. Advocates for dental assistants have indicated to Committee staff that many items that DAF members have requested be included on agendas but have been removed, requests that meetings be held in conjunction with DBC so that there can be open lines of communication and establish greater efficiency have been denied, and dental assisting issues are placed on the agenda for DBC's DAC, instead of on the DAF agenda. Additionally, Committee staff is unclear as to DBC's policy for referring issues to the DAF and DAC, how recommendations are referred from the DAF and DAC to DBC and what kind of discretion DBC has over deciding dental assisting issues; how often are issues referred to DAF and DAC and how often are they taken up by DBC, and how often are DAF and DAC recommendations accepted. Essentially, the establishment of two groups to deal with dental assisting issues has resulted in very inefficient and ineffective process. It is also unclear why DBC established a bifurcated process for hearing dental assisting issues.

Recommendation: ***It would appear as if the intent of the Legislature was that the Dental Hygiene Committee was created so that it could make independent decisions on issues related to the regulation of the hygienist profession unless it involved scope of practice changes which would need to be worked out between both the dentistry and hygienist professions. Clarification may be needed to assure that the Dental Hygiene Committee maintains its independence over that of DBC. Additionally, the Committee should ask DBC to explain the purpose for establishing two groups to deal with dental assisting issues, and consider merging the DAC and DAF into one entity.***

DENTAL WORKFORCE AND DIVERSITY ISSUES

ISSUE #5: (IMPACT OF FEDERAL HEALTH CARE REFORM ON THE DENTAL WORKFORCE?) Will California meet the increased demand for dental services with the enactment of the Federal Health Care Reform, and what can DBC do to assist in the implementation of the Federal Health Care Reform?

Background: A June 2009 Health Policy Fact Sheet (Health Policy Fact Sheet) by the University of California, Los Angeles Center for Health Policy Research indicated that California has about 14% of the total number of dentists nationwide (the largest percentage of any state). The dentist-to-population ratio in California is estimated as 3.5 dentists per 5,000 or a dentist for every 1,440 persons. This ratio is higher than the national estimate of three dentists per 5,000, or a dentist for every 1,660 persons. However, the Health Policy Fact Sheet revealed that although there is a large number of practicing dentists in California, many areas in the state continue to have a shortage of dentists, and these areas are mostly located in rural areas, including Yuba, Alpine, Colusa, Mariposa, Mono and San Benito Counties. The Health Policy Fact Sheet indicated that there are 233 dental health professional shortage areas statewide. These areas generally have a dentist-to-population ratio of one per 5,000 or lower; a high population need with a ratio of at least 1.25 dentists per 5,000 (or 1 per 4,000); and a public or non-profit health center that provides dental services to shortage areas or populations. Additionally, the Health Policy Fact Sheet indicated that the percentage of dentists who may be nearing retirement

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT H:

Registered Dental Hygienist in Alternative Practice (RDHAP): Increasing Access to Dental Care in California

(May 2008, p. 14)

Registered Dental Hygienists in Alternative Practice: Increasing Access to Dental Care in California

Elizabeth Mertz, MA

Center for the Health Professions

University of California, San Francisco

May 2008

THE CENTER
FOR THE HEALTH PROFESSIONS
University of California, San Francisco

The mission of the Center for the Health Professions is to assist health care professionals, health professions schools, care delivery organizations and public policy makers respond to the challenges of educating and managing a health care workforce capable of improving the health and well being of people and their communities.
The Center is committed to the idea that the nation's health will be improved if the public is better informed about the work of health professionals.

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Acknowledgements

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I would like to thank the numerous people at the California Dental Hygienists' Association and the Committee on Dental Auxiliaries for their wonderful assistance in my quest to understand the intricacies of the laws and regulations as well the political history of the profession. Thanks also to my colleagues Sharon Christian and Catherine Dower for their assistance reviewing the historical and legal analyses and providing invaluable feedback, and to the numerous other colleagues and friends who reviewed sections of the report.

Finally, I would like to express my sincere gratitude to the Registered Dental Hygienists in Alternative Practice who took the time to share their practice experiences with me. I believe your inspirational stories hold many valuable lessons for improving access to care, and importantly, improving the oral health of all Californians.

Introduction

Lack of access to dental care is a persistent problem for vulnerable populations in California resulting in extensive untreated dental disease.[1-3] The State has invested in multiple programs and policies aimed at improving access to dental treatment. These efforts include provider targeted incentives such as loan repayment and scholarship programs, residency training programs, and licensure by credential, as well as public targeted incentives such as funding dental benefits and public clinics.[4] Most efforts seek to expand access to the existing care delivery model, which consists primarily of private dental offices and community dental clinics. Relatively recent additional State efforts promote disease prevention in non-dental office settings.

Registered Dental Hygienists (RDH) are dental disease prevention specialists. They are not well-positioned to significantly improve access for underserved populations because only 2.5% of RDHs practice in non-private practice settings.[5] A key problem of the existing system is that many Californians cannot access care in dental offices as they either do not have the financial means to pay for dental care (i.e. uninsured or low income), or face physical impediments to getting to a dental office, (i.e. not in geographic proximity, institutionalized).[6]

In 1998, California officially recognized a new dental health profession: the Registered Dental Hygienist in Alternative Practice (RDHAP). To become an RDHAP, candidates must have a baccalaureate degree (or equivalent), hold an RDH license, have 2000 hours of clinical practice in the past 36 months, complete a 150-hour accredited educational program and pass an examination on California Law and Ethics administered by the Committee on Dental Auxiliaries (COMDA), a subcommittee of the California Dental Board (CDB). RDHAPs may practice *unsupervised* in homes, schools, residential facilities and other institutions, and in Dental Health Professional Shortage Areas.[7]

Recent RDHAP licensees (over two hundred in the last few years) have been able to set up practices successfully, however they do report difficulties with providing services in underserved areas for a variety of reasons. These obstacles could be removed through policy adjustments.[5] This study explores the ways in which reasonable policy modifications may

improve utilization of the RDHAP workforce. Accordingly, we examine the evolution of RDHAP practices and their progress in creating and expanding access to care for vulnerable populations. The specific aims of this research project are to:

- Profile the RDHAP workforce and compare it to the RDH workforce to understand the unique practice settings, patient demographics and services of RDHAPs.
- Explore the practice realities of RDHAPs as they enter underserved communities and devise new models of care delivery outside of the traditional dental office.
- Discuss laws specific to the RDHAP profession and develop policy recommendations to further enable RDHAPs to expand access to preventive dental care for underserved Californians.

Historical Development of the RDHAP

The dental care system consists of a variety of organizations that strive to meet the dental needs of diverse populations in the U.S. The expansion of private practice dental services in combination with public health interventions such as water fluoridation and the expanded use of personal dental hygiene products have resulted in improvements in oral health status over the past 50 years. However, there is a growing segment of the population which increasingly can not access services and is shouldering a disproportionate burden of dental disease.[6, 8] To address the widening disparities in oral health status, in 2000, the Surgeon General issued a National Call to Action, to which many organizations responded.[2] Proposed solutions ranged from more traditional ways to increase the health workforce through state planning and expansion of educational programs to small pilot projects testing multiple pathways to addressing access issues locally.[4, 9, 10]

The dental workforce is a critical component of health care delivery. Views differ on how providers may best reach underserved people. There have been multiple proposals recommending new categories of providers, more ethnically diverse providers or simply more of the same in greater numbers. Some of these proposed models have been tried, but have not significantly advanced against the dominant delivery system of private practice dentistry. Only in the last decade have alternative models of independent and public health dental hygiene begun to attain legal recognition across the U.S [11]

Figure 1: Historical Overview of the Dental Hygienist Profession in the U.S.

Early 1900's
Dentists generally oppose the utilization of dental assistants and hygienists.

1950s & Post WWII
Unexpected consumer demand for dental care arises from the baby boom. In response, the dental hygienist workforce, comprising mostly of women, emerges to help meet this demand. The dental profession regulates the training and practice of hygienists from the beginning.

1965
Medicaid and Medicare laws are enacted without provisions for dental care, setting Medicine on a new trajectory but leaving dentistry untouched.

1970's
Predominantly female dental hygiene workforce continues to expand, coinciding with a continued overall expansion of women in the workforce and rising feminist projects regarding equality in working conditions and pay. Efforts toward professional independence originate.

1980s and 1990s
Market solutions to health care crises are explored. The increasing popularity of cosmetic procedures makes private practice dentistry more lucrative. Access to dental care becomes a major policy issue. Dental hygiene continues to push professional independence. States begin to consider using different delivery models, including independent or expanded dental hygiene scopes of practice.

1990s -2000's
Turmoil in health care increases. The Surgeon General's report on Oral Health and Call to Action address health care access, disparities and market failures. States begin to adopt new delivery models, including public health, independent and expanded dental hygiene scopes of practice. California legally recognizes the RDHAP profession, and establishes two educational programs. As of late 2007, the State has 202 RDHAPs.

Several studies have been conducted to examine these new practice models.[11-14] Most have focused on the safety and efficacy of pilot programs, not the actual process of implementation or impact on access of alternative dental hygiene practice. For example, economic and practice studies have been conducted in Colorado where RDHs may now practice independently.[15, 16] In Alaska, preliminary results of the Dental Health Aide Therapist program have shown safe and effective outcomes of the few providers in practice.[14] In California, studies conducted by researchers as a component of the Health Manpower Pilot Projects Program (HMPP) (now, Health Workforce Pilot Projects Program (HWPP))

examined the RDHAP pilot in terms of practice settings, quality of service and patient satisfaction and demographics. These studies provided the positive evidence needed for the establishment of the RDHAP profession.[17-20] Still, few alternative dental workforce models have been implemented, given the opposition from the mainstream dental community. In spite of this past opposition, however, initiatives to develop new workforce models have finally emerged as a legitimate undertaking, as evidenced by new workforce models being developed by the American Dental Association, the American Dental Hygienists' Association, and others.[14] The RDHAPs' experiences provide the best evidence as to *how new models already in practice actually are working*.

This study does not evaluate the "outcomes" of the RDHAP practices in the traditional way through counts of utilization or services delivered, quality of care, or economics of practice. These areas may be ripe for study in the future; however, they provide no understanding of the change process, only its outcomes. Rather, I examined the qualitative experiences and backgrounds of RDHAPs to understand their motivations, experiences and aspirations that greatly impact what they do, how they do it, and why they do it. Unveiling such data is an important first step in allowing more stakeholders to understand and consider the utilization of alternative dental providers. Accordingly, this paper discusses the context surrounding RDHAP practices, including strategies to develop practices, successes and shortcomings. It then presents policy recommendations to increase the capacity of RDHAPs to treat underserved people.

Research Task and Methods

This study utilized a mixed methods approach, which was approved by the UCSF Committee on Human Research. First, I conducted a standard statistical analysis of the 2005-2006 California Survey of Registered Dental Hygienists.[5] The survey sample represented the State's dental hygiene workforce as of September 2005. The response rate was 74%.

Second, I examined legislative histories, current regulations and commentaries from the 2005-2006 California Survey of Registered Dental Hygienists. I also interviewed practicing RDHAPs and experts from educational institutions and professional associations involved in

the development and regulation of the RDHAP profession. The legislative review includes an overview of RDHAP licensure requirements and scope of practice. Sources for the literature review include OSHPD archives.

The open-ended portion of our statewide sample survey of RDHAPs was invaluable to the study. Fifty-two percent of the respondents provided comments on their practices and experiences. These comments were used in combination with other background research to create our final interview protocol. The protocol was used to interview: 1) one focus group, which consisted of seven RDHAPs (five in practice, one graduate currently developing her practice and one student) and 2) five additional practicing RDHAPs, individually. I also interviewed representatives of several key organizations and institutions regarding their roles in the professional development of RDHAPs: the California Dental Hygienists' Association (CDHA), the California Dental Association (CDA), the Committee on Dental Auxiliaries (COMDA), the California Dental Board (CDB), the University of the Pacific (UOP) and West Los Angeles College (WLAC).

Legislative Review[i]

Historical Development of Alternative Providers

In 1972 the California Legislature enacted AB1503 (Duffy), The Health Manpower Pilots Act, setting the stage for efforts to bring the RDHAP into existence. Today, this program is the Health Workforce Pilot Projects Program (HWPP). It "allows organizations to test, demonstrate, and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes in licensing laws are made by the Legislature." [22] Organizations may use HWPPs to study the potential expansion of a profession's scope of practice to a) facilitate better access to healthcare, b) expand and encourage workforce development, c) demonstrate, test and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives, or d) help inform the legislature when considering changes to existing legislation in the Business and Professions code.[22]

[i] A review of the history of legislative policies conducted by the California Dental Hygienists' Association formed the basis of much of the following analysis.(21. Hurlbutt, M. and K. Menage-Bernie, RDHAP: Past, Present, Future. 2007, California Dental Hygienists' Association: Glendale.)

In 1980, California State University at Northridge in collaboration with the Southern California Dental Hygienists' Association[ii] submitted an application (HMPP #139) to "teach new skills to existing categories of health care personnel and expand the role of dental auxiliaries, specifically dental hygienists."[23] The approved application was underway in 1985 when Maxine Waters introduced companion bills AB844 and AB845, which would have allowed RDHs to practice without supervision in selected sites.[21] These bills were defeated, and in 1987, a lawsuit against the HMPP project host and participants was initiated by the California Dental Association (CDA). This lawsuit was dismissed. A second class of HMPP participants then entered independent practice, only to be followed by a second lawsuit in 1990 that focused on a technicality of the HMPP process. This lawsuit terminated HMPP#139; however, a subsequent application for HMPP#155 to continue the project was approved. During this time, a payment mechanism had been authorized by Denti-Cal to pay the hygienists enrolled and active in the employment phase of the project.[23]

The second HMPP stated as its purpose to "expand the role of dental auxiliaries to allow the independent practice of dental hygienists."[24] As the safety and efficacy of independent practice had been established by this time, the project objectives of the second HMPP were more specific to examining the metrics of the project, including the economic viability and sustainability of independent hygiene practice, as well as patient flows and outcomes. Two bills sponsored by Areias (AB2353 in 1992 & AB221 in 1993) sought to codify a series of changes in the law regarding licensure and regulation of dental hygienists and establish the independent hygiene category; however they were both defeated.

In 1995 AB560 (Rosenthal/Perata) was introduced to again try to establish the category of independent practice. After becoming a two year bill it was signed into law in 1997. It amended the Business and Professions code to extend the scope of practice for dental hygienists, and added a new category of provider, the RDHAP, who could provide

[ii] In 1980, Dental Hygiene had two separate associations for Northern and Southern California. Today these are combined into the California Dental Hygienists' Association. The initiative was spearheaded by a group of hygienists in the Southern California Association who raised approximately $500,000 to fund the pilot.

independent services *with the prescription of a dentist or physician and surgeon*[iii]. The passing of this legislation also terminated the HMPP project #155. The participants in the original HMPPs were considered as having satisfied licensing requirements and were allowed to continue their practices.[24]

Figure 2: Summary of RDHAP Scope of Practice

COMDA Regulations:

Once licensed, an RDHAP may practice as (1) an employee of a dentist; (2) an employee of another registered dental hygienist in alternative practice; (3) an independent contractor; (4) a sole proprietor of an alternative dental hygiene practice; (5) an employee of a primary care clinic or specialty clinic that is licensed pursuant to Section 1204 of the Health and Safety Code; (6) an employee of a primary care clinic that is licensed pursuant to Section 1204 of the Health and Safety Code; (7) an employee of a clinic owned or operated by a public hospital or health system; or, (8) an employee of a clinic owned and operated by a hospital that maintains the primary contract with a county government to fill the county's role under Section 17000 of the Welfare and Institutions code

They may perform the duties established by Board regulation in the following settings:
(1) Residences of the homebound.
(2) Schools.
(3) Residential facilities and other institutions.
(4) Dental health professional shortage areas, as certified by the Office of Statewide Health Planning and Development in accordance with existing office guidelines.

Prior to the establishment of an independent practice, an RDHAP must provide to the board documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services. The dentist's license must be current, active and not under discipline by the Board. Any changes must be reported to the Board in writing, within 30 days following such change.

Existing Practitioners under the HMPP

Persons who completed the required coursework under the HMPP (Health Manpower Pilot Project) and established an independent practice by June 30, 1997, do not need to comply with the above requirements. They may apply for a license by obtaining an application from COMDA. Applicants must provide proof of having established a practice by June 30, 1997, complete the application, and pay a $20 application fee and a $56 fingerprint fee. A license will be issued once the person's criminal history background investigation has been completed.

The original participants of the pilot project have been practicing independently since the completion of the HMPP; however a formal education program for RDHAPs did not become available until 2003.[25] Although the curriculum was already developed, it took several years

[iii] The original HMPP pilot did not require a prescription requirement for independent hygiene services.

to find a new host for the program. The first RDHAP class graduated from West Los Angeles College in 2003 and, following a Request for Proposals from the CDHA for a distance education program, a second program opened at the University of the Pacific, which has been graduating RDHAPs since 2004.

The enactment of the RDHAP category and state institutional support through education, licensure and billing status of these providers were the critical first steps toward enabling the implementation of RDHAP practices around the state. Since that time, additional legislation has modified the conditions and restrictions on RDHAP practices.

Current RDHAP Legislation (2002-present)

AB1589 (Perata) allowed RDHAPs to be employees of specified clinics in addition to the other areas of practice they are allowed in their licensure category. SB2022 (Figuroa) specified in detail the parameters of practice of dental hygiene and set new limitations on any other profession (besides the RDH or DDS) performing these procedures. Additionally, the bill allowed dental hygienists to provide education and preventive services without supervision in public health programs. Finally, it specified that a dental hygienist may use any material or device approved for use in the performance of a service or procedure within his or her scope of practice if they have the appropriate level of education and training required. This provision essentially allowed hygienists to use new technology as it becomes available without having to revisit the legal requirements of their scope of practice.

AB1334 (Salinas) changed the prescription requirement so that rather than needing a prescription prior to providing care, RDHAPs must *obtain written verification that a patient has been examined by a dentist or physician if the hygienist provides services to the patient 18 months or more after the first date the hygienist provides service… valid for a period not to exceed two years*. Finally, SB238 (Aanestad) was enacted in 2007 allowing a Federally Qualified Health Center (FQHC) to bill directly for an RDH or RDHAP encounter. This allows a clinic to employ an RDH or RDHAP regardless of whether they employ a dentist.

Dental Hygiene Practice - Related Legislation

The practice of RDHAPs may be affected by legislation pertaining to the practice of dental hygiene. For example, California now allows for RDH licensure by credential. RDHs from other states may thus be re-licensed in California through an expedited application process.[iv] However, the State cannot grant similar reciprocity to RDHAPs because the profession is not recognized outside of California.

In 2006, a California bill proposed to establish a Dental Hygiene Bureau in the Department of Consumer Affairs. The bill would have shifted the licensure and consumer protection duties over the state's RDHs and RDHAPs from COMDA to the self-regulating bureau. However, the bill was vetoed by the Governor.[v] In 2007 another bill proposed to create the Dental Hygiene Committee of California within the jurisdiction of the Dental Board. The new committee would have been responsible for the licensure of the state's RDHs and RDHAPs. However, the Governor likewise vetoed this bill.[vi] Both bills primarily sought to shift the professional oversight responsibilities from one entity to another, along with reconstituting the oversight committee. If implemented, these changes would not immediately affect RDHAP practice, but might have unknown long-term effects on RDHAP practice.

In 2007, two bills were introduced which would have improved access to oral health care. The bills would have permitted FQHCs to bill for services for FQHC patients when the services are delivered at locations other than FQHC sites. If passed, the bills would have allowed FQHCs to contract with providers in designated offsite locations, such as migrant camps and homeless shelters. However, one bill has been suspended in the Senate Appropriations Committee since summer 2007, while the other has been inactive since January 2008.[vii]

Also in 2007, a bill passed which will require COMDA licensees, including RDHs and RDHAPs, to report information regarding their specialty board certification and practice

[iv] Cal. Business & Professions Code §1766 (AB 2818 (2002, Aanestad)); "RDH Licensure by Credential," COMDA (2007), http://www.comda.ca.gov/rdhlbc.html.
[v] SB 1472 (2006, Figueroa).
[vi] SB 534 (2007, Perata).
[vii] AB 363 (2007, Berg); SB 400 (2007, Corbett).

status upon initial licensure and subsequent applications for renewal. The information will be posted on either COMDA's or the Dental Board of California's Internet Web site. Moreover, licensees will be permitted to report their cultural background and foreign language proficiency upon licensure renewal.[viii] The new law will not directly impact RDHAP practices. However, the tracking of the dental workforce may assist the State in pinpointing dentally underserved populations.

Examination of Legal Requirements for RDHAP Practice

RDHAP practice is bound by a set of requirements. The first is a condition of practice (see form in Appendix 1). Under the California Code of Regulations, prior to the establishment of independent practice, an RDHAP must provide the Dental Board of California with *documentation of an existing relationship with at least one dentist for referral, consultation, and emergency services*.[ix] However, the Code of Regulations does not define "existing relationship." The minimum standard for the relationship is therefore ambiguous. The standard for the circumstances that warrant "referral, consultation, and emergency services" is similarly vague.

Thus, to provide a frame of reference, we examined the nature of other legally-mandated relationships in the medical community, specifically, between physicians and 1) nurse practitioners (NPs);[x] 2) certified nurse midwives (CNMs); 3) physician assistants (PAs);[xi] 4) direct entry midwives;[xii] and 5) public health nurses.[26] We also found similar legally-mandated agreements between hygienists and dentists in other states, particularly in public health settings where the hygienists may work without dentist supervision if "a stipulated standing order and protocol" is in place.[26]

[viii] Cal. Business & Professions Code §1715.5 (AB 269 (2007, Eng)).
[ix] Cal. Code of Regulations §1090.1.
[x] For an example of an NP agreement see http://www.rn.ca.gov/pdfs/regulations/npr-b-20.pdf
[xi] For physician assistants, the relationship requires a delegation of services agreement, which explicitly sets out the type of procedures delegated, consultation requirements, practice setting/sites, and emergency specifications. (see Sjoberg 2002)
[xii] For the legal code outlining direct entry midwife requirement http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2505-2521

The mandated relationship between an RDHAP and a dentist is unique in many ways. First, the relationship is required even for procedures that are already within RDHAP scope of practice. Second, other non-physician professions are not required to maintain such relationships as a condition of licensure. Rather, mandated relationships between physicians and non-physicians generally must be maintained only where the non-physician intends to provide services beyond his legal scope of practice.

Table 1: Comparison of Professional Practice Agreements in California

	Supervision Requirement	Expanded Duties	Agreement Type	Institutional Role in Agreement
RDHAP	No	No	Documented DDS Relationship	No
Public Health Hygienists	Yes-General	No	Standing Orders	Yes
Direct Entry Midwife	No	No	Referral Agreement with MD	No
Nurse Practitioner	No	Yes	Standardized Procedure	Yes
Certified Nurse Midwife	No	Yes	Standardized Procedure	Yes
Physician Assistant	Yes - Direct	Yes	Delegation of Services Agreement	Yes
Public Health Nurse	No	No	Standardized Procedure	Yes
Registered Nurse	No	No	Standardized Procedure	Yes

For example, the "Standardized Procedure" legally permits NPs and CNMs to *perform functions which are considered the practice of medicine*. These procedures must be *developed collaboratively by nursing, medicine and administration in the organized health care system in which they practice*.[xiii] They do not need any agreement with a physician to perform duties within their nursing scope of practice.

The PA-physician agreement constitutes a formal delegation of medical duties from the supervising physician to the PA. The supervising physician must be available in person or by electronic communication whenever the PA is treating patients. Therefore, the physician need not be onsite at all times.[26] The mandated relationship between direct-entry/lay midwives and

[xiii] Regulations can be found at http://www.rn.ca.gov

physicians is more analogous to that between RDHAPs and dentists. Both groups must maintain a relationship with a medical provider in the event of unforeseen circumstances. However, the two groups differ with regard to education and training. Midwives are trained "on the job" to provide services entirely outside of the medical model. The sole purpose of the mandated midwife-physician relationship is therefore to provide pregnant patients with emergency medical care in case a life-threatening need arises. RDHAPs, on the other hand, must maintain relationships with dentists for referral and consultation in addition to emergency situations.

The mandated relationship for RDHAPs is also unique because such agreements between physicians and other non-physician providers are typically overseen by the medical institution in which they practice, such as a hospital or a clinic. Since there are few major "dental institutions" or hospitals with dental departments, the mandated RDHAP-dentist relationship is, in practice, really an agreement between two individual providers, with no organizational support to ensure standardization, good-faith and fairness.

While unique in many ways, the RDHAP is similar to other providers in that it has *Standards for Clinical Dental Hygiene Practice.* These standards guide professional practice both in the "provider-patient relationship" as well as the facilitation of "implementation of collaborative, patient-centered care in multi-disciplinary teams of health professionals."(p3) These standards hold providers accountable to all local, state and federal statutes and regulations over their scope of practice.[27]

The prescription requirement is a separate provision that limits RDHAPs ability to freely practice under their scope. As discussed, a patient must obtain a dentist or physician prescription for dental hygiene services if the patient seeks treatment from an RDHAP 18 months or more after the first RDHAP visit. This is unique in that most restrictions requiring a prescription of one provider to another are for specialty care, not for primary preventive health care services.

Finally, many RDHAP practices are with the elderly so federal and state laws regarding dental care in nursing homes affect them. Under federal law, nursing homes and skilled nursing

facilities are required to "assist residents in obtaining routine and 24-hour emergency dental care."[xiv] Under California law, "arrangements shall be made for an advisory dentist to participate at least annually in the staff development program for all patient care personnel and to approve oral hygiene policies and practices for the care of patients."[xv] Further, "[i]f [a] service cannot be brought into the facility, the facility shall assist the patient in arranging for transportation to and from the service location."[xvi]

Significant confusion has arisen among nursing home administrators, RDHAPs and dentists over the interpretation of these laws. For example, most facilities comply with the regulations by contracting with a dental provider (usually a Denti-Cal provider) to meet patients' dental needs. Because these contracts are not specifically required by law, their scope and reach are often unclear. For instance, a large percentage of RDHAPs are developing their practices in nursing homes, providing on-site preventive care and education, and referring restorative treatment needs to a dentist. However, many dentists with whom the nursing homes have a contractual relationship *assume* that the relationship grants them exclusive authority to provide dental care to the nursing home patients (which the law does not require), and have sought to have the RDHAPs removed from the homes. This is causing much frustration for nursing home administrators who want to both provide on-site preventive care as well as have a dentist available for treatment needs but who are told they may only have the latter if they deny the former.

Legislative Summary: Impacts on Access to Care

In summary, any legislation regarding dental hygiene education, training, licensure, scope of practice, or reimbursement mechanisms may impact the practice landscape of RDHAPs, and consequently, their ability to improve access to care. Neutrally-worded legal provisions can, in effect, constrict the profession's practices. Policy-makers should thus consider potential impediments to access that may follow from seemingly innocuous proposals, such as proposals to "restructure" reimbursement schemes.

[xiv] 42 CFR Ch. IV (10-1-01 Edition) p. 528-29, section 483.55 Dental Services
[xv] Cal. Code of Regulations §72301.
[xvi] Id.

The restrictions placed on the RDHAP profession are the result of a political compromise that allows for independent hygiene practice in exchange for improving access to dental care for underserved populations in California. Legislators understood that permitting RDHAPs to practice independently was imperative to meeting this goal because RDHAPs often practice in communities where few dentists practice and few dentists accept Denti-Cal. Logically, therefore, the more ties RDHAPs are required to maintain with dentists, the more constrained RDHAPs will be from reaching the underserved.

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

Profile of the RDHAP Workforce

The results from the 2005-2006 UCSF Statewide Survey of Dental Hygienists in California provide a baseline understanding of who is choosing to enter this licensure category and what kind of work they are doing. [5] The RDHAP workforce, while still small in numbers[xvii], is distinct in many important ways. First of course is its very existence. Dental hygienists have been working to expand their scope of practice and reduce their supervision requirements for over twenty years. California was one of the first states to allow a pilot of independent practice and subsequently legislatively enact this new category of provider.[19] The following section describes the overall profile and practice characteristics of the 119 RDHAPs in comparison to the 11,083 RDHs in the workforce as of 2005-2006.

[xvii] The survey included 119 RDHAPs as of September 2005. As of September 20, 2007, there were 202 individuals ever licensed as an RDHAP in California, and 196 active licenses (Personal Email Communication, Elizabeth Ware, Executive Officer, Committee on Dental Auxiliaries, September 20, 2007).

Demographics

In many ways, the RDH and RDHAP workforce are alike given that RDHAPs are a subset of the RDH workforce. The age distribution of the two groups is similar, as are the marital status and gender distributions.

Table 2: Comparison of Workforce Demographics

	RDHAP	RDH
Age Distribution		
18-30	5%	7%
31-40	22%	26%
41-50	31%	33%
51-65	41%	32%
65+	2%	2%
Marital Status		
Single	15.0%	13.6%
Married/Partner	64.5%	72.5%
Divorced / Separated / Widow	20.6%	13.9%
Gender		
Male	3.7%	2.5%
Female	96.3%	97.5%
Underrepresented Minority**		
African-American, Hispanic, Native American*	21%	9%

**Statistically significant differences*
*** Reported together due to small sample size*

There are some significant demographic differences, with RDHAPs more likely than RDHs to be from an underrepresented minority group (African American, Hispanic, Native American), more likely to speak a foreign language (35% vs. 27%), and less likely to have children living at home (41% vs. 55%).

Education

The RDHAP workforce is required to have a baccalaureate (or equivalent) education as a pre-requisite for licensure. Hence, RDHAPs are more likely than RDHs to have a bachelor's degree or above (70% vs. 48%). RDHAPs who participated in the original Manpower Pilot Projects (HMPP #139 & #155) were not required to be baccalaureate educated. RDHAPs are equally likely as RDHs to have been educated in-state (78% vs. 77%).

Clinical practice

Many RDHAPs reported that they are maintaining a traditional RDH job in addition to developing their RDHAP practice. Therefore, the clinical practice data we collected cannot be used to specifically distinguish the clinical work of an RDH vs. an RDHAP. In spite of this, we can make some general observations about practice differences between the two groups. First, RDHAPs work a half day more per week on average (3.8 days) than the average RDH (3.4 days). They reported significantly greater difficulty finding an acceptable salary range (18% vs. 11%) and/or benefit package (23% vs. 14%) when last looking for work.[xviii] RDHAPs did not report a significant difference from RDHs in difficulty finding work, opinion of the supply of RDHs in the state, or years they intended to work.

Table 3: Comparison of Clinical Practice Experience

	RDHAP	**RDH**
Difficulty Finding Work		
None	77.5%	78.3%
Some Difficulty	13.5%	16.8%
Difficult	7.9%	3.5%
Extremely Difficult	1.1%	1.4%
Opinion of RDH Supply		
Too Many	18.4%	12.1%
Adequate Number	62.1%	67.5%
Not Enough	19.5%	20.4%
Years Intending to Practice		
<2	6.6%	4.1%
2-5	11.0%	16.7%
6-10	36.3%	30.4%
10+	46.1%	48.5%

**no statistically significant differences in these categories*

Patient Populations

RDHAPs and RDHs reported similar numbers of patients per day (8.5 and 8.4 respectively) and similar racial, ethnic and age breakdowns of their patient populations. The only category showing a statistically significant difference is the 0-1 year olds, however the percentages were extremely low. RDHAPs reported a slightly higher percent of patients (3.5%) they had difficulty communicating with due to language barriers than did RDHs (1.9%), however the

[xviii] Respondents did not differentiate whether this was when last looking for a traditional RDH job or when looking for work as an RDHAP. Therefore, it may reflect a difficulty with traditional practice that would have been an impetus to become and RDHAP, or could reflect difficulty establishing RDHAP practice.

differences were not statistically significant. The largest differences in patient populations between the RDHAPs and RDHs were those considered medically compromised, developmentally disabled, mentally ill and having a behavioral management problem[xix].

Table 4: Comparison of Patient Characteristics

	RDHAP	RDH
Age of Patients		
0-1*	0.6%	0.1%
2-5	5.0%	4.2%
6-17	12.3%	12.3%
18-64	61.2%	61.8%
65+	21.3%	21.3%
Race/Ethnicity of Patients		
African-American	5.6%	5.8%
American Indian	0.9%	1.4%
Asian/Pacific Islander	6.9%	8.4%
Hispanic/Latino	18.0%	15.0%
White	67.2%	67.3%
Other	2.4%	2.4%
Special Needs Patients		
Medically Compromised*	25.8%	16.8%
Developmentally Disabled	4.7%	2.9%
Mentally Ill*	5.6%	2.6%
Behavior Management	2.6%	1.4%

**Statistically significant difference*

Practice Characteristics

There are quite a few differences in the practice characteristics of RDHAPs and RDHs. RDHAPs are more likely to work at multiple sites but for fewer clinical hours on average, across all sites than an RDH (31.8 hours vs. 34.6 hours per week).[xx]

Work settings of RDHAPs are much more diverse than for RDHs, with 24.5% of their reported practice sites being something other than a private dental practice, compared to 2.5% of RDHs.

Figure 3: Work Settings of Clinically Active RDHs in California

[xix] These data are reported for all their patients across all their practice sites. They do not distinguish which patients are in their "RDHAP" practices versus those in a traditional RDH practice.

[xx] These data differ from the total hours worked data reported above in that the question was how many hours you work at each individual site. RDHAPs are working many hours either in independent practice or doing other activities, so while their weekly practice site hours are fewer, their total weekly hours are greater.

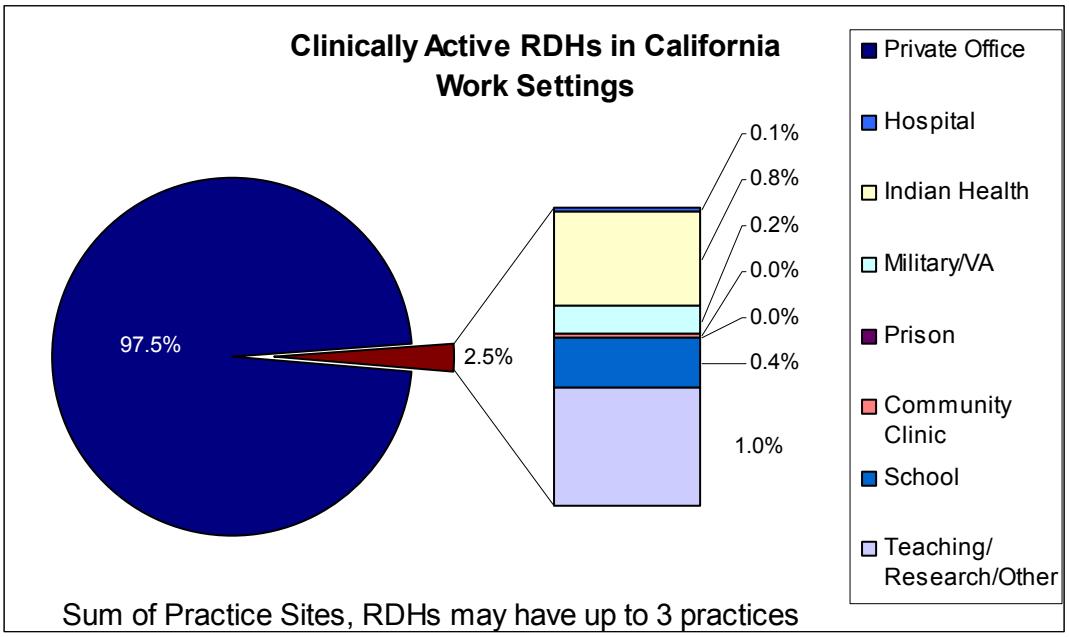
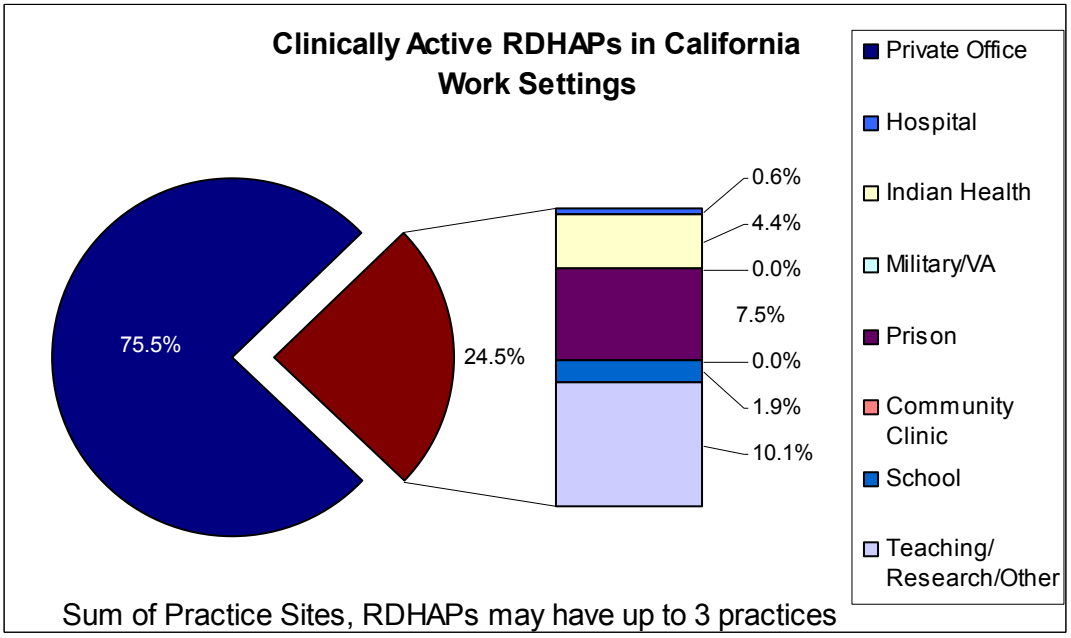


Figure 4: Work Settings of Clinically Active RDHAPs in California



The practice type (general practice, pediatrics, endodonics, etc) of the practices they are in do not vary significantly, except for among "other" types of practices, indicating that for those that continue to work as an RDH, they continue to mirror their peers in work patterns, but as an RDHAP they are in alternative settings. This pattern is further elaborated as RDHAPs

report being employed for one or two practice sites, but self-employed for a second or third. No RDHs reported being self-employed. Significantly more RDHAPs reported they had a contract for their second (40.0% v. 19.4%) and third (62.5% vs.12.0%) practice settings than did RDHs.

Table 5: Comparison of wages, benefits and health care consultations

	RDHAP	RDH
Benefits		
Continuing Education	45.7%	52.4%
Dental Care/Coverage*	51.1%	64.8%
Disability Insurance	10.9%	7.3%
Medical Insurance	25.0%	26.7%
Paid Liability/Malpractice	9.8%	5.9%
Paid Sick Leave*	12.0%	20.4%
Paid Vacation	45.7%	48.8%
Production Bonus	25.0%	29.0%
Paid Professional Dues	5.4%	2.8%
Retirement/Pension Plan	35.9%	35.4%
Hourly Wage		
Practice 1	$46.47	$45.63
Practice 2*	$48.22	$45.52
Practice 3*	$52.19	$45.06
Average Wage - All Practices*	$50.73	$45.28
Consultations		
Dental Specialist	46.7%	52.6%
Physician*	57.6%	47.4%
Physician Assistant*	14.1%	4.5%
Nurse Practitioner*	14.1%	5.1%
Registered Nurse*	18.5%	6.0%
Nutritionist*	8.7%	2.1%
Other*	12.0%	3.7%
None	26.1%	28.2%

**Statistically significant difference*

RDHAPs reported higher hourly wages across practice sites than RDHs did ($50.73 vs. $45.28)[xxi]. The benefits reported by RDHAPs and RDHs varied significantly in two categories. RDHAPs reported less coverage for dental benefits and paid sick leave. A significantly greater number of RDHAPs reported consultations with non-dental professionals in the care of their patients. Finally, there were no differences between the two groups in the number of years worked at each practice site.

[xxi] This is not the wage reported for their AP practice, rather the average of the wage they reported at each practice site, one or more of which may have been a private practice.

Scope of work

An RDHAP may perform any preventive or therapeutic duty that an RDH is allowed to perform under general supervision. We found differences in the distribution of work done within this shared scope of practice between the two groups. Table 6 reports the average percent of procedures in each category done by group. Each category encompasses multiple procedures. On average, RDHAPs were performing a greater mix of procedures in each category than were RDHs. As well, RDHAPs, while working an equivalent number of patient care hours per week, were spending significantly more hours in administration, public health and other categories of work than were RDHs.

Table 6: Comparison of Scope and Hours of Work

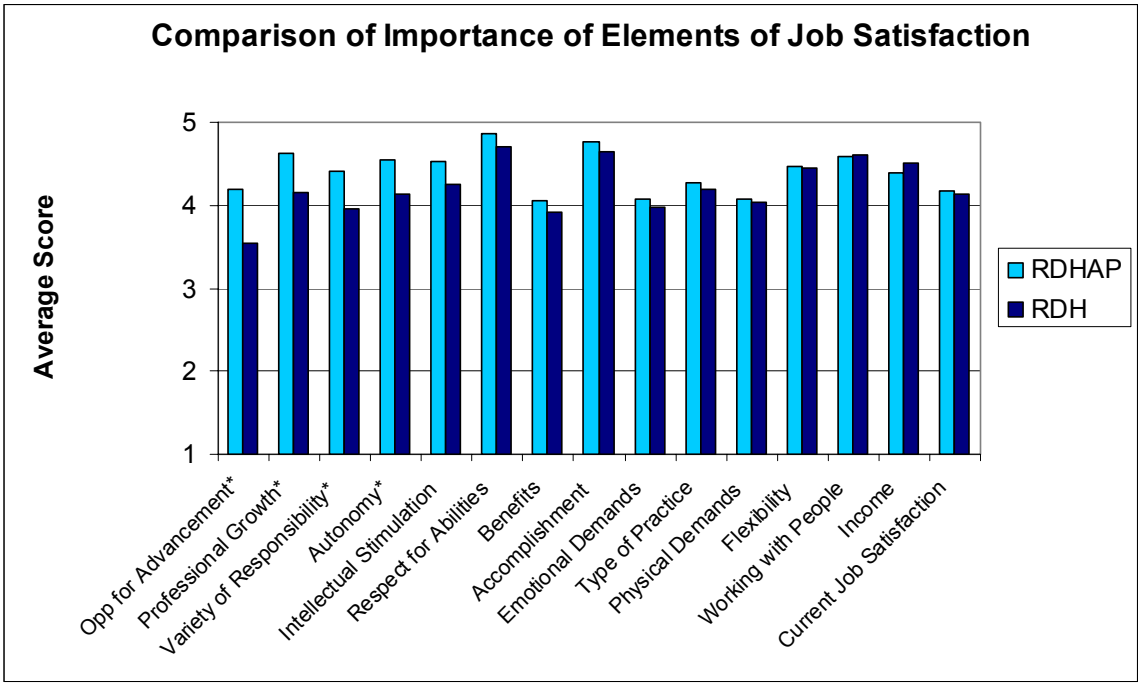
	RDHAP	**RDH**
Scope of Work	Average Percent of Procedures in Category Reportedly Done in Practice	Average Percent of Procedures in Category Reportedly Done in Practice
Diagnostic	73%	68%
Preventive	87%	82%
Therapeutic	94%	92%
Restorative*	16%	8%
Surgical	41%	37%
Cosmetic	23%	13%
Weekly Hours Worked		
Patient Care	22.91	23.33
Administration*	2.20	0.77
Public Health*	1.88	0.11
Teaching	1.38	0.35
Research	0.01	0.02
Other*	1.26	0.20

**Statistically significant difference*

Job Satisfaction

Both RDHAPs and RDHs report high levels of job satisfaction (4.16 and 4.12 respectively on a 1-5 scale, 5 being greatest). However, they differ in what factors contribute to their job satisfaction. The top items contributing to RDHAP satisfaction are “Respect for Abilities”, “Sense of Accomplishment” and “Professional Growth”. The top items contributing to RDH job satisfaction are “Respect for Abilities”, “Sense of Accomplishment”, and “Working with People”. The items where there was significant difference between the groups, with RDHAPs

rating the factor higher than RDHs, were "Opportunity for Advancement", "Professional Growth", "Variety of Responsibility", and "Autonomy".



Opinions on Professional Issues

Survey respondents were asked to personally agree or disagree with a set of statements about professional issues. There was a statistically significant difference on answers to all questions between RDHs and RDHAPs. A much greater percentage of RDHAPs think access to care is an important issue and express a personal desire to work with underserved patients and communities. In addition to significant differences in opinion on the major issues facing the profession, 78.8% of RDHAPs report being a member of their professional association, vs. 36.1% of RDHs.

Table 7: Comparison of Professional Opinions on Hygiene Practice

	RDHAP	**RDH**
Professional Issues*	Percent Agreeing	Percent Agreeing
Would like Self Employment without Supervision	95.9%	39.1%
Would like General Supervision Only	91.8%	69.5%
Would like Prescriptive Authority	94.9%	64.8%
Would like to do Restorative Procedures	70.4%	40.1%
Is Not Practicing to Full Extent	59.0%	34.5%
Thinks Current Environment Good Fit	87.4%	93.9%
Would like to Work Outside Dental Office	95.8%	49.8%
Would like to be Directly Reimbursed	88.4%	28.1%
Desires to Work with Disadvantaged Patients	**88.7%**	**31.9%**
Desires Work with Underserved Community	**77.1%**	**30.0%**
Thinks Improving Access is Important	**94.9%**	**66.5%**
Thinks Current Regulatory Structure is OK	16.5%	58.0%
Would Agree to License Fee Increase for Self-Regulation	94.7%	56.7%
Would like to Interact with non-Dental Health Providers	95.8%	67.3%
Would Have Liked Loan Repayment Option	69.5%	51.9%
Would be part of Volunteer Emergency Registry	81.3%	53.7%
Is Interested in Job in DH Administration or Education	79.4%	57.6%

**Statistically significant difference in all categories*

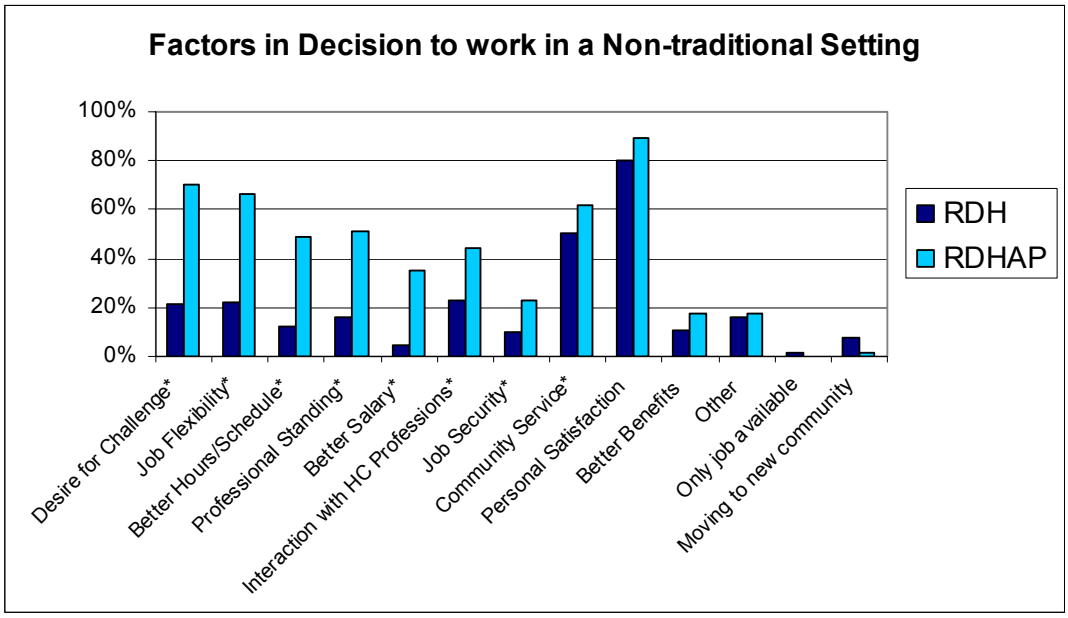
Non-Traditional Practice

Consistent with their scope of practice and restrictions on work settings, RDHAPs are significantly more likely to work in non-traditional settings. These are defined as any practice site that is not a private dental office or clinic. RDHAPs were more likely than RDHs to provide services in a non-traditional setting under general supervision of a dentist or other employer (67.0% vs 9.8%), to work unsupervised in a public health program (25.0% vs. 1.4%), and to desire to work in a non-traditional setting in the future (88.8% vs. 23.6%). Of those hygienists working in a non-traditional setting, RDHAPs are more likely than RDHs to be compensated by patients (60.8% vs. 3.5%), and less likely than RDHs to be compensated by an employer (20.3% vs. 32.3%). They are equally likely to be compensated by the institution they work for (33.8% vs. 34.0%).

Both RDHAPs and RDHs report personal satisfaction as the number one reason for choosing to work in a non-traditional setting. However, RDHAPs report different additional reasons for choosing a non-traditional setting than do RDHs. Overall, RDHAPs were more likely to feel

an alternative setting provided more challenge, flexibility, salary, professional standing and intra-professional contact than were RDHs.

Figure 5: Factors in Decision to Work in a Non-traditional Setting



RDHAP Workforce Profile Summary

These results are important in that they document the baseline practices against which the future characteristics of the profession can be measured. The RDHAP workforce is being educated and licensed to work independently with the goal of increasing access to care for underserved populations and communities. The survey results show that RDHAPs take this role seriously and are in fact fulfilling their mission in these preliminary stages of practice development. As a group, RDHAPs are more educated and diverse than RDHs. They are also more active in the labor market, work longer hours per week with more administrative time, and more likely to consult with other health care providers than are typical hygienists. As well, RDHAPs are more likely to see special needs patients, provide a broader range of services within their scope, work in non-traditional settings, and express a commitment to professional growth, improving access to care and providing services to underserved populations and communities.

It is essential to understand that this professional model is evolving rapidly, so the results presented here reflect the experiences of the first several cohorts as of 2006. Today, in 2008, there is almost double the number of RDHAPs, so their practices may have evolved. What is unlikely to have changed is the profile of the larger RDH workforce from which RDHAPs are drawn.

The RDHAP Experience

To explore the evolution of RDHAP practice, I interviewed a variety of RDHAP providers. The interviews focused on understanding the experiences RDHAPs are having setting up their practices, developing their business models, and providing services. While the development of alternative practice has been many years in the making, the RDHAP as a practicing provider is new to the dental care marketplace. Understanding what successes and barriers the new RDHAPs are encountering in finding employment and/or establishing practices with underserved communities will shed light on the oral health care landscape in these communities and identify ways to build on the expansion of access to dental care they have begun.

Pressing Practice Issues: 2005-2006

In 2005-2006 RDHAP respondents to a statewide sample survey indicated concerns in three areas. The first concern was the impact of structural issues arising from the regulatory, fiscal and administrative environment in which they work. The second concern was the business aspect of their work. The final concern was professional issues that both advance and hinder their practices. I structured my interviews around these themes and found that RDHAPs felt that while improvements had been made in the intervening years, many challenges remained. In the following section, I report on the main findings from my interviews with RDHAPs. I group these findings into four sections: a) motivations for practice, b) patient populations, c) business challenges and d) structural conditions. Responsibility for the interpretation of their statements is my own. However, whenever possible I try to use the RDHAPs' own words, so the reader may understand the experience of an RDHAP from their own perspective.

RDHAP Motivations to Practice

> *"To do things well it takes much effort and hard work. This whole vision takes a special person, not all hygienists would do this work."*

The RDHAP workforce is engaged in independent dental hygiene practice that is limited to underserved communities. Entrants into the field tend to be experienced, innovative and sincerely motivated to increase access to dental care.

> *"I think you really need to be a dynamic dental hygienist, a go-getter, seasoned, able to handle any situation. I really enjoy it."*

RDHAPs reported many attractions to their type of practice. The rewards of being able to serve patients in their communities, and the sense of accomplishment from building their own unique practices, were the two most common themes.

> *"I think it's people who have always worked with developmentally disabled, always worked with the elderly population, always worked in the schools. All of us had some extended involvement with the community outside of just working for three days, five days a week in a regular dental practice. We all were involved in a different capacity, and I think that's what this program attracts is people who really, sincerely want to help. It's not a money thing."*

RDHAPs feel their practices provide opportunities for teamwork and collaboration with medical and dental providers not normally afforded to a dental hygienist in a private practice[xxii]. The work itself, while challenging, is also interesting, rewarding, and needed in the community.

> *"There's enough business out there for all of us. I mean, I could work 24 hours a day 7 days a week and still not fill the void."*

The RDHAP provides a career opportunity for hygienists who are dissatisfied with private practice, allowing them to remain in the profession, but in a new capacity. Hygienists seeking alternative practice have expressed frustration with being bound to a private practice model that does not afford full employment or professional advancement for hygienists and where job conditions, security and satisfaction depend more on the quality of the interpersonal relationship with a dentist than the on the quality of their work.

> *"I have worked 20 years full time and have no pension plan or benefits to show for it, and certainly no respect. The dentist expects much but gives little. As an RDHAP I have become partners with a dentist who provides mobile services. I will not work for him, but with him."*

[xxii] As shown in Table 5, RDHAPs are two to three times more likely to collaborate with a non-dental health care professional than an RDH.

Hygienists also expressed dissatisfaction that within a traditional dental practice they are unable to provide the quality of services they want to provide, and work with the special populations in their communities they know need care.

> *"Our population was getting booted left and right out of dental care because of behavior issues. Many of our federally qualified health centers, our safety net clinics, are so busy putting out fires they don't have time for behavioral support and behavioral management. So many of the patients that I was seeing to route into care – there was no place to route them. It was a frustration for me. I even went to work at a community clinic so I could see – I took a job for a lot less money in a clinic so that I could actually provide good preventive hygiene care to these patients because I saw the need."*

In sum, the interviews showed that while each RDHAP has a unique and personal motivation to do the work they do, they share a commitment to working with underserved patients in a model of care delivery responsive to patients as well as personally and professionally satisfying.

RDHAP Patients and Communities

Central to any assessment of access to care is the question of "for whom." The law specifies which communities and institutions may be served by RDHAPs[xxiii]. The particular situation of individual providers is unique and specific to the communities in which they work and live. RDHAPs take the mission to work with vulnerable and marginalized populations seriously. The patients they are reaching out to, for the most part, have been neglected by the dental care system. This is particularly true of the homebound and institutionalized frail elderly patients for whom many RDHAPs provide care.

> *"The hygienists in my office, they in no shape, way, or form want to do this. One girl said, "I don't know how you could do that." But these patients are just like you and I -- they just haven't been seen in a while. There's a person attached to those teeth. She just thinks it's all yucky. But we've all seen that yuk. We just don't see it as much in private practice. Maybe once a month we'll get somebody who hasn't been -- or once every couple of months we'll get somebody who has not been seen in years. Where as, opposed to this, it's just daily.*"

[xxiii] Defined as (1) Residences of the homebound. (2) Schools. (3) Residential facilities and other institutions. (4) Dental health professional shortage areas. The specific populations they received training to treat are geriatric, pediatric, developmentally disabled and medically compromised patients. B&P Code 1073.3 (e)(1)(c).

Medicare does not provide dental benefits for the elderly population, adding dental disease to the already heavy burden of multiple health problems many older people shoulder. In nursing home and long-term care settings, dental health is usually neglected. Few dentists attend to the preventive health care needs of nursing home residents, and the nursing and medical staff in these homes is minimally trained in the provision of oral health care. One RDHAP who specialized in nursing homes provides a particularly graphic example of the implications of this neglect:

> *"They don't even know what's wrong with him and why he smells. But they're thinking maybe it could be his teeth because they kind of know nobody's really taken care of it. And when we- I had a nurse with me. I said, "Will you just open his mouth for me?" I took a picture, and there's blood everywhere. And there's no caries. It's just, you know, deep sub and no saliva, and the smell. The other nurse wouldn't come with me – but the RN wanted to come, and we finally put him on some medication. And then I had a nurse holding his arms. I asked the doctor yesterday what would be better. I would like something that is a little -- he doesn't want to flail like that, but it's involuntary. And so we've cleaned his teeth three times now, you know, gotten in there. And there are other cases like that. I think that, you know, you'll find degrees of that statewide. So the advent -- and I love this part too -- the advent of the RDHAP has opened a can of worms. Not only were these people underserved, they were underserved even when they were being served."*

RDHAPs report that they are choosing to focus on the people who need the most care in their communities. The homebound and institutionalized elderly population is often one of these underserved groups.

> *"We are there to provide services and to make these people have a sense of dignity and care because they are basically forgotten. Nobody wants to take care of their dental needs. Some of these people have been going to the dentist for years and then they get into a situation where they're in a nursing home and all of that is gone."*

The following list of the populations RDHAPs report working with is representative of the type of underserved communities the profession is reaching out to: homebound and institutionalized elderly, migrant farm-worker families, pregnant women on Denti-Cal, rural school children, developmentally disabled children and adults, wards of locked state institutions, and low income rural and urban families. Although they are unable to provide the restorative care their patients need, the preventive interventions they provide are making a difference for their patients. RDHAPs are creating accessible preventive dental services where none existed before, and improving the health of these communities in the process.

> *"I think that we have accomplished a lot with our fluoride varnish program, and we're talking about a rural area with limited access to care. I have seen children where literally people are living like squatters in a lot of these areas. It's just really sad. I see kids who are just filthy and never brushing yet the decay is arresting itself. I just last week, in two days, saw 137 children. Seven children that I actually saw that had caries three years ago still had not been treated. After treating them, none of them had pain. The tissue was healthy at those sites because the caries were arrested. It's just phenomenal. What we have seen from the program that we've done is just -- I honestly think if this kind of thing were adopted statewide it would just save taxpayers hundreds of thousands of dollars in restorative dentistry; it really would"*

A constant focus on the needs of communities and patients is a core value emphasized by RDHAP providers. Their practices engender a commitment to a patient-centered, consumer responsive model of care delivery. RDHAPs are dedicated to developing mechanisms for reaching out to patients and improving ways of managing care for patients with special needs.

> *"Most of us that have gone in there are not looking at the business, but as an opportunity to go serve all these people and make a difference and help. It's a helping vocation. And it's really pronounced with the RDHAP. Because this is what they really, really -- like once they get seeing these patients and they help these little ladies and the staff, they feel real good about what they're doing. And that's real common in almost all of them."*

In sum, the RDHAPs I interviewed all described a high level of commitment to the patients they provide services and advocate for. RDHAP patients fall squarely in the standard policy definition of "underserved populations." The number and diversity of their patients is emblematic of how many different people are unable to access services in the traditional way.

The Business of RDHAP Practice

RDHAPs are allowed by law to work independently in underserved settings. There are two ways to achieve this: they must either fill an existing position in an organization or develop their own business. RDHAP training programs (located at West Los Angeles College and The University of the Pacific) may devote a maximum of 25% of their curriculum to business development. Both programs cover business topics, and the WLAC program ensures that RDHAPs graduate with a business plan in hand. As there are rarely RDHAP positions waiting for graduates, a business plan is essential to their success. A number of RDHAPs are currently enrolled in, or have already finished, formal education programs in various fields (public health, education, geriatrics, business) to help them succeed in their practices. In the following section, I outline the multitude of successes and barriers RDHAPs are having developing their businesses.

Practice Diversity: The types of practices RDHAPs are developing vary as widely as the local populations they serve. Many RDHAPs continue to work part-time in a traditional hygiene practice as they develop their RDHAP business. Unfortunately, some dentist/employers, rather than seeing a partnership as an opportunity to improve community health, only see RDHAPs as competition. The result is that RDHAPs have been laid off from their hygiene job when their dental employer discovered they were attending the RDHAP program.

RDHAPs grandfathered in from the original HMPP, or those who work in a Dental Health Professional Shortage Area (DHPSA), are able to set up an independent dental hygiene clinic. The more common business model is to set up a mobile practice and work in skilled nursing facilities, long-term care or residential care homes, schools, or public health clinics, or some combination of settings, as this hygienist does:

> *"I work 2 days a week with elementary school children in a rural area conducting exams, and placing fluoride varnish applications and sealants. Two days a week, I treat patients at an FQHC facility. I work two days a week in my own practice, as well as many evenings. I incorporate my mobile practice within this two-day period."*

RDHAPs offering preventive treatment in all of these settings report collaborating with medical and dental providers in their communities. Regardless, it continues to be challenging to find restorative treatment options for patients who are immobile (such as the institutionalized or homebound), or unable to pay (such as the poor uninsured and some of those covered by Denti-Cal). A hygienist working in a rural area with very few dentists and no Denti-Cal providers recounts:

> *"The way I refer -- there's one gentleman in there. He had his last extraction -- he's had pain for the last two years. I went to my office and talked to my dentist about it -- my private office. He gave me a referral to the oral surgeon. I gave it back to nursing -- I made him an appointment. I went back to the social worker and said okay, I've got an appointment for him on this day. They gave the referral to his physician who has to write a referral. So he got to the oral surgeon. So I had to go a long way around… some of these people aren't able to travel. They're bed-bound. To get them in a wheelchair and to get them on the bus and get them to a dental office, and then just sit there for hours on end -- because they're Medi-Cal, they're Denti-Cal. They're not going to -- they'll filter them in with the rest of their patients. Somebody needs to come in."*

As this example shows, case management and developing referral networks are essential skills for RDHAP's in practice, in addition to clinical work (hygiene services, sterilization, client

charting) and business development and administration (billing, marketing). In some settings such as a regional center (part of the department of developmental services), or a public health department, case management and program management are what RDHAPs are hired to do full time. In sum, RDHAPs have a diversity of practice types, as well as the option of diversifying across traditional and alternative practices to balance their personal, professional and client needs.

The Logistics of Business: The logistical issues RDHAPs face in setting up their business are start-up costs, developing a record keeping system, creating a fee schedule and getting a provider number with Denti-Cal and other insurers. RDHAPs found these logistics to be the more tedious and frustrating aspects of developing their practices. Start-up costs for an RDHAP are far less than what would be required for a stand alone dental practice. However, most RDHAPs need a small business loan to get started as the mobile equipment costs about $25,000. Many providers do custom modifications to their mobile kits to make them more user and patient friendly. The dental equipment companies have reportedly been enthusiastic about working with RDHAPs; however, the equipment currently available is not entirely satisfactory, as one hygienist notes,

> *"A friend of mine went out and purchased the equipment and then we thought, "Oh my goodness. This is heavy. This is too noisy; patients do not like all the noise. I find the mobile equipment quite cumbersome and am waiting for better equipment to be made available."*

RDHAPs can set up their business as a sole proprietorship, or they may incorporate. They can work independently or contract as vendors with public and/or private health organizations and institutions. They need billing numbers, vendor numbers and malpractice insurance, all of which have been challenges to obtain.

> *"We also had trouble getting malpractice insurance. They don't know who we are and we have to send in COMDA. Even though I've had malpractice insurance for years, especially being with a regional center, I had to send you know, all this paperwork. They don't even know."*

If an RDHAP is employed by an organization (such as in a case management or public health program role) they may be paid as an employee. If working as a sole proprietor or corporation, an RDHAP may employ other RDHAPs and staff such as a receptionist or an unlicensed

dental assistant, but they may not employ a registered dental hygienist or any type of licensed dental assistant[xxiv].

RDHAP's are billable providers of clinical services for all major public and private insurance plans, including Denti-Cal. Both RDHs and RDHAPs are now billable providers in FQHCs. Most RDHAPs report setting up their Denti-Cal provider number right at graduation, due to the paperwork and time needed to secure a provider number. RDHAPs can only bill as a sole proprietorship, causing some frustrations with differentiating individual and business income for tax purposes. RDHAPs can legally incorporate with IRS the same as dentists, but the code does not list an RDHAP corporation as billable [xxv]. Many RDHAPs noted struggles with getting payors to recognize them as providers, particularly payors located in other states where RDHAPs do not exist. However, many of the California-based insurers now have RDHAPs in their system, so new providers can more easily get set-up.

Balancing payment sources and setting fees for private pay patients is an area of contention within the RDHAP community. RDHAPs expressed tension between what fees to charge in comparison with one another, in comparison to what they would make (and would be charged to the patient) in a private office, and in comparison to what patients they wanted to serve could afford. One AP states:

> *"Financially I know I'm not charging as much as some of these other people I've talked to, as far as private home visits. I don't know, I'm having an issue with what to charge."*

While RDHAPs do not want to undersell their services they also realize that if they charge rates equivalent to a private dental office they will exclude the very people they are trying to help. Insurance companies have a set rate of reimbursement that varies by insurer and can change over time, adding another layer of complexity.

In order to make their practices work financially, RDHAPs can balance the number of patients they accept from different payment sources and in different settings. A major concern

[xxiv] Laws on the regulation of dental assisting have changed significantly as of January 1, 2008. New laws state an RDHAP may not supervise a licensed dental assistant. http://www.danb.org/main/statespecificinfo.asp#CA
[xxv] Cal. Business & Professions Code §1775 (a) Responsibilities of RDHAPs & Welfare & Institutions Code Section 14132(q)(2)

expressed by RDHAPs is the projected changes in Denti-Cal billing for services provided to elderly residents of nursing homes and long-term care facilities. The Denti-Cal program, in an attempt to emulate private insurance plans (none of which are designed to cover these populations) is proposing restricting the preventive work that can be done for the frail elderly and other at-risk populations. As one RDHAP put it:

> *"Well that's not helping the patients at all. And the presumed care is just going to be worse because eventually that means I really can't see patients more than once a year -- a Medi-Cal patient. And the beauty of RDHAP over the last five or six years is you can see them four times a year and give good, preventive care. And it's amazing how well that has worked. I mean, we have pictures of before and after of at how easy these people get to be as far as agreeing to the treatment and not being combative, and having the treatment done."*

In sum, RDHAPs face many challenges in setting up their businesses, some of which are typical of any small business owner, and some of which are unique to the regulatory and fiscal environment of dental services. As RDHAPs become established some of these challenges may lessen.

Marketing and Building Awareness: RDHAPs are a new provider in the field of dentistry and health care. A major part of the business development RDHAPs are doing is in marketing the services to their local communities. Much of this marketing is simply raising awareness in the dental and medical community, as well as with patients and administrators, as to what RDHAPs are, what they can do and what added value their services can bring. Many RDHAPs noted that "word of mouth" was the primary way they found clients. In communities or institutions where people currently are not receiving any care, the RDHAPs have been a welcome addition.

> *"When I called her [the nursing home administrator], she said, "Where have you been all my life, you know? I didn't even know you did this." And I was in. And I'm still in.*"

Unfortunately, this outreach has not always resulted in positive attention, particularly from local providers who are determined to keep competition away from their dental practices. One frustrated RDHAP sums it up:

> "*And I think that comes down to, again, the fight – who wants to fight the fight. If we market ourselves then someone is going to come out of the woodwork and come up against us. And I know a lot of hygienist APs have said this to me: "I'm working way down here on the radar screen for the purpose of that. I've already run into trouble. I don't want to initiate it again." And it's really unfortunate because there is such a thing as fair trade, you know? And it is*

unfortunate that we feel like we can't go out there and toot our horns and say, "Look, we're providing a wonderful service."

Negative responses have varied and several lawsuits against RDHAPs have ensued. One dental provider mailed notices to every patient in his practice "warning" them about a local RDHAP, and a mobile dental company faxed slanderous leaflets to nursing homes across the states "warning" them against hiring RDHAPs. These tactics have not succeeded in stopping RDHAPs from practicing, but have cost them time and energy – both of which they would have preferred to spend on care provision.

Competition vs. Collaboration in the Business of Dental Care: The final business issue RDHAPs confront is how to develop a collaborative model of business practice within their communities when local dental providers view the RDHAP profession as competition. The business practice experiences of RDHAPs are contingent on the local community structure and resources, their prior relationships with other providers in the community, and the level of support from the institutions within which they work. One woman recounted how positive her experience had been:

"Oh, no, he's [the local dentist] real supportive. He's not in the least bit -- he's been in practice for 30 some odd years and he's getting ready to retire. He thinks I'm doing a wonderful service. He's in no way threatened that I'm going to steal all his patients. Actually, he's going to be getting patients, from my referral… if I get this one residential care facility, one of our patients is there. I plan on giving her the option to see if they still want to take her there, and I'm definitely going to tell him about it. I'm not out to steal anybody's patients. I have not come across anybody who's been negative. I'm sure I will, but all the ones that I've talked to think it's a real good idea. They don't want to see these people -- the people in the nursing homes. They know they've been neglected. A couple of the dentists say how can you stand to do that? I've seen what their hygiene's like…"

Despite some positive experiences, RDHAPs expect to encounter resistance, particularly in the nursing home arena. A woman who had been providing care for nursing home residents for months describes the backlash:

"So one day I come in, and the social services director says, "The dentist was here, and he yelled and screamed and swore at me that you were taking his patients." And I said, "Well you know that's not true. I'm just cleaning their teeth. And I swear to God, these teeth have never been cleaned before. So I'm really not -- " She goes, "I know that, but I don't know what to do, you know?" And I said, "Well, I don't know what you're supposed to do either."

This situation, unfortunately, is a common one, where providers at odds put patients out of options. Not only are RDHAPs losing the business they have developed, but patients who had been receiving regular preventive care return to being neglected.

> *"And we're seeing this on a daily basis and new dentists are coming into the facilities or wherever we are and they're threatening the facilities and saying "If you let that RDHAP come in I will go away and you will not be able to fill your state requirement." So I think a lot of APs are not willing to walk away from that safety home of a dental office and employment to risk their whole entire – everything they've built for their twenty years in dentistry to have some guy come in and put them out of business after they've already invested $25,000 in equipment."*

RDHAPs are very cognizant of their role and their mission. Given the restrictive nature of their practice, both in scope and community type, they do not see themselves as competing with dentists. RDHAPs feel very strongly that developing relationships with dentists willing to collaborate is essential to ensure the provision of restorative treatment to their patients. However, relatively few dentists take any sort of sliding fee, accept Denti-Cal, or work in nursing homes, hospitals or with disabled patients, thus restricting RDHAPs ability to get their patients the restorative dental care they need. This woman working with disabled patients describes a typical situation.

> *"I have a young lady who had a stroke. She's a respiratory therapist and she's got it made at this place. She needs a filling and she's in a huge wheelchair and she can't get to any dental office where I live in my community. We need help with dentists for us to refer to once we're out there and that's a big – we need someone that cares to go out there and do that as well. "*

In communities with an FQHC or some other safety net provider, RDHAPs find it easier to route patients to treatment than in communities with no dentist willing to provide this care. In this case the referral network can be divided between a dental clinic for low income people and a dentist who takes private pay, as this RDHAP describes:

> *"Well, I have a Dentist who I work with at the FQHC, and then I have another general dentist who years ago I filled in for him… I actually contacted his office when I opened my practice and said, "Look, if I have patients that have private insurance or self-pay and I need to send them to somebody and they're not already established would you take these?" And he said, "Absolutely." And I'll tell you, I have sent hundreds of patients. His whole staff takes me out to lunch and they're like, "We just love the patients you send. They're healthy, they're educated."*

In other cases dentists are the ones motivated to find better ways to manage their patients and initiate collaboration with an RDHAP, such as illustrated in this story:

> "A *dentist that I work for right now has five different facilities that he goes to and he needs a hygienist. And he doesn't want to do any of the cleanings. So he talked to me and he said, "Why don't you go and take the course and get your AP? I want to bring you in. I'm going to*

do the dentistry part, do the exams, do the restorations, and I want you to help me out. We'll be in partnership and you do the cleaning."

The possible avenues for productive collaborations that benefit providers and patients are numerous, however they are still in the beginning stages. As the RDHAP workforce grows, a further transformation of care delivery focused on improving access to care for underserved populations in California can be expected.

"I think it has a long way to go, but more and more dentists and the dentist communities in the different counties that I'm in are treating me more as a colleague rather than an auxiliary person. And I think once that is established, and again it's just a matter of time. "

In sum, there is no single career path for an RDHAP; the opportunities for practice are as diverse as the individuals and communities in which they live and work. Like any new business owner, RDHAPs face logistical issues and start-up costs. In order to succeed, RDHAP have developed unique and community-specific ways to practice. Given the small number of RDHAPs in the field, they face a considerable uphill battle in raising awareness among their colleagues, other health care providers, and the broader public, of the services they offer, while still fighting to overcome the historical negativity toward independent practice from within the dental community. RDHAPs have developed many positive, collaborative relationships with dental providers, organizations and patients from which there is great potential to transform access to care in their communities. There is a long way to go, and there are clearly major issues with the structural conditions of practice that impact RDHAPs ability to succeed.

The Structural Environment of RDHAP Practice

Much of the explanation for how any particular RDHAP practice develops can be linked to the motivations of the individuals who enter this practice, the strategies they develop to serve patients, and the business or employment opportunities that exist in their individual communities. What ties these strategies together into a common set of RDHAP practices is the structural environment in which they work, including the legal and regulatory framework, financing systems, other health care and social institutions, and the system of professional education. All RDHAPs share these common elements, although how they adapt within this

structure varies by community. Policy intervention at the state level can have an important impact on the components of this structural environment, and hence, the practices of RDHAPs.

State Laws & Regulations: As outlined in the regulatory review section of this report, there are a number of state laws and regulations that impact practice; who can be an RDHAP, how RDHAPs are trained, where an RDHAP can practice and under what conditions, what an RDHAP can do (scope), and who an RDHAP can bill. This regulatory framework was first codified with the establishment of RDHAP as a licensure category. Since 1998, "clean up" legislation has been introduced and passed to address continuing issues as needed[xxvi].

The RDHAPs in practice feel there are still many details that need to be changed by the legislature in order for them to be able to provide more effective services to underserved patients. The prescription requirement is felt to be an unnecessary administrative hurdle, (it was noted that the medical and dental providers who must provide the "hygiene" prescription are many times annoyed at the administrative paperwork and do not understand why they are being asked for it), as is the documented relationship with a dentist as a condition of licensure. RDHAPs felt that the law places too many restrictions on their practice. They feel that they should be able to work in any setting, all consumers should have a right to their services, they should have the full scope of dental hygiene practice that they are licensed for, and they should be able to prescribe the necessary treatments and medications required to provide comprehensive hygiene care. Some in the public health community feel that an expansion of scope of practice to allow for a few basic restorative services would help RDHAPs better serve patients who have no way to get restorative dental treatment. The rationale for these further modifications expanding the scope of what RDHAPs can do, as well as where they can do it, is to enable them to continue to build practices that are responsive and focused on serving the needs of their communities.

Oversight of the hygiene profession is another issue RDHAPs feel passionately needs to change, and they favor instituting a mechanism of state regulation specific to hygiene.

[xxvi] See Legislative Review Section for full history

> *"I feel that a board or a committee, or whatever you want to call it, is needed for oral hygiene for hygienists. This board should set the standards for hygienists and make sure they follow them to the best of whatever system we can develop. It's a tremendous policy issue."*

The current regulatory requirements for RDHAPs are a means of consumer protection. State boards are the entity legally required to enforce these protections, not other health care professionals (such as employers). It is particularly problematic to have one profession with a stake in the terms of employment of another profession also to regulate that profession, as is the history in dental hygiene. Binding RDHAP (or RDH) practices to the dentist sets up a dynamic where political actions are focused on regulating the terms of employment under the guise of consumer protection or quality of care.

> *"I think oversight is a big, big issue. And oversight for dentists stinks. Oversight for hygienists doesn't exist. If you think that the dentists are supposed to be providing oversight in the office are doing that when they don't even know what they're doing, you know, what the hygienist is doing, -- they don't allow us -- when I clean a person's teeth that has subcalculus and pockets, and we're not going to send them to the periodontist, I would like to see them in one month to see whether what I did worked. You cannot do that. So I have never been able to see the fruits of my own labor except when I go into the nursing home. It may not be economically feasible, but at least I'm learning whether or not I am actually producing –hygienists do not know what their outcomes are."*

The Dental Board of California (DBC) delegates the licensing function of hygienists to COMDA, but the complaint and disciplinary functions rest with the Board. When requested, the DBC could not provide data that differentiated among the complaints filed against the different types of dental professionals the board regulates. Therefore reporting how RDHAPs compare to the other dental professions is impossible.

> *"it's just absolutely important that a group who has a certain scope of practice be in control of that scope and be able to monitor their own licensees for the good of the public. And I think that's a tremendous issue. And how it has gotten to this point, you know, power and money speak a lot, but, you know, who's going to speak for the consumer down there and make sure that our own people are practicing to the extent that they promised to do."*

The process of continuing to modify and improve the legislation and regulation surrounding practice is a contested area, with opposition lining up along the traditional division between dentistry -- which prefers to restrict the practice of other professions -- and dental hygiene -- that seeks to expand the scope and reduce the supervision requirements of their practice. Both professional groups acknowledge the problem this contentious history is causing when trying to move forward:

> *"I don't believe that the fear and feelings that dentistry needed to be threatened by what may happen with hygiene exists in any way to the degree that it used to. And I think with that has come a much greater openness to reacting with an open mind about alternatives. And whether they really do make the most sense for the patient, as opposed to whether it just is something that we like or hygiene likes. But is this going to be the best way to get care to patient. If I ever see a day where leadership within hygiene and leadership within dentistry truly acknowledge the -- are actually respectful of one another's roles and approach discussions with an open mind and not in a fear-based way, I would say -- what that would do to really facilitate the collaboration would be tremendous."*

Both representatives of the dental and hygiene associations that I interviewed see access to care as an important issue to address and acknowledge each other's roles, however they continue to be unable to agree on a common strategy of action to address the problem.

State Financing of Dental Care: A second area of structural constraint is the pubic financing mechanisms for dental care through Denti-Cal, Healthy Families and FQHC payment systems. These payment systems are essential for the patients that RDHAPs treat. Whether an elderly patient in a skilled nursing facility on Medi-Cal, or a migrant farm worker receiving treatment at a FQHC, or a pregnant mom trying to get herself and her kids' dental needs addressed, these payment systems are essential to connecting underserved patients to the care they need. Ensuring that treatments and procedures that patients need are covered is of great concern to RDHAPs. The current financing system is inadequate, and what does exist is oriented to support private dental practices or clinics, not comprehensive preventive care. The vulnerability of these already fragmented and under-funded systems to political whims and budget negotiations is an area of serious concern. Indigent, medically compromised, or otherwise disabled patients must have, at minimum, a basic financing system to help them access both preventive and restorative dental care.

The Health Care Environment and Care Delivery Systems: A third structural issue affecting RDHAP practice is the organizational environment of the care systems they work with. While RDHAPs are "independent" providers, this independence refers only to supervision by a dentist. In fact, almost all RDHAPs are working in some capacity within complex institutional setting such as schools, long-term care facilities, residential care homes, FQHC clinics, grant or state funded public health programs, state prisons or wards, hospitals, skilled nursing facilities and regional centers. Each of these institutions has its own set of rules, customs,

certification processes, payment and patient tracking systems, as well as administrative and professional staff. RDHAPs are new to many of these organizational environments, and are creating working relationships that must bridge a professional and institutional divide that has traditionally kept dental care separated from the rest of health care.

As RDHAPs create new systems of integrating dental services into these institutions, it will be inevitable that rules and regulations will need to adjust to accommodate a new set of services and interactions. RDHAPs can help reformulate guidelines to make sure patients are not neglected and that health outcomes, not simply regulatory checkboxes, drive the decisions care givers and administrators make, as this AP explains:

> *"The MDS report is the guideline the nursing homes follow for the health of the patient. On admission, within the first 14 days of admission, all of these different things -- their diet has assessment, and if they can't feed themselves. If they can walk. If they need assistance in their bowels, or anything. And there is supposed to be a dental assessment within the first 14 days of admission. And that has never been done. I've never seen it done. Not since I started. And then if they haven't been to the dentist within the last six months, they are supposed to have a dental exam. And then every year thereafter. The MDS report on oral care should be extended in the dental category. The dental hygiene should be separate from hygiene care. It should not be whether they shaved that day and washed their hair and brushed their teeth. Dental care should be separate. It should be its own separate part in the MDS report."*

As RDHAPs gain more experience working across a variety of settings they will be a valuable resource for administrators and policy makers for their insight in how to incorporate oral health into institutional care delivery systems. Those who are working with homebound patients can be a source of referral for all sorts of services these homebound patients may need. RDHAPs have a skill-set of prevention-oriented dental care that is transportable across care delivery settings. This allows them to play a facilitative role in community health, adding value far beyond just the hygiene services they provide. In this example, an RDHAP describes how she helped severely disabled adults achieve better dental health:

> *"They're wards of the state, and they're disabled adults who can't live anywhere else; in group homes, or in their own home. They've tried everything. And they're really severe cases. I mean they are a danger to themselves and others. And they didn't want any part of going to the dentist. And they started this project with my practice in this one state developmental center so that -- too see how well it would work because they still have to take them out to the dentist somewhere. But by me being there, I'm there once or twice a month and I see as many people as I can that day, and we've got them all cleaned up, and they all now come in and sit down and open their mouths and we have a good time. And then when they go to the dentist, they're very good patients. They'll sit and have their work done."*

In sum, working across a variety of institutional and organizational settings in the community is both a challenge and a great opportunity for RDHAPs. While RDHAP practices are expanding access to care, they are also stimulating new collaborations, which is opening up new avenues to improving access to oral health care.

Professional and Continuing Education: Dental hygienists are educated at the upper division level in community colleges as well as four-year colleges. Either an associate or baccalaureate degree will qualify a graduate for the RDH license. All of these programs focus on educating hygienists for the private dental office environment.

> *The way that dental hygienists developed in California in the community colleges, it's a four-year program for which somebody gets a two-year degree. And focusing on the clinical as much as we do in some schools, instead of the bigger picture in terms of health outcomes-- it's a problem in education in general is that we tend to compartmentalize.*

The existence of a differentiated education system without differentiated practice is similar to the situation that nursing has struggled with for many years. The RDHAP provides a level of differentiated practice, as the current requirements for the RDHAP are higher than what an RDH requires. The current RDHAP education programs however, are not degree-granting programs, which some feel they should be, given the effort it takes to complete the curriculum.

> *"It's a certificate of continuing education, and I can tell you I've put in a lot more than 144 hours. That degraded what I had done and all the effort that I had put into it, and that to me was really, really frustrating."*

Also, the practice requirements (2000 hours in the last 36 months) for licensure restrict some qualified RDHs (those working in public health for example) from receiving an RDHAP license due to lack of clinical hours. Some practitioners felt that waivers for this clinical competence requirement should be provided. Others felt that more advanced education at the master's degree or higher should be provided for hygienists wanting to go on to roles in research and education.

Both education programs have been adapting as quickly as possible to the changing laws, financing rules and equipment available in order to best provide their students with all the information they need to practice. Each program must follow guidelines on the basic curriculum, but they structure the experience differently. The WLAC program meets in

person several times a year[xxvii], while the UOP program primarily a distance education program, meeting only at the start and end of the program. Balancing the curriculum content to meet the needs of students who will end up going into such diverse settings has been challenging for the programs.

RDHAP education programs have plenty of capacity for the current level of interest in the licensure category. The first few classes were the largest due to the backlog of demand for the program. Enrollment has evened out at around 10-20 students per class. It is not known whether interest in the program will grow as more providers graduate and develop awareness of the versatility of RDHAPs practice opportunities. RDHAP alumni resources include annual symposiums and regional meetings, as well as numerous dental and hygiene association meetings. The California Dental Hygienists' Association (CDHA) has also created a set of resources for RDHAPs, providing the current students and graduates access to helpful information and guidance as they set up their practices. The California Dental Association (CDA) has opened up an auxiliary membership status (not full membership) to all allied dental occupations, which includes RDHAPs, and has extended offers of assistance in finding dentists for RDHAP patient referrals. However, due to the contentious history between the CDA and CDHA, most RDHAPs remain suspicious of these efforts.

All of these structural systems are important in California, as they are a model for other states trying to implement similar measures to address the preventive dental care needs of their populations. This is happening on an informal basis already, as one AP notes.

> *I get people to call me back and I get calls from all over the country of different states that want to get started and why they want to do it, and how to get started. And then when they get their first patient they call me back and they're so happy to be doing what they're doing.*

California has been at the forefront of innovation in many fields, but in health care and technology in particular. RDHAPs have adapted to the constraints they are given, but as preventive care providers, they can only work on one end of the spectrum. The State should ensure that all constraints on practice balance ensuring the safety of the public with improving to access to affordable and quality health care.

[xxvii] Originally, the WLAC program met every three weeks for a 3-day weekend class. The implementation of internet technology has reduced the meetings required and shifted some of the learning to online format.

In summary, there is tension between the needs of individuals in communities, and the structural constraints on providers seeking to meet those needs. These interviews reveal a general consensus among practicing RDHAPs that there are barriers in place that prevent them from being able to provide the level of care that they are capable of providing. A number of regulations seem to be unnecessarily constraining practice, neither protecting the public's safety nor enhancing access to services, and in fact may be working against the public's welfare on both fronts by limiting their consumer choices. Financing care is an endemic problem for all underserved populations. RDHAPs, unlike dental practices with much greater overhead costs, have been successful within the constraints of the existing payment systems. However, if these financing systems are further constrained, this situation may change. When the benefits of RDHAP services become more recognized across a variety of other institutions, there will inevitably emerge a number of new avenues for innovative solutions to improving access. The RDHAP educational system will need to continue adapting to the changing needs of these practitioners as they create pathways for positive change.

Conclusions

The simple answer to the question, "are Registered Dental Hygienists in Alternative Practice (RDHAP) increasing access to care?" is yes. The combination of professional independence and a required focus on underserved populations is powerful in both motivating and structuring RDHAP practice. Their professionalism is central to their success. "The ideology of professionalism asserts above all else devotion to the use of disciplined knowledge and skill for the public good."[28] RDHAPs embody this devotion. The diversity of strategies employed by RDHAPs in developing their practices has opened up multiple pathways to creating and improving access to dental care. These include but are not limited to:

- Reaching out to individuals and communities who need care but can not get to a dental office;
- Creating new consumer choices for preventive treatments and services;
- Providing services in settings and at times that are convenient for patients;
- Decreasing the fear of dental treatment in people who are not used to having their dental care needs addressed, through a gradual introduction to dental procedures;

- Providing referrals for dental care for patients needing restorative treatment;
- Developing collaborative practice models with dental, medical and nursing professionals in a variety of settings;
- Developing data collection systems to track patient outcomes with the goal of showing how dental hygiene care can lead to improvements in oral health and overall health;
- Educating individuals, families, care givers and health providers on the basics of oral health and dental hygiene, and on oral health's connection to overall health and well-being.

The lack of access to dental care in California has created enormous need in populations that are underserved by the traditional system of care. RDHAPs are "social entrepreneurs," using entrepreneurial principles to create and manage a venture of social change, and measuring the impact of their success not only in profit and return, but in the impact on the health of their communities. By doing this, they are truly innovators, using their skill and passion to repackage oral health services to reach some of California's most vulnerable citizens.

Improving access to care, however, is not an undertaking that a profession with a limited scope of practice can do alone. The *independence* of RDHAPs as providers allows them the freedom and flexibility to reach out to patients in new and creative ways. To transform these innovations into comprehensive care delivery for patients, new *collaborative practice* models, with dental, medical, and other caregivers are needed. Many of these models are beginning to emerge in California, but much work remains to be done in both regulating practice and financing care. Meeting the challenge of transforming the system and reconnecting oral health with overall health will require a professional commitment to ensuring a high quality workforce, a regulatory environment flexible enough to allow for innovation, and a care delivery system that is consumer-responsive and affordable.

A central element of success of the RDHAP experience in California is the community-responsive and patient-centered strategies employed. National efforts to develop new models for the dental workforce should carefully review the experiences of RDHAPs. The process of

development of a new provider type, from legislative efforts, to developing education, to implementing practice holds many lessons for similar efforts in other states as these are necessary parts of any overall effort to improve the oral heath status of the nation.

Recommendations

Policy Framework

RDHAP practices provide great insight into both the care providers and underserved people who populate the oral health landscape. The sheer complexity of this landscape indicates many levels on which public policy may have an impact, and likewise, may be improved. To guide policy making toward improvements in access to dental care it may be helpful first, to provide a framework for thinking about the direct and indirect impact of policy on access to care, and second, to provide specific examples in several policymaking areas that exemplify strategies that can be employed towards this end.

Reform is needed in dental care for all the same reasons as health care reform is needed. The cost of care is high, access is problematic, and quality of care in dentistry is difficult for any consumer to determine. As policy-makers decide on funding, regulation, legislation and education they must consider whether the reforms they implement actually help people obtain affordable, accessible, and quality care. Alternative care delivery models such as the RDHAP are *essential* to improving oral health and reducing health disparities in California's diverse population. *Public policy should create an environment that supports innovation and creativity, has flexibility to meet needs, focuses on prevention-oriented solutions, and enhances consumer choice while ensuring consumer protection.*

The current policy environment is filled with incentives (statutory, regulatory, financial, educational, etc.) geared toward maintaining and sustaining the existing dental delivery system – a system not equipped to address the problems of cost, access and quality. Continuing to do more of the same is not going to solve these problems. Alternative models of care are needed. For these alternative practice models to succeed, the incentive structures

must adapt to support the new models of dental care. Incentives should encourage innovations in care delivery, as well as collaborative, patient-centered health care models that can be responsive to local communities and populations.

This study's findings indicate that the policy change that allowed for independent hygiene practice has succeeded in spurring innovations in care delivery and improvements in access to dental care. However, many restrictions on alternative practices remain which prevent more Californians from benefiting from these services. Further policy modifications could continue to reduce barriers to alternative practice, and enhance the workforce and financing available for care delivery.

Recommendations: Regulatory Systems

State laws restricting the provision of health care services are beneficial only when there is a clear need for public protection. Some of the current restrictions on RDHAP practice do not provide any clear consumer protection or contribute to the health of the public. Rather they place unnecessary limits and administrative burdens on practice, and restrict consumer choice. To help improve regulatory systems, policymakers should work to:

- Remove the mandated referral agreement as a condition of licensure for RDHAPs. Licensure should be granted based on qualifications. There is no precedent for requiring a practice agreement for *licensure,* nor for services delivered *within a professional's own scope of practice;*
- Remove the prescription requirement for dental hygiene services provided by RDHAPs. In practice, this is simply an administrative hurdle, time consuming for providers, and has not been shown to contribute to positive patient outcomes. Patients should have their choice of dental hygiene care provider, and the public should not need a prescription to receive *basic preventive care*.

It would be beneficial for state policy makers to continue to explore avenues (such as new health workforce pilot projects) for expanding the capacity of the allied dental workforce (including RDHAPs, dental hygienists and dental assistants) to facilitate more efficient and accessible care.[29] Any new models should be based on proven competency; therefore some

expansions would require additional training, while others would not. Examples of possible expansions of RDHAPs scope of practice might include:

- The duties of an RDH that they are already trained to do, but which currently require direct supervision (and hence are not within the RDHAP scope);[xxviii]
- Atraumatic restorative techniques (ART);
- Placement of glass ionomer fillings;
- Extractions of deciduous teeth.

To facilitate the expansion of options for increasing the capacity of the workforce, policy makers should *reform the system of reviewing proposed changes to scope of practice*.[30] Many of the issues brought to the attention of the legislature regarding dental practice are the result of the tension between the state dental society and the state dental hygiene society (or dental assisting society) around supervision, scope of practice and allowable duties. Pilot studies have consistently shown that high quality care can be achieved in expansions of scope of practice for the allied dental workforce,[31] yet concerns about quality of care are employed by organized dentistry to maintain strict requirements over allied personnel. Legislators in the middle of this professional turf battle have few objective resources at their disposal to help them understand the real costs and benefits for their constituents. To remedy this:

- Appoint an independent committee to review and make recommendations to the legislature on scope of practice matters, as has been done successfully in many other States and countries.[32]
- Develop competency based practice models that are more flexible and responsive than the current silos of professional practice that restrict health care from being responsive and adaptive.[33]

In addition to changing the administrative process for deciding on scope of practice and supervision matters, the state might restructure professional boards in a way that allows each profession to regulate members of their own profession to ensure the safety of the public.

- Dental hygiene, including RDHAPs, should be self-regulating. It is inherently a conflict of interest for the dental profession (which employs hygienists and thus has a significant stake

[xxviii] http://www.comda.ca.gov/lawsregs/dutytable3-20-06.doc

in reducing the autonomy of hygiene) to regulate the hygiene profession. Dental hygiene practitioners should be regulated by their own board or bureau, as has been proposed in the past few legislative sessions.

- California should work with other states to encourage reciprocity across state lines for all new models of the dental workforce, including but not limited to the Advanced Dental Hygiene Practitioner being developed in Minnesota [xxix] and the Dental Health Aide Therapist developed in Alaska.[14]

Recommendations: Financing Systems

A solid financing system is necessary for building any alternative models for dental care, as shown by the number of RDHAP patients who depend on Denti-Cal as an insurer or require lower cost or free services supported through grant funding. This funding should complement, not replicate, the private financing system, as the private system does not cover any of these vulnerable populations. Current funding structures need enhancement to ensure access to care for our most vulnerable populations.

- Denti-Cal needs to focus on meeting the needs of the population it serves, as well as the providers that it pays. Cuts in adult benefits have been shown to result in decreases in provider participation and patient utilization, resulting in extreme pressures on FQHCs and other clinics, and exacerbating unmet oral health needs.[34] The State can solidify its commitment to supporting access by strengthening Denti-Cal to support the dental health care needs of underserved populations.
    - The proposed cuts to adult Denti-Cal would decimate the RDHAP services now provided to our State's most vulnerable populations. Enhancements, not cuts in services are needed, particularly for preventive services.[35, 36] If the State cuts these basic preventive services, they will pay much more in treatment later on.[37]
    - Denti-Cal should expand reimbursement to RDHAPs for non-clinical services such as case management, health education and prevention services. These services are essential to RDHAP practice specifically, but also to the development of alternative oral health delivery systems in general.

[xxix] https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S2895.1.html&session=ls85

- The state should support new funding mechanisms such as AB 363/SB400 which allow FQHCs to bill for services provided outside their four walls. Because RDHAPs are mobile, they can treat individuals who are homebound and institutionalized. Legislation that allows for flexibility in payment will enhance flexibility in treatment locations.
- RDHAPs should be able to bill for their services as a corporation, as is common for dentists to do, not just a sole proprietor. This will allow RDHAPs to separate business and personal income for tax purposes.

Recommendations: Quality Improvement and Research

More research is needed to determine the most efficacious and appropriate treatments for health outcomes in vulnerable populations, and help define appropriate benefit levels. Efforts to systematize patient information and outcomes are needed. Dental insurers use a model of insurance based on the expectation of a healthy middle-to-upper income person. This model does not apply to many of the underserved populations that RDHAPs and other safety net providers work with.

- Tracking health outcomes from dental treatment is almost impossible due to the separation of financing and patient record systems between dentistry and medicine. Electronic information systems have been the backbone of many quality improvement initiatives. Recent research calls for better integration of these systems in order to reduce health disparities.[38] RDHAPs in some settings are in a position to begin re-integrating dental records into the medical patient record.
    - Denti-Cal participants are also Medi-Cal participants. While currently separate systems, they could be integrated. If the State were to integrate them, it would be in a unique position to develop a comprehensive data infrastructure able to track expenditures, utilization, diagnoses and health status, leading to an unprecedented research capacity for quality improvement (i.e. examining savings on health costs for diabetes resulting from treatments of dental disease).
- Policy makers might consider incentives for the oral health community to develop better measurements of quality of care that include health outcomes measures and track patient outcomes. Consumers have no resources from which to judge the quality of their dental

practitioner and hence have no information from which to make an informed health care choice.

Recommendations: Care Delivery System

The State should encourage new models of collaborative practice with a variety of new alternative providers such as the RDHAP. These collaborative models can exist across all levels of dental practice, but also across many medical and other care delivery models in the state. Having multiple models of care delivery provides actual options for consumers – convenience of location, choice of provider and ability to access basic preventive dental care.

RDHAPs have shown that more attention needs to be given to dental services provided in health care institutions. Regulation within health care industries, particularly long-term care and skilled nursing facilities, should include more specific standards and care delivery options for the provision of oral health care.

- RDHAPs should be eligible to fulfill the Title 22 provider requirement for a dental program in nursing homes. RDHAPs are well suited, both in skill set and practice model, to be on-site primary dental care practitioners providing preventive and educational services in these settings. In addition, RDHAPs can work as dental case managers for nursing home residents, working with administrators to develop referral networks of local dental providers to ensure avenues for necessary restorative and surgical treatment, and dentures.
- As has been suggested by a statewide taskforce on oral health for aging Californians, policy should support the development of new collaborative models of providing services in institutions such as long-term care settings, using new technology and practice arrangements.[39] One such pilot project is currently underway, funded by the San Francisco Foundation and run by the California Dental Association Foundation.[40]

Recommendation: Workforce Development

Ensuring a high quality workforce will be essential to expanding alternative models of dental care. Regulatory and financing systems will need to be flexible to be able adapt to these new models and support them, and the education system must be able to respond by providing the skills and competencies to new graduates so they are prepared to work in multiple settings.

- RDH programs are primarily located in community college settings, restricting the ability of educators to train the dental team together. New models of dental and hygiene education should be developed which provide training for teams of dental practitioners who can work collaboratively in a variety of health care environments.
- Medical and nursing education needs to have more oral health curriculum, and there needs to be more interdisciplinary educational models to ensure that oral health is not neglected by medical practitioners.
- Much policy discussion focuses on education and practice strategies to encourage doctors and dentists to work with underserved populations. In the case of RDHAPs it is a practice requirement. A set of similar mandates for dental practitioners may go a long way towards improving access to the restorative and surgical treatments needed by many underserved populations.

The preceding recommendations are just a sampling of key issues that need to be addressed if policymakers want to continue to support the success of alternative practice hygiene as well as create an environment that allows for future innovations in care delivery. Most of these recommendations echo previous studies' findings, as indicated throughout in the references provided. With out innovations, lack of access to care and disparities in health outcomes are sure to remain problems for many Californians in the future.

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Appendix 1: Glossary of Acronyms

ADHA	American Dental Hygienists' Association
CDA	California Dental Association
CDB	California Dental Board
CDHA	California Dental Hygienists' Association
COMDA	Committee on Dental Auxiliaries
FQHC	Federally Qualified Health Center
HMPP	Health Manpower Pilot Project (renamed HWPP, Health Workforce Pilot Project)
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienists in Alternative Practice

Appendix 2: Documentation of Relationship Form

DOCUMENTATION OF RDHAP RELATIONSHIP WITH DENTIST

RDHAP Name:_____

Address:_____

City/State/Zip:_____

RDHAP License Number:_____

Pursuant to Business and Professions Code Section 1775(g), I have an existing relationship with at least the following dentist for referral, consultation, and emergency services:

Dentist Name:_____
License Number:_____
Address:_____
City/State/Zip:_____
Telephone Number:___(_____)_____

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____ _____
DENTIST Signature Date

_____ _____
RDHAP Signature Date

Pursuant to California Code of Regulations Section 1090.1, the dentist's license must be current, active and not under discipline by the Board. An RDHAP must report any changes to the Board, in writing, within 30 days following such change.

THE DHCC 2017/18 SUNSET REVIEW REPORT

SECTION 12 - ATTACHMENT I:

DHCC Year-end Organization Charts for the Last Four Fiscal Years:

FY 2014-15

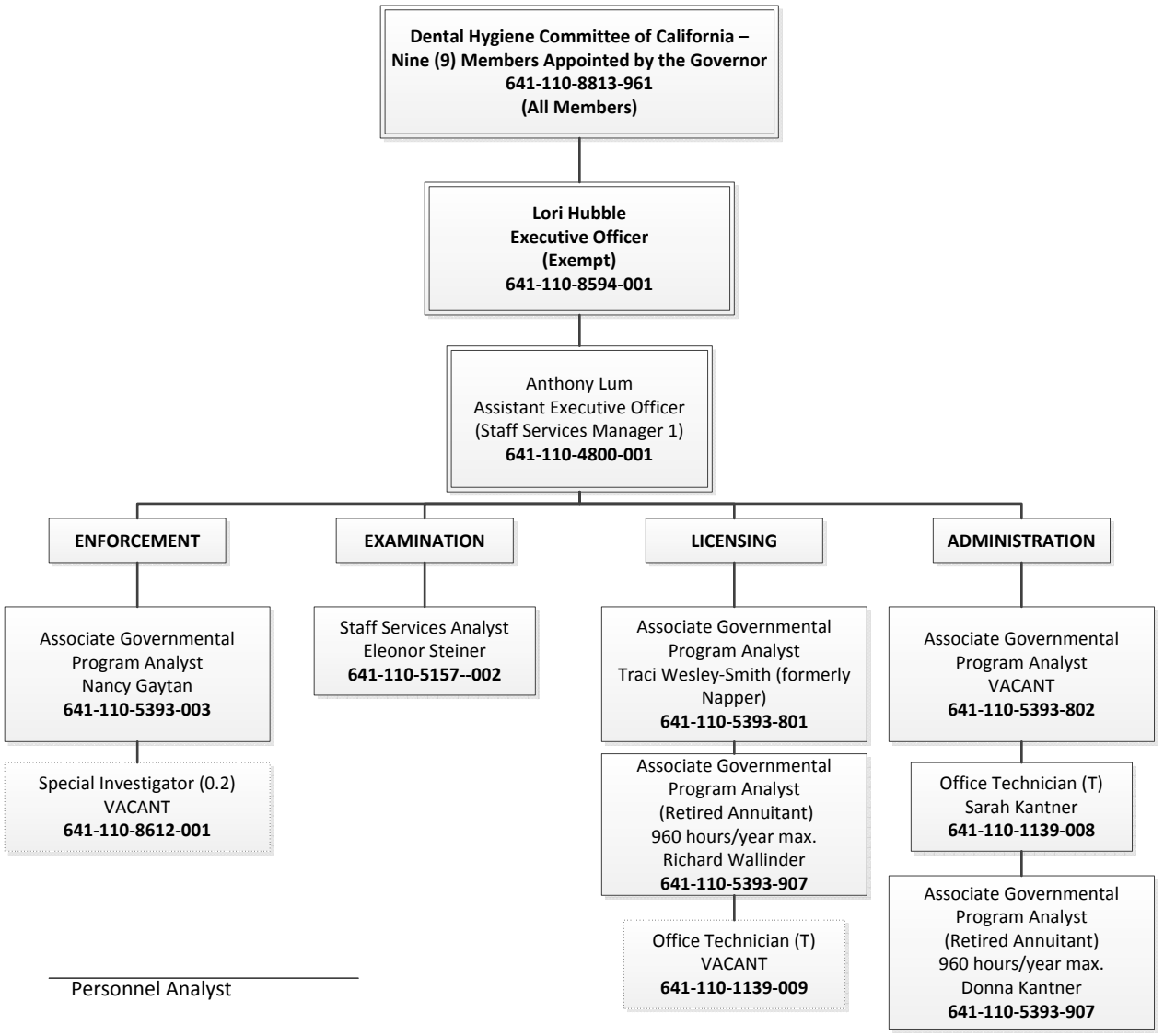
FY 2015-16

FY 2016-17

FY 2017-18

CURRENT ORG CHART
FY 2014-15
July 31, 2014
8.2 Authorized Positions

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE COMMITTEE OF CALIFORNIA



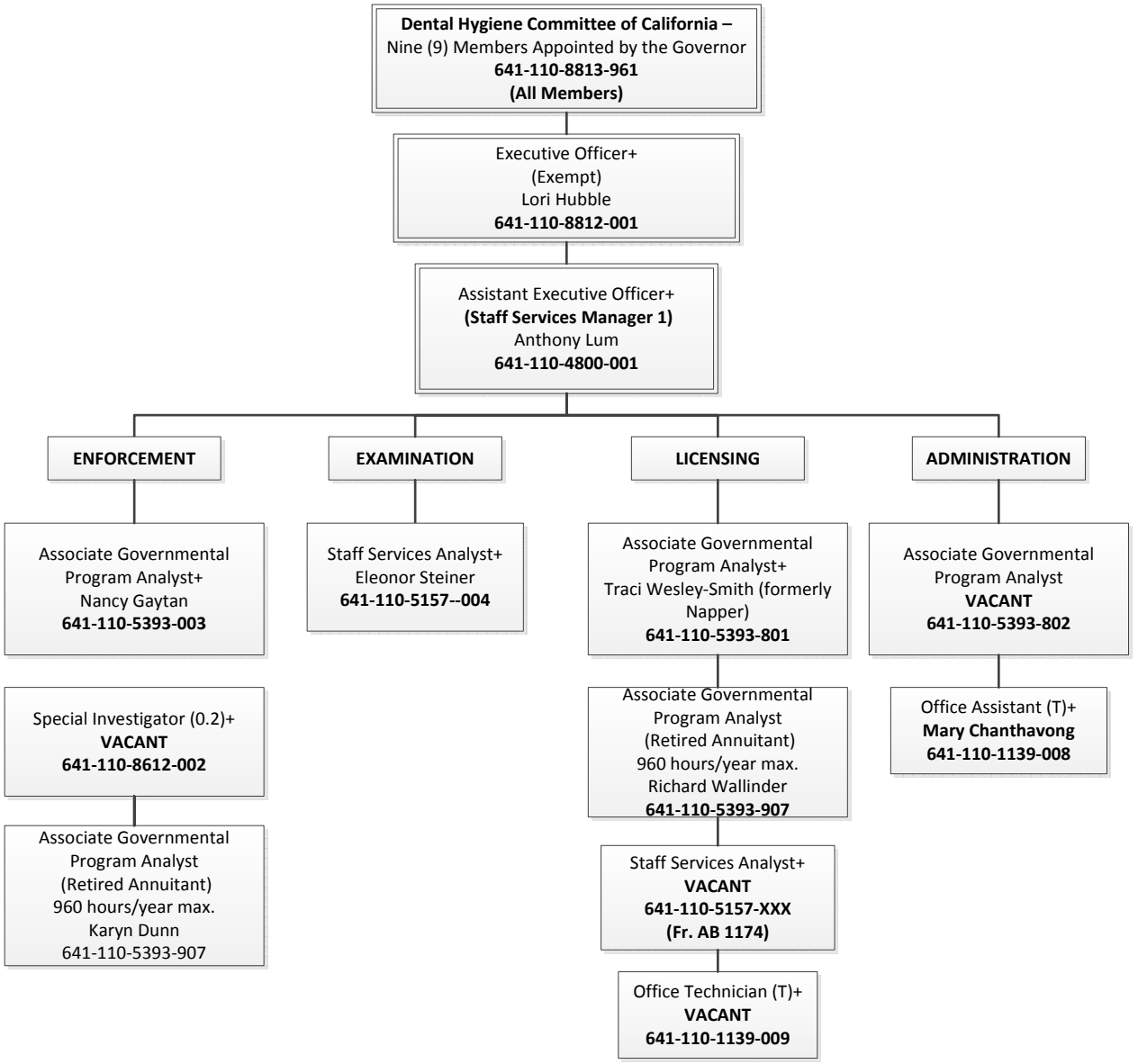
Lori Hubble, Executive Officer

Personnel Analyst

CURRENT ORG CHART
JANUARY 1, 2016

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE COMMITTEE OF CALIFORNIA

FY 2015-16
Authorized Positions: 9.2



Lori Hubble, Executive Officer

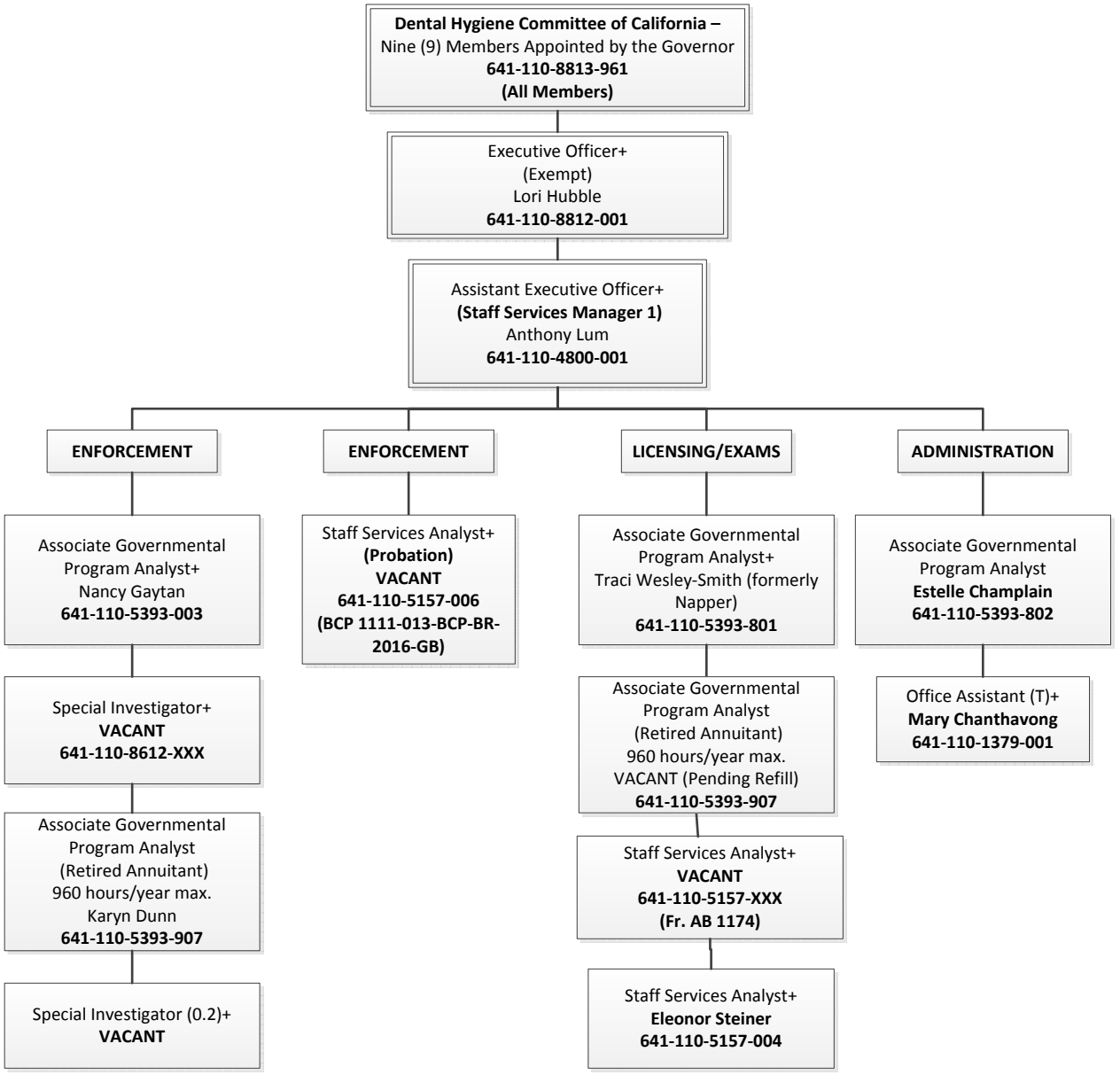
Personnel Analyst

(+) CORI Positions (Fingerprint Clearances Required)

CURRENT ORG CHART
JULY 1, 2016

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE COMMITTEE OF CALIFORNIA

FY 2016-17
Authorized Positions: 10.2



Lori Hubble, Executive Officer

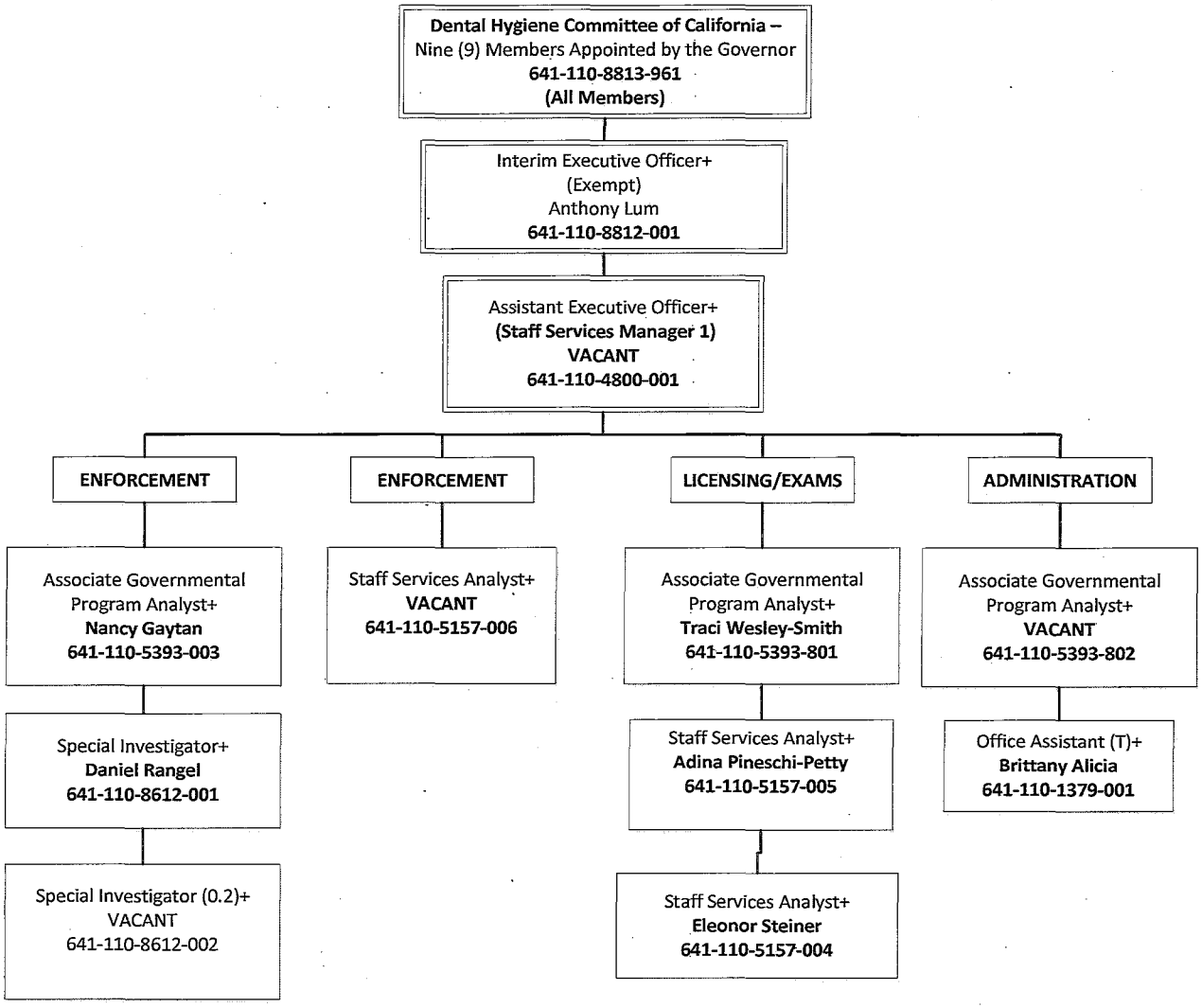
Personnel Analyst

(+) CORI Positions (Fingerprint Clearances Required)

JANUARY 1, 2018

DEPARTMENT OF CONSUMER AFFAIRS - DENTAL HYGIENE COMMITTEE OF CALIFORNIA

CURRENT ORG CHART
FY 2017-18
Authorized Positions: 10.2



Anthony Lum, Interim Executive Officer

Personnel Analyst

(+) CORI Positions (Fingerprint Clearances Required)

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Items 11 - 14
Subcommittee Meetings:

Education
Enforcement
Licensing & Examination
Legislative & Regulatory

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 15

Closed Session

The DHCC may meet in closed session to deliberate on disciplinary matters pursuant to Government Code § 11126 (c)(3)

Friday, November 17, 2017

Dental Hygiene Committee of California

Agenda Item 16

Recess until Saturday, November 18, 2017 at 9:00 a.m.