BACKGROUND PAPER FOR THE Dental Hygiene Committee of California

(Oversight Hearing, February 26, 2018, Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions)

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA

BRIEF OVERVIEW OF THE DENTAL HYGIENE COMMITTEE OF CALIFORNIA

History and Function of the DHCC

The Dental Hygiene Committee of California (DHCC) regulates three categories of mid-level dental professionals: registered dental hygienist (RDH), registered dental hygienist in alternative practice (RDHAP), and registered dental hygienist in extended functions (RDHEF).[1] DHCC is also responsible for approving and overseeing RDH, RDHAP, and RDHEF educational programs.

While statutorily under the jurisdiction of the Dental Board of California (DBC), DHCC functions as an independent committee and has the sole authority to regulate all aspects of dental hygienist licensing and enforcement, including approval of education programs. DHCC's statutory mandate 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."[2]

The DHCC's mission statement is as follows:

> ***The DHCC licenses, enforces and regulates the Dental Hygiene professionals to protect the public and meet the oral hygiene needs of all Californians.***

The practice of dental hygiene includes dental hygiene assessment and development, planning, implementation of a dental hygiene care plan, health education, counseling, and health screenings. Dental hygiene does not include diagnosis or comprehensive treatment planning, placing or removal of permanent restorations, surgery, prescribing medication, or administering anesthesia or conscious sedation.

[1] Dental assistants (DA) and registered dental assistants (RDA), lower-level dental auxiliaries, are regulated by the Dental Board of California (DBC).

[2] Business and Professions Code (BPC) Section 1900

The hygiene and dental assisting professions were previously regulated by the DBC through its Committee on Dental Auxiliaries (COMDA), established by the Legislature in 1974. However, COMDA was criticized by the Joint Legislative Sunset Review Committee (JLSRC) in 2001 and 2003 for its longstanding failure to effectuate its mandate to "permit the full utilization of dental auxiliaries in order to meet the dental care needs of all the state's citizens."[3] A central flaw of COMDA was that it did not have independent authority to regulate dental auxiliaries – it made recommendations to DBC -- and COMDA's efforts to promote the use of auxiliaries were regularly stymied by DBC's dentist majority. As a result, the JLSRC recommended that the Legislature consider making COMDA into an independent licensing agency for dental auxiliaries if DBC continued to advocate only for dentists' interests.[4]

The Legislature tried to create a separate regulatory body in 2006 (SB 1472, Figueroa) and 2007 (SB 534, Perata), but it wasn't until 2008 (SB 853, Perata, Chapter 31, Statutes of 2008) that DHCC was created with the mandate "to permit the full utilization of RDHs, RDHAPs, and RDHEFs in order to meet the dental care needs of all the state's citizens."[5] This bill also eliminated COMDA and continued the regulation of dental assistants through the DBC, with recommendations from a newly-created Dental Assisting Council.

Board Composition

DHCC is composed of nine members, all appointed by the Governor. There are four public members and five professional members, one of whom is required to be a practicing general or public health dentist licensed in California. Of the four RDHs, one is required to be either a RDHAP or RDHEF, and one is required to be a dental hygiene educator. The public members are prohibited from being licensed by either DHCC or DBC for five years prior to appointment and must not have any current financial interest in a dental-related business.[6]

The current members are as follows:

Name and Background	Appointment Date	Term Expiration Date
Susan Good, Board President Ms. Good has been the president of Susan Good Consulting, which advises businesses on marketing, sales, management, government advocacy, media and event planning issues, since 2010. Her public service includes positions as the district director for California Senate Majority Leader Dean Florez (2002-2010), Senator Jim Costa (1996-2001), and Principal Consultant for Assembly Speaker John Perez (2011-12). She also served in various positions at the 21st District Agricultural Association-Big Fresno Fair, including as director and president from 2001-2005. Her private sector experience includes serving as the senior vice president of marketing and compliance for Bank One from 1988 to 1996, and in multiple positions at Coast Savings and Loan from 1978-1998, including vice president, branch manager and director of advertising.	April 5, 2013	January 1, 2018

[3] BPC 1740
[4] COMDA Background Paper for the Joint Legislative Sunset Review Committee, 2003.
[5] BPC 1900
[6] BPC 1903

Nicolette Moultrie, RDHAP, Board Vice President Ms. Moultrie has been teaching dental hygiene as adjunct faculty at Diablo Valley College and Chabot College since 2013, and has been an owner and RDHAP at Strategies for Healthy Smiles since 2008. Prior to these positions, she was program manager and clinical supervisor at the Contra Costa County Health Services Children's Oral Health Program from 2007 to 2013, project liaison for the Contra Costa County Regional Medical Center's Fluoride Varnish Project from 2010 to 2012, and a RDH in private practice from 2000 to 2009. Moultrie earned a Master of Science degree in dental hygiene from the University of California, San Francisco.	January 15, 2014	January 1, 2018
Edcelyn Pujol, Board Secretary Ms. Pujol has been a financial advisor at Frontier Wealth Strategies Inc. since 2012. She was previously a financial advisor at Northwestern Mutual from 2010 to 2012, and a financial planner at Sampson Investment Management from 2006 to 2010. Ms. Pujol is a Certified Financial Planner and a member of the Filipina Women's Network.	January 25, 2016	January 1, 2020
Michelle Hurlbutt, RDH Ms. Hurlbutt has been dean of dental hygiene at West Coast University since 2015, where she also serves as an associate professor. Prior to this, she was an associate professor at Loma Linda University from 1999 to 2014. Ms. Hurlbutt earned a Doctor of Health Science degree from Nova Southeastern University and a Master of Science degree in dental hygiene education from the University of Missouri, Kansas City.	January 6, 2016	January 1, 2020
Joyce Noel Kelsch, RDHAP Ms. Kelsch has been the program director at Cabrillo College since 2017. She has also been the owner at Noel Brandon Kelsch, RDHAP since 2008. She has also been an infection control columnist at the Registered Dental Hygienist Magazine and an international speaker and consultant since 2002.	January 6, 2016	January 1, 2020
Sandra Klein Ms. Klein has been the executive director at the Congregation B'nai Israel since 2001. Prior to this position, she was the executive director at YMCA of Orange County from 1997 to 2001, a managing provider for support services at Initiatives for Children from 1994 to 1995, and director of the Evelyn Rubenstein Jewish Community Center of Houston's Family Parenting Center from 1986 to 1994. Ms. Klein has experience in the public sector as a management analyst at the U.S. Veterans Administration from 1983 to 1986 and a senior budget analyst at the U.S. Department of Health and Human Services from 1980 to 1983. She earned Masters of Public Administration and Social Welfare degrees from Syracuse University.	January 6, 2016	January 1, 2020
Timothy S. Martinez, DMD		

Dr. Martinez has been the associate dean for Community Partnerships and Access to Care at Western University of Health Sciences since 2009 and president of Outer Cape Dental Center since 2003. Prior to these positions he served as a program evaluator at Forsyth Institute from 2010 to 2011, the Director of Dental Medicaid for the Commonwealth of Massachusetts, Executive Office of Health and Human Services from 2006 to 2009, and as a dental consultant at the Office of Public Protection, Board of Registration in Dentistry, Massachusetts Department of Public Health from 2005 to 2009. Dr. Martinez owned Mid-Cape Dental Center from 2000 to 2005, and served as the dental director at various clinics since 1994. He earned a Doctor of Dental Surgery degree from the Harvard School of Dental Medicine.	January 21, 2014	January 1, 2018
Garry Shay Mr. Shay has been an attorney specializing in workers' compensation law for nearly 40 years, and is currently an associate at the firm Mullen & Filippi. He previously served as a Judge Pro Tem and as member of the West Hollywood Transportation Commission. Mr. Shay graduated cum laude from the California Polytechnic University at Pomona and Southwestern University School of Law.	April 5, 2013	January 1, 2018
Evangeline Ward, RDH Ms. Ward has been a dental hygienist in private practice since 2009. Prior to this she was a probation counselor for the Contra Costa and Fresno County Probation Departments.	January 15, 2014	January 1, 2018

General statutes require the DHCC to meet at least three times per year, once in northern and once in southern California.[7] DHCC has met this mandate by meeting biannually both in northern and southern California and via teleconference since its last Sunset Review in 2014.

DHCC is vested with the independent authority to implement and enforce the provisions of law pertaining to the RDH, RDHAP, and RDHEF professions, including adopting, amending, and revoking rules and regulations related to the practice of dental hygiene. However, responsibility for hygienists' scope of practice is complicated; DHCC is required to make recommendations to the DBC regarding dental hygiene scope of practice issues, which DBC is then mandated to approved, modify, or reject within 90 days.[8] The value and impact of this consultative relationship is unclear and will be discussed more fully later in this report.

[7] BPC 101.7(a): "Notwithstanding any other provision of law, boards shall meet at least three times each calendar year. Boards shall meet at least once each calendar year in northern California and once each calendar year in southern California in order to facilitate participation by the public and its licensees." However, DHCC's enabling statutes have different requirements: "The committee shall meet as least two times each calendar year and shall conduct additional meetings in appropriate locations that are necessary to transact its business." (BPC 1904). It is the Committee's intent to revise the general statute to require meetings a minimum of twice per year for consistency.

[8] BPC 1905 (a)(8), 1905.2

Standing and Advisory Committees

DHCC has four subcommittees, staffed by three to four members appointed by the DHCC President, which review, discuss, deliberate, receive public comment, and vote on issues pertaining to hygiene practice. Each subcommittee brings recommendation(s) to the full Committee consisting of all DHCC members to discuss and take possible action.

The subcommittees and functions are as follows:

- Education Subcommittee – oversees the dental hygiene educational programs and makes recommendations to the DHCC on policy matters related to curriculum, faculty, administration, and approval. The subcommittee's oversight includes enforcing dental hygiene program standards to increase consistency, safety, and quality. This subcommittee may also aid in the development of informational publications and plan outreach events for consumers, applicants, and licensees.

- Enforcement Subcommittee -- advises the DHCC on matters pertaining to the enforcement of its statutes and regulations, which includes maintaining the disciplinary guidelines.

- Legislative and Regulatory Subcommittee – advocates for legislation to amend statutes, promulgates regulations, and adopts policies and procedures that strengthen and support the DHCCs mandate, mission, and vision. This subcommittee also reviews and tracks legislation and makes recommendations to the DHCC for position statements.

- Licensing and Examination Subcommittee – advises 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 to protect consumers while allowing reasonable access to the profession.

Fiscal and Fund Analysis

The DHCC is a self-supporting, special fund agency that obtains its revenues from fees, which in turn support the licensing, examination, enforcement, and administration programs of DHCC.

The DHCC's fund is projected to remain solvent through FY 2019/20 and has a current fund reserve of $1.48 million, which is equivalent to about 8.3 months of operations.[9]

DHCC anticipates raising fees in the next two years.[10] Its last fee increase was in 2014, which was projected to maintain fund solvency for five years, which has now stretched to six. Revenue is primarily generated by the biennial license renewal and delinquent renewal fees for RDHs, RDHAPs, and RDHEFs.

Factors necessitating a fee increase include additional expenses related to overseeing approved dental hygiene educational programs in California and the need for additional staff to address existing and future workloads.

[9] This is well within the statutory mandate of 24 months, per BPC 128.5

[10] Most of DHCC's fees are well under the statutory limits and may be increased by regulation.

Staffing

DHCC's EO is responsible for managing nine staff and a personnel budget of $484,000. The main challenge for the DHCC has been to acquire authorization for additional positions to address current workloads.

DHCC, in tandem with the Commission on Dental Accreditation (CODA) of the American Dental Association, is responsible for approving and overseeing RDH, RDHAP, and RDHEF educational programs.[11] New hygiene programs are required to submit a feasibility study to DHCC and pass a site visit.[12] Continuing approval for such programs requires a DHCC educational specialist to review a program's self-study document, faculty qualifications, and conduct a site visit at the time the program reaffirms CODA accreditation, which occurs every seven years.[13] DHCC will also visit programs sooner in response to a complaint, if warranted. To date, complaints have been filed against six of 27 hygiene programs, and two were found by DHCC to be severely deficient of the law. Unfortunately, there is only one staff available and dedicated to these efforts.

DHCC requested additional staff for this and other program areas in FY 2017/18 and 2018/19, but requests have been denied by either the DCA or the Business, Consumer Services, and Housing Agency, even though DHCC demonstrated its ability to fund these positions. The DCA recommended that DHCC gather additional data to help support the next position requests, but DHCC claims that its staff does not have the capacity to handle their existing assignments, let alone gather additional data. To exacerbate this problem, DHCC is facing imminent staff retirements, and it would be helpful to hire staff who could be trained by seasoned personnel prior to their departure. However, while DCA purports to be engaged in succession planning, DHCC has not yet seen tangible assistance.

Licensing

DHCC issues licenses for RDH, RDHAP, and RDHEF:

- A RDH is a dental professional who is authorized to perform all duties assigned to dental assistants (DAs) and RDAs, plus those additionally enumerated in statute and regulation, under the supervision of a licensed dentist.

[11] Although DHCC requires much of the same information as CODA, which also visits schools to ensure compliance, DHCC does not believe consumers are adequately protected by relying on accreditation alone. DHCC recently investigated complaints against a program which had recently reaffirmed its accreditation and found problems with infection control, faculty/program director qualifications; student entrance/reentry standards, and student to faculty ratios.

[12] 16 CCR 1104, 1104.1

[13] "The self-study is the principal component of the process by which the Commission on Dental Accreditation carries out its program of accrediting dental and dental-related education programs. The self-study is intended to involve all the communities within the institution in an internal examination of the ways in which the institution and its programs meet its own stated purposes and the accreditation standards approved by the Commission. The United States Department of Education (USDE) requires the use of an institutional or programmatic self-study as a part of the accreditation process. … The self-study should evaluate the outcomes of the educational process in relation to the institution's goals and the Commission on Dental Accreditation's standards for dental education programs." From the Commission on Dental Accreditation's Self Study Guide for Dental Education Programs, 2018.

- A RDHAP may perform all the functions of a DA, RDA, and RDH under general supervision, and certain RDH duties independently, if prescribed by a dentist or physician and under other qualifying conditions.

- A RDHEF may perform all the functions of a DA, RDA, and RDH under general supervision, and other procedures specified in regulation under the direct supervision of a dentist.

Licensee Population					
		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
	Delinquent	2,326	2,602	2,700	2,940
Registered Dental Hygienist in Alternative Practice (RDHAP)	Active	496	540	562	543
	Delinquent	18	19	28	52
Registered Dental Hygienist in Extended Functions (RDHEF)	Active	31	29	29	25
	Delinquent	1	3	3	4

DHCC issues approximately 800 licenses and completes between 8,500-9,000 renewals per year.

DHCC also approves educational programs for each of these license types; there are currently 27 approved dental hygiene educational programs.

To qualify for licensure as an RDH, a candidate must meet the following requirements:

1) Completion of a DHCC-approved and CODA-accredited RDH educational program conducted by a degree-granting, postsecondary institution.
2) 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.
3) Satisfactory completion of the National Dental Hygiene Board Examination.
4) Satisfactory completion of the examination in California law and ethics.
5) Submission of a completed application form and all fees required by the committee.
6) Satisfactory completion of committee-approved instruction in gingival soft tissue curettage, nitrous oxide-oxygen analgesia, and local anesthesia.[14]

An individual with out-of-state RDH credentials may license in California by providing proof of his or her education and experience, as specified by law.[15]

An RDH may become an RDHEF by completing additional clinical training and passing an exam. An RDH may become an RDHAP after he or she has practiced as an RDH for over 2,000 hours, completed a bachelor's degree, and taken an additional 150 hours of educational requirements.

DHCC is well within its performance targets for issuing licenses. Its goal is 120 days, and it is currently processing licensing applications within 30 business days. Applications with deficiencies are even within the timeframe, taking an average of 58 days.

[14] BPC 1917
[15] BPC 1917.1

90-95% of DHCC's licensee population is currently fingerprinted; the remaining individuals have either an inactive license status or reside out of state. Anyone wishing to return to practice in California will be required to submit fingerprints.

Educational programs that meet the statutory and regulatory requirements set by the DHCC, which includes CODA accreditation, may be granted approval. 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 DHCC approval prior to seeking CODA accreditation. Each program must also be a college or institution of higher education accredited by a regional agency recognized by the United States Department of Education. Current regulations stipulate that dental hygiene educational programs be equivalent to two academic years and not less than 1,600 hours, and must lead to an associate or higher degree.

Continuing Education (CE) and Continuing Education Provider (CEP) Requirements.

RDHs and RDHEFs must complete 25 hours of CE every two years, and RDHAPs must complete 35.[16] In addition to generally specified course requirements, the following must be completed every two years:

- Two hours of Infection Control specific to California regulations.
- Two units of education in the California Dental Practice Act (in which dental hygiene is included) and its related regulations.
- A maximum of four hours of a course in Basic Life Support.

Licensees indicate on the license renewal application the number of CE hours completed to affirm completion of their CE requirement. Although the DHCC plans to continuously audit up to 10% of its licensees' CE participation annually, it currently does not have the staff to do so, and audits CEs only in conjunction with enforcement or educational program review (i.e., review of educational requirements and qualifications for faculty at dental hygiene educational programs). DHCC has conducted 47 CE audits in the past four years in this manner, finding failure of 10 licensees to complete these requirements, or 21% of the total sample. Were this figure to be consistent across the entire licensee population, it would be an alarming rate of noncompliance.

DHCC has the authority to approve CE courses and providers, but it does not have enough staff or resources to do so. It currently relies on DBC-approved providers to offer CEs acceptable to the DHCC.[17] DHCC reports that once it is able to hire additional staff, it plans to promulgate regulations to clarify and strengthen its CE and CEP approval policies.

[16] 16 CCR 1017
[17] 16 CCR 1016

Enforcement

The DHCC's highest priority is the protection of the public and is committed to investigating and resolving complaints as quickly as possible. Impressively, the DHCC is largely meeting its enforcement targets.[18]

In the last two years, the DHCC has seen a 22% increase in the number of investigations first assigned and a slight increase (5%) in the number of closed investigations. DHCC has also seen an increase in the number of new probationers, which is the result of the DHCC exercising its statutory authority to issue initial probationary licenses to applicants who are not qualified for a non-restrictive license due to a criminal background.[19]

In the last four years, the DHCC received 10 reports of unlicensed activity annually. Nine of these allegations involved licensees who were practicing with an expired license. Such 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 the specific details of the case. Other examples of DHCC's use of cite and fine include:

- 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
- Failing a CE audit.
  - **Cost Recovery**
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  - DHCC is authorized to seek cost recovery and typically requests it at the onset of administrative cases. DHCC also lists reimbursement of costs as a standard term of probation. In the last four years, the DHCC has ordered cost recovery in approximately 5 cases per year, which has resulted in an average collection of $5,750.
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  - The recovered amount could be higher if DHCC used the Franchise Tax Board to collect outstanding fines; DHCC currently does not do so, but plans to start.
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Cost Recovery (dollars in thousands)

	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.

[18] The only outlying disciplinary figures are for formal disciple cycle times during FY 2015/16. The EO identified the delay as resulting from a personnel matter; this issue has since been resolved.
[19] BPC 1932

Workforce Development

Current data from the Office of Statewide Health Planning and Development indicates there is no shortage of dental hygienists in California, although there continues to be a mal-distribution of these professionals due to practice limitations. The DHCC indicates that it continuously monitors workforce reports.

The primary reasons impeding the full utilization of dental hygienists are restrictive supervision requirements, scope of practice limitations, and the inability for dental hygiene practitioners to obtain direct-payment for their services. The DHCC is seeking legislation to remove certain direct supervision restrictions and is investigating the expansion of dental hygienists' ability to provide fluoride varnish without supervision.

The DHCC is also exploring using the portfolio concept, similar to the requirement for dentists, to demonstrate professional competency for dental hygienists prior to licensure in addition to, or instead of, satisfactory completion of a practical examination.

(For more detailed information regarding the responsibilities, operation and functions of DHCC, please refer to the *2017/18 DHCC Sunset Review Report*. This report is available on DHCC's website, http://www.dhcc.ca.gov/formspubs/sunset_2018.pdf)

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

DHCC was last reviewed by the Legislature through sunset review in 2013-14. During the previous sunset review, 7 issues were raised. In November 2017, DHCC submitted its required sunset report to the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions (Committees). In this report, DHCC described actions it has taken since its prior review to address the recommendations made. The following are some of the more important programmatic and operational changes, enhancements, and other policy decisions or regulatory changes. For those which were not addressed and which may still be of concern to the Committees, they are addressed and more fully discussed under "Current Sunset Review Issues."

- The DHCC's original Executive Officer (EO) retired in December 31, 2016. At its November 17 – 18, 2017 DHCC meeting, the DHCC conducted interviews and selected the interim executive officer, Anthony Lum, to fill the EO position.

- The Education/Outreach Subcommittee was renamed the Education Subcommittee to better highlight its primary focus, although outreach activities remain a responsibility.

- The DHCC's office was relocated to a larger suite in the same building. Unfortunately, this move is temporary, and DHCC may seek a new office location or expansion of the existing office space in the future.

- The DHCC created and adopted a new 5-year Strategic Plan in 2016 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 following regulatory changes were approved by the DHCC:

    - RDH Educational Programs (operative 10/1/2016) –provides the authority required to properly oversee and review the state's dental hygiene educational programs.

    - Remedial Education (operative 2/18/2016) – 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 following a single incidence of imposing gross trauma on a patient.

    - Definitions (operative 4/20/16) –provides additional clarity and meaning to frequently used dental hygiene terms.

    - SLN Course Approval (operative 8/4/2014) – 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) –provides additional clarity for written examination issues.

- Infection Control Standards (operative 10/1/2016) – references current infection control standards.

- Uniform Standards Related to Substance Abuse and Disciplinary Guidelines (operative 1/16/2014) – the policies and standards used when addressing licensees who have deviated from the standard of care, been found guilty of unprofessional conduct, or have issues with substance use and alcohol.

- The following regulations are pending:

    - 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.

    - Interim Therapeutic Restorations – 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 certain requirements to wear a name badge showing that they cannot perform certain functions. 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.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the DHCC or areas of concern that should be considered, along with background information for each issue. There are also recommendations Committee staff have made regarding particular issues or problem areas DHCC needs to address. DHCC and other interested parties have been provided with this Background Paper and DHCC will respond to the issues presented and the recommendations of staff.

DHCC ADMINISTRATION

ISSUE #1: DHCC is completely comprised of Gubernatorial appointees.

Background: The DHCC currently functions as an independent entity, but grew out of COMDA, which was a dependent committee within the DBC. In that structure, full gubernatorial appointment authority for DHCC was immaterial, since the DBC's parent body had public appointments by the Legislature, ensuring ultimate input into both entities.

Staff Recommendation: ***The Committees may wish to amend BPC § 1903 to designate appointing authority for two of the public members to the Legislature, similar to that of other healing arts boards.***

ISSUE #2: DHCC is struggling to meet statutory mandates because of staffing shortages.

Background: DHCC indicates that it needs additional staff in the following areas:

- Continuing Education (CE): Staff is needed to audit licensees for CE compliance and to review CE providers.
- Licensing: Staff is needed to process applications for new and renewal licenses for RDH, RDHAPs, and RDHEFs.
- Enforcement: Additional staff is needed in enforcement, as the number of cases has increased by 147% over the past four years.
- Educational programs: Additional staff is needed to review dental hygiene educational programs to ensure they have appropriate faculty, infection control procedures, administrative functions, grading systems, and other aspects in compliance with the DHCC law and CODA standards.

DHCC will also need increased office space to accommodate these staff.

Staff Recommendation: ***DHCC should work with DCA to determine appropriate staffing levels in each division, ensure its budget can support additional staff, and develop and submit necessary BCPs. DHCC should report to the Legislature on the result of these efforts.***

ISSUE #3: There may be more effective means to test clinical skills than the traditional hygiene clinical exam.

Background: DHCC reports that the clinical exam has been the backbone of hygiene assessment and qualification for initial licensure for decades. While 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.

DHCC requests statutory authority to implement any of these alternative pathways.

Staff Recommendation: ***The DHCC should explore these alternative testing platforms and investigate their advantages and disadvantages. It would be helpful for DHCC to present these results to the Committees in order to determine whether statutory changes are appropriate and necessary at this time.***

ISSUE #4: DHCC wants to be renamed as an independent board under the DCA and sever its remaining ties to DBC.

Background: The DHCC indicates that it has functioned as an independent entity since its inception in 2009, handling its own licensure, enforcement, and budget authority. While this is true, there are some vestiges of its connection to DBC in statute: DHCC is technically under the jurisdiction of DBC, and it is required to consult with DBC on matters related to dental hygiene scope of practice issues.[20] It is unclear what this consultation was intended to do, however; statute requires only that DHCC make recommendations to DBC, and that DBC approve, modify, or reject such recommendations within 90 days.[21] Current law is silent as to the impact of DBC's opinion, and this matter has not yet been tested to its logical end. Further, scope of practice matters are generally decided by the Legislature, and as issues related to mid-level dental practitioner issues continue to rise, it is important that there be independent regulatory entities who can advocate equally for the distinct professions.

The issue of whether DHCC's name should be changed to the Dental Hygiene Board was explored in DHCC's prior sunset review. Staff's recommendation at the time was that, despite DHCC's stated ability to operate independently, DHCC should undergo further reviews before becoming an independent board.

DHCC has now been in existence for 8 years and completed two Sunset Review processes with no major issues. DHCC believes a name change would clarify its independence and resolve any confusion as to the autonomy of its decision making.

Staff Recommendation: ***The Committee may wish to consider whether statutes should be amended to establish DHCC as the independent Hygiene Board of California.***

[20] BPC 1901(a), 1905(a)(8)
[21] BPC 1905.2

RDHAP PRACTICE SETTINGS

ISSUE #5: According to DHCC, RDHAPs are only authorized to provide unsupervised dental hygiene services only in specified areas which create barriers to practice in other dental health care settings.

Background: During the prior Sunset Review, the DHCC identified barriers to RDHAP practice, which includes the closure of a dental practice when the area no longer meets criteria as a designated shortage area. This year, the DHCC expressed concerns that RDHAPs could not provide dental hygiene services in dental and medical offices.

A RDHAP is trained and authorized to provide unsupervised dental hygiene services in the following limited practice settings:

- Residences of the homebound
- Schools
- Residential facilities and other institutions
- Dental health professional shortage areas[22]

This means that RDHAPs may perform unsupervised services on vulnerable and challenging populations: children, individuals with limited access to healthcare (and therefore likely with more advanced oral health conditions), and patients with compromised mobility or other health concerns that impede their ability to get dental care in more traditional settings. If an RDHAP chooses to practice in more traditional settings, like a dentist office, clinic, or hospital, he or she must perform those same services under general supervision licensed as an RDH. This does not align with the statutory authority of an RDHAP to be employed by a dentist, community clinic, free clinic, surgical clinic, chronic dialysis clinic, rehabilitation clinic, alternative birth center, specialty care clinic, clinic owned and operated by a federally recognized Indian tribe or tribal organization, or various iterations of a public hospital.[23] Essentially, an RDHAP may not practice in many of the same settings as his or her employer.

Currently, an RDHAP may set up practice in a dental health professional shortage area, but once that shortage is deemed to no longer exist, the RDHAP must relocate his or her practice. AB 502 (Chau, Chapter 516, Statutes of 2015) originally contained provisions that would have allowed a RDHAP to continue practicing. This language was later removed, but not before the California Health Benefits Review Program (CHBRP) performed an independent, evidence-based analysis of the legislation.[24] It determined that the services RDHAPs provide are largely effective in improving oral health and that "The reductions in administrative barriers associated with RDHAP practice may result in increasing numbers of RDHAP licensees. Thus, the long-term effects would likely increase access to dental health services and improve dental health for patient populations in RDHAP practice settings. [25] Essentially, CHBRP stated that RDHAPs improve oral health where they practice, and if there were fewer barriers to expanded practice, more people would benefit from their care.

[22] BPC 1926
[23] BPC 1925
[24] HSC 127660
[25] CHBRP, p. iv

The Federal Trade Commission (FTC) recently commented on a similar situation in Georgia, in which the FTC was asked to comment on a bill proposing to relax supervision requirements on dental hygienists providing care in certain settings.[26]

In stating its support for the legislation, the FTC wrote, "Various authorities have concluded that direct supervision of dental hygienists is not necessary for them to provide preventive services safely. According to the National Governors Association, there is no clear evidence to support state dental boards' concerns about quality and safety, which boards sometimes raise to justify restrictions on hygienists' practicing without supervision in settings where dentists are not available. The Institute of Medicine has likewise concluded that restrictive scope of practice and supervision laws and regulations governing dental hygienists 'are often unrelated to competence, education and training, or the safety' of the services they provide. The IOM recommends that state legislatures increase access to basic oral health care by amending dental practice acts to allow allied dental professionals such as hygienists to work to the full extent of their education and training 'in a variety of settings under evidence-supported supervision levels[.]'"[27]

FTC also noted that relaxing supervision standards could improve access and improve cost-effective care, since hygienists generally cost less than dentists.

Further, any concern about any dentist involvement should be obviated by the existing requirements that a RDHAP is required to have a dentist of record with whom he or she consults, and the requirement that a RDHAP patient receive a prescription from a dentist or physician to continue receiving services after a certain period of time.[28]

Staff Recommendation: ***DHCC should examine whether it is in the best interest of public health and safety to authorize RDHAPs to practice unsupervised in any setting, which may include all settings authorized to employ an RDHAP. DHCC should include the DBC in discussions in order to determine the original intent of the restrictions.***

ISSUE #6: RDHAPs report difficulty in receiving payment from insurers based outside of California due to insurers' unfamiliarity with the title.

Background: The DHCC noted in its Sunset Review Report that RDHAPs have difficulty collecting payment for services from insurance companies based outside of California because insurers are unfamiliar with the RDHAP license. Although mid-level dental providers are expanding across the country, states call them variously RDHAPs, Dental Health Aide Therapists, or Advanced Dental Hygiene Practitioners.

As a solution, the DHCC requests to add the following language to BPC § 1928: Registered dental hygienist in alternative practice, submitting of insurance and reimbursement of providers:

[26] The Federal Trade Commission, letter to the Honorable Valencia Seay, in regards to House Bill 684, January 29, 2016, available at https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-georgia-state-senator-valencia-seay-concerning-georgia-house-bill-684/160201gadentaladvocacy.pdf
[27] Ibid.
[28] BPC 1930, 1931

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

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

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

Staff Recommendation: ***The DHCC should provide the Committees with information and justification that this proposed language is sufficient to resolve reimbursement issues. The Committees may wish to amend the Act to ensure that necessary clarifications are made in order to better allow RDHAPs to receive the payment for services they provide.***

ISSUE #7: RDHAPs are required to receive a prescription from a dentist or physician prior to providing prolonged patient treatment.

Background: A RDHAP can provide hygiene services to a patient for up to 18 months before state law requires the patient to present a prescription for dental hygiene treatment from either a physician or dentist. A prescription may be for up to two years of dental hygiene services.

DHCC's Sunset Report states that 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."

It is unclear whether it is difficult for RDHAPs to obtain a prescription because the patient cannot find or afford a diagnosis and prescription from a dentist or physician, or merely it is inconvenient. A prescription itself does not necessarily imply ongoing care by a physician or dentist, merely that the physician or dentist has examined the individual and determined that hygiene care is appropriate going forward.

Staff Recommendation: ***The DHCC should survey RDHAPs, as well as consulting physicians and dentists, to evaluate the utility of prescriptions for ongoing care. DHCC should also consider whether referral language should clarify that a prescription does not legally bind a dentist or physician and surgeon to oversight. It would be helpful for the Committees to understand the average amount of time RDHAPs treat patients and how often a prescription is required of patients.***

RDH PRACTICE SETTINGS

ISSUE #8: According to DHCC, a RDH can only perform dental hygiene preventive services in public health settings.

Background: Existing law states that a RDH may provide, in any setting, educational services, oral health training programs, and oral health screenings without supervision.[29] All other procedures must be performed under either general supervision or direct supervision, which requires a dentist's physical presence.[30]

However, a RDH may provide dental hygiene preventive services including, but not limited to, the application of fluorides and pit and fissure sealants without any supervision if doing so in any public health program created by federal, state, or local law, or administered by a federal, state, county, or local government entity.[31]

The DHCC believes that "foundations and other non-profit charity entities have need of the services that dental hygienists provide. Amending [current law] …would allow these other public health or community organizations to utilize the services of the dental hygienist without the supervision of a dentist."[32] There does not appear to be any evidence that public settings have greater support services for an RDH, that patients tend to be lower-risk, or that RDHs have been shown professionally incapable of unsupervised preventive practices in other settings.

Staff Recommendation: ***The DHCC should engage stakeholder groups to explore whether it would be in the best interest of public health and safety to expand the unsupervised hygiene practices of an RDH. DHCC should determine what specifically about public health programs make them ideal settings for the current practice restrictions.***

ENFORCEMENT

ISSUE #9: DHCC does not have the authority to place dental hygiene educational programs on probation or have the ability to cite and fine programs in violation of law.

Background: DHCC only has binary statutory authority to approve or withdraw approval from a dental hygiene program in violation of the law. DHCC reports that this is too severe for those programs with only minor violations and those working towards compliance.

Allowing the DHCC to place programs on probation and establish a time frame for coming into compliance will give programs the opportunity and flexibility to correct deficiencies prior to approval, and authorizing cite and fine will both compensate the DHCC for its enforcement expenses and penalize programs out of compliance.

Staff Recommendation: ***The Committees may wish to authorize DHCC to place dental hygiene programs on probation and issue citations and fines for minor violations.***

[29] BPC 1911(a)
[30] BPC 1902(d)
[31] BPC 1911(c)
[32] DHCC 2017/2018 Sunset Review Report, p. 63.

ISSUE #10: DHCC does not use its authority to support a diversion program.

Background: The DHCC has the statutory authority to provide a Diversion Program to its licensees with substance use issues. While the DHCC is sensitive to the possibility that its licensees may need recovery assistance, the DHCC does not want to be in a position to fund and oversee these efforts. No participants, voluntary or otherwise, have presented themselves since 2014.

Staff Recommendation: ***The Committees may wish to remove the requirement for DHCC to establish a diversion program.***

ISSUE #11: DHCC could help spread awareness about screening for domestic abuse.

Background: Initiatives across the country are enlisting healthcare practitioners to identify and assist victims of domestic abuse. As reported in the online news source *STATnews*, one program called P.A.N.D.A., short for "prevent abuse and neglect through dental awareness" has created a course to train dentists and hygienists in detecting abuse and neglect.

The article reports that an estimated 70 percent of injuries from abuse are on the head and neck, which puts hygienists in an ideal position to spot victims. One survey of domestic abuse victims found that over half had visited a dentist when signs of abuse were present, but nearly 90 percent of those individuals weren't asked about their injuries. The majority said they wished their dentist had asked.[33]

The article continues, "Although bruises and other evidence of physical trauma are most obvious, other signs are more subtle -- victims might miss an appointment, or be late. They might be particularly jumpy in the dentist's chair. Sometimes, a perpetrator won't leave a victim's side during the appointment.

'They present with a lot of anxiety, and they don't like anything going into their mouths,' said Dr. Kanchan Ganda, a physician who teaches at the dental school at Tufts and who started the school's Dental Outreach to Survivors program."

Hygienists typically spend more time with patients than dentists, and could use this opportunity to assist a patient's total wellbeing.

This idea has precedence with AB 326 (Salas, Chapter 312, Statutes of 2017), which authorized the Board of Barbering and Cosmetology (BBC) to promote awareness of physical and sexual abuse. This bill also authorized the BBC Health and Safety Advisory Committee to provide advice and recommendations on how to ensure licensees have awareness about physical and sexual abuse their clients may be experiencing.

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[33] Megan Thielking, "Dentists are pushed to screen patients for domestic abuse — and offer help." STAT news, May 31, 2017. Available at https://www.statnews.com/2017/05/31/domestic-abuse-dentists/

Staff Recommendation: ***DHCC should include information about this and similar programs in its newsletter to licensees.***

ISSUE #12: Dental Hygiene practice act updates

Background: DHCC has submitted the following requests to the Committee for practice updates:

- Establish a five-year limitation on the window available to submit for licensure after taking the clinical examination.
- Establish fees commensurate with DHCC's expenses to conduct site visits to educational programs.
- Establish a retired fee.
- Allow an out-of-state applicant or licensee residing out of state to submit hard copy fingerprints if LiveScan is unavailable.
- Add DHCC to the list of DCA programs that require fingerprinting.
- Add DHCC to the list of DCA program funds.

Staff Recommendation: ***The Committees may wish to amend the Act according to DHCC's suggestions.***

CONTINUED REGULATION OF THE HYGIENE PROFESSION BY THE DHCC

ISSUE #13. (CONTINUED REGULATION BY THE DHCC) Should the licensing and regulation of the hygiene profession be continued and be regulated by the current DHCC membership?

Background: Patients and the public are best protected by strong regulatory boards with oversight of licensed professions. DHCC has proven to be a competent steward of the hygienist profession DHCC should be continued with a four-year extension of its sunset date so that the Committees may review once again if the issues and recommendations in this Background Paper and others of the Committees have been addressed.

Staff Recommendation: ***The licensing and regulation of the dental hygiene profession should continue to be regulated by the current members of the DHCC. DHCC should be reviewed again in four years.***